

PD-ABH-037
84996

HIV/AIDS PREVENTION

PROJECT

ZAMBIA

611-0221

(PP)

SEPTEMBER 1992

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A

A = Add
C = Change
D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY

ZAMBIA

3. PROJECT NUMBER

611-0221

4. BUREAU/OFFICE

AFRICA

06

5. PROJECT TITLE (maximum 40 characters)

HIV/AIDS PREVENTION PROJECT

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
019 | 31 | 09 | 7

7. ESTIMATED DATE OF OBLIGATION
(Under "B:" below, enter 1, 2, 3, or 4)

A. Initial FY 09 | 2

B. Quarter 4

C. Final FY 09 | 7

8. COSTS (\$000 OR EQUIVALENT \$) =

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	4,100	1,400	5,500	14,600	5,100	19,700
(Grant)	(4,100)	(1,400)	(5,500)	(14,600)	(5,100)	(19,700)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
Other U.S. 2.						
Host Country						
Other Donor(s)						
TOTALS	4,100	1,400	5,500	14,600	5,100	19,700

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	510	563				2,150		16,350	
(2) DA	510	563				3,350		3,350	
(3)									
(4)									
TOTALS						5,500		19,700	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

510

520

549

563

550

11. SECONDARY PURPOSE CODE

530

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

BU

BR

DEL

PVON

TNG

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To reduce the incidence of HIV transmission in target populations.

14. SCHEDULED EVALUATIONS

Interim MM YY : MM YY Final MM YY
0 | 3 | 9 | 3 | 0 | 3 | 9 | 4 | 0 | 3 | 9 | 7

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000

941

Local

Other (Specify)

935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment)

17. APPROVED BY

Signature

Title

FRED E. WINCH
DIRECTOR

Date Signed

MM DD YY
0 | 9 | 2 | 8 | 9 | 2

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS. DATE OF DISTRIBUTION

MM DD YY
0 | 5 | 2 | 9 | 3

ACTION MEMORANDUM FOR THE DIRECTOR

September 28, 1992

THROUGH: Bruno Kosheleff, Deputy Director *BK*
FROM: John Wiebler *Wiebler* Program Officer
SUBJECT: HIV/AIDS Prevention Project (611-0221); Request
for Approval of HIV/AIDS Prevention Project
Description and the Project Authorization

Problem: Your approval is requested for a grant of \$19,700,000 from the "Sub-Saharan Africa, Development Assistance" appropriation to Zambia for the HIV/AIDS Prevention Project. It is planned that a total of \$5,500,000 will be obligated in FY 1992.

Background: The Government of the Republic of Zambia ("GRZ") officially recognized AIDS as a public health problem in Zambia in 1986. Today the epidemic poses a health threat of almost unimaginable proportions. HIV sero-prevalence in Zambia is among the highest in the world. The GRZ established a Sentinel Surveillance System in 1990 to monitor trends of HIV infection among the population. Although epidemiologic data concerning HIV/AIDS are not comprehensive and, are at times, conflicting, the sentinel surveys conducted in 1990 reflect an HIV-positive rate of over 25 percent among urban/peri-urban ante-natal clinic attendees.

Some experts estimate HIV seropositivity at numbers that range from 200,000 to 400,000 among the general population. Because there is no cure for the disease, the HIV seropositives will convert to symptomatic AIDS and die. The two groups most likely to be decimated will be those under five years old and adults aged 35 to 49; the latter group represents the productive work force and the effects are likely to be economically devastating.

The GRZ is committed to addressing the epidemic. In January 1988, the Ministry of Health ("MOH"), working closely with the World Health Organization - Global Program on AIDS (WHO/GPA), developed a Medium Term Plan (MTP) for the prevention and control of AIDS for the period 1988 - 1992. The GRZ initiated a National AIDS Prevention and Control Programme (NAPCP) to carry out the activities proposed in the MTP.

Under NAPCP, the MOH established and staffed a Program Management Unit and an AIDS Secretariat. The NAPCP program is comprehensive. It attempts to: maintain low-risk behavior or modify behavior of the general population, improve the quality of life of those infected, monitor trends of the epidemic and its impact on development, prevent the transmission through blood and

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blood products, and improve case management of HIV-infected individuals.

The GRZ recognizes the AIDS epidemic, has done an excellent job of designing a program for prevention, monitoring, and care of HIV/AIDS related diseases, and has a progressive national health strategy with the objective of a financially sound program of health for all. Unfortunately, the GRZ health sector is underfunded and in many instances short of the experienced technical skills required to implement the necessary programs. The HIV/AIDS Prevention Project proposes to address the problem of underfunding of the GRZ's AIDS prevention activities, and provide it with technical expertise as needed.

Discussion:

1. Project Design: The purpose of the Project is to reduce the incidence of HIV transmission in target populations. It will do so by providing technical assistance, training, and commodities to and through the Ministry of Health and various non-governmental organizations (NGOs). The Project will achieve the Project purpose with activities in five components: Public Health Education, Voluntary Testing and Counseling, Condom Social Marketing, STD Control, and Policy and Small Grants Fund.

Public Health Education will support programs to provide AIDS/STD prevention education, HIV counseling, and condoms through selected workplaces, traditional healers, and NGOs working with youths. It will also increase the media awareness of and standards for reporting on AIDS. Condom Social Marketing will establish distribution of condoms in a minimum of 3,000 retail outlets, STD clinics, selected workplaces, and NGO programs for youths. The STD Control Program will provide HIV/AIDS risk reduction counseling, testing, and medications. Policy and Small Grants will produce policy papers and update politicians on the state of the epidemic and the options before them. A Small Grants Fund will accommodate NGOs and community groups involved with small HIV/AIDS prevention projects. The project will fund a rigorous sampling and testing regimen to monitor and evaluate the effectiveness of each of the Project's components.

AID/W reviewed a PID-like document for the HIV/AIDS Prevention Project, and identified two issues for Mission consideration in the preparation of the Project Paper. The Mission will comply with the first by buying American goods and services to the extent possible with Project funds. The Mission has responded to the second issue by incorporating HIV testing and surveying into the design of all Project activities.

The Project Paper for the HIV/AIDS Prevention Project is feasible on technical, economic, institutional, financial, socio-cultural, and environmental grounds.

2. **Beneficiaries:** The Public Health Education component expects to provide information on AIDS and access to condoms to 30,000 individuals. The AIDS-related education activities about sexually transmitted diseases and medications should reach 30,000. Over 36,000 Zambian's will benefit from anonymous testing and counseling. Beneficiaries will have access to affordable condoms at over 3,000 retail outlets.

The ultimate beneficiaries are, of course, those individuals who as a result of Project activities either modify their behavior or never adopt practices which put them at risk for AIDS.

3. **Waivers:** The Assistant Administrator for Africa waived the requirement under Section 110 of the Foreign Assistance Act of 1961, as amended, calling for a host country contribution of at least 25 percent of Project costs.

4. **Congressional Notification and Availability of Funds:** A Congressional Notification for the Grant was sent to Congress, and the statutory waiting period expired on June 30, 1992.

5. **Authorities:** Pursuant to Delegation of Authority No. 551 from the Assistant Administrator for Africa to the Mission Director, you may approve a five year grant to support HIV/AIDS prevention activities in an amount not to exceed \$19,700,000.

Recommendations: That you approve the HIV/AIDS Prevention Project by approving this Action Memorandum and the Project Paper Face Sheet, and that you authorize the Grant by signing the attached Project Authorization.

Approve:



Disapprove:

Date:

September 28, 1992

Attachments: Project Paper
Project Authorization



ACTION MEMORANDUM FOR THE DIRECTOR

September 28, 1992

Drafted: PDO: DStraley DS

Clearance: CONT: MGweshe MG 09/28/92
RLA: TFillinger TF 09/28/92

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PROJECT AUTHORIZATION

Country: Zambia
Project Title: HIV/AIDS Prevention Project
Project Number: 611-0221

1. Pursuant to Delegation of Authority 551 (revised), I hereby authorize the HIV/AIDS Prevention Project (the "Project") involving planned obligations of not to exceed Nineteen Million Seven Hundred Thousand United States Dollars (\$19,700,000) in grant funds (the "Grant") over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is five years from the date of initial obligation.
2. The Project will assist the Government of the Republic of Zambia (the "GRZ") to reduce the incidence of HIV transmission in target populations. The Project will do so by supporting public health education, making condoms more readily available, offering HIV-testing and counseling, and improving the delivery of sexually transmitted diseases (STD) services. The Project will provide technical assistance, training, commodities, and local support to the GRZ and selected Non-Governmental Organizations. The GRZ's Ministry of Health will be the host country counterpart organization and coordinator.
3. The Project Agreement shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Commodities, Nationality of Suppliers of Services

Except as A.I.D. may otherwise agree in writing:

Commodities financed by A.I.D. under the Project shall have their source and origin in countries included in A.I.D. Geographic Code 935. Except for ocean shipping, the suppliers of commodities or services shall have countries included in A.I.D. Geographic Code 935 as their place of nationality. Ocean shipping financed by A.I.D. under the Project shall be financed only on flag vessels of countries included in A.I.D. Geographic Code 935, subject to the requirements of Section C.6(c) of the Project Grant Standard Provisions Annex of the Project Agreement with respect to cargo preference. Air travel and transport to and from the U.S. shall be upon certified U.S. flag carriers to the extent possible.

b. Condition Precedent

Prior to the first disbursement under the Project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., the name and title of the individual at the Ministry of Health who has been appointed as an authorized representative for the Project.

c. Covenants

The Government of the Republic of Zambia shall covenant that, unless A.I.D. otherwise agrees in writing, it will:

- (1) provide appropriate office space, equipment, supplies and support personnel required for the effective operation of the HIV/AIDS Prevention Project;
- (2) establish a National Health Council to improve the coordination of Non-Governmental Organization and donor health care activities in Zambia; and
- (3) draft a health care financing plan that recommends sustainable funding sources in Zambia which might pay for an adequate level of care for Zambians.

d. Waivers

The Assistant Administrator for Africa waived the requirement under Section 110 of the Foreign Assistance Act of 1961, as amended, pertaining to a host country contribution of at least twenty-five percent of project costs.



Fred E. Winch
Mission Director

Date: 28 Sept '92

Drafted: PDO: DStraley 12/2

Clearance: CONT: MGweshe draft 09/28/92
PRO: JWiebler draft 09/28/92
ADIR: BKosheleff draft 09/28/92
RLA: TFillinger draft 09/28/92

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Bulk Annex

Social Marketing for HIV Prevention in Zambia: PSI

I. SUMMARY AND RECOMMENDATIONS

A. Program Summary

USAID/Lusaka proposes to grant \$19,700,000 in project assistance to the Government of the Republic of Zambia (GRZ) for the HIV/AIDS Prevention Project. The Project will have a five year life. Even though the GRZ will contribute personnel and office space to the Project, the Mission and the GRZ will not be required to account for this contribution. The GRZ has received a Section 110 waiver of a mandatory 25 percent of total Project cost counterpart contribution. A.I.D. will obligate \$5,500,000 in Fiscal Year 1992.

The purpose of this Project is to reduce the incidence of HIV transmission in target populations. It will do so by providing technical assistance, training, and commodities to and through the Ministry of Health, various non-governmental organizations (NGO) and other organizations. The Project will achieve the Project Purpose with activities in five components: Public Health Education, Voluntary Testing and Counseling, Condom Social Marketing, STD Control, and Policy and Institutional Strengthening.

Public Health Education will support programs to provide AIDS/STD prevention education, HIV counseling, and condoms through selected workplaces, traditional healers, and NGOs working with youths. It will also increase the media awareness of and standards for reporting on HIV/AIDS. Condom Social Marketing will establish distribution of condoms in a minimum of 3,000 retail outlets, STD clinics, selected workplaces, and NGO programs for youths. The STD Control Program will provide HIV/AIDS risk reduction counseling, testing, and medications. Policy and Institutional Strengthening will produce policy papers and update politicians on the state of the epidemic and the options before them. The project will fund a rigorous sampling and testing regimen to monitor and evaluate the effectiveness of each of the Project's components. It is expected that by the End of the Project, the GRZ will have reduced the incidence in specifically identified and targeted¹ high-risk populations by 15 percent, and by 30 percent in low-risk populations.

¹ Targeted for the purposes of this Project refers to direct Project beneficiaries. For instance, employees at the workplaces selected for Project activities are a targeted population. Project evaluators will classify proportions of a selected population as high risk and low risk. High risk population for this Project does not refer to commercial sex workers.

B. Program Issues

AID/W reviewed a PID like document for the AIDS Prevention Project, and identified several issues for Mission consideration in the preparation of the Project Paper (PP). A summary of the issues and their resolution is:

1. Buy America: Although specific waivers are not required for vehicles procured with DFA funds, Mission should fully justify reasons for non-U.S. procurement. If non-U.S. procurement of pharmaceuticals is contemplated, a compelling reason and strong justification is necessary.

Response: The Project will procure U.S. vehicles and U.S. pharmaceuticals. Since a U.S. manufacturer will begin selling a right-hand drive vehicle in the near future, the Mission will procure from this source.

2. Counseling and testing: Counseling and testing may have a limited prevention impact; that is, there is no evidence that counseling and testing have resulted in safer behavior. If the Project includes a testing and counseling component, the Mission should establish a comprehensive evaluation plan for monitoring the components impact.

Response: The Mission does not agree with the statement that there is no evidence that counseling and testing have resulted in safer behavior. Mission understands that results are mixed. Most of the research on this subject has been completed in industrialized countries, and in this research, some of studies have provided convincing evidence that knowledge of one's HIV status does impact on one's behavior. Nevertheless, the Mission has made a comprehensive system of HIV testing and evaluation an integral part of the Project design.

C. Recommendations

The proposed Project fully supports the Mission's objective of a socially stable, economically productive population. Slowing the rate of transmission of HIV will help to keep a generation of Zambians alive during the years they are most capable of contributing to the nation's social and economic development.

The Project has been designed to be technically, financially, socially, and economically sound. Therefore, it is recommended that the USAID/Zambia Mission Director authorize the Project Paper.

II. BACKGROUND AND PROJECT RATIONALE

A. Economic Performance and Problems

The Zambian economy has essentially been in a downward spiral since the mid 1970's. The economy's fundamental problem is rooted in its heavy dependence on a single commodity (copper) and the economic policies it followed in the past. The prior government under the United National Independence Party (UNIP) implemented import substitution policies, maintained an overvalued exchange rate, kept interest rates artificially low, and embarked on a program of nationalization of firms to the point that the GRZ controlled almost all sectors of the economy.

Rising copper prices at first concealed the distortions and allowed the economy to grow at an annual rate of four percent per annum during the first decade after independence. When copper prices began to fall, however, Zambia experienced a general deterioration in terms of trade, coupled with a failure to develop a dynamic, diversified economy. Attempts to support continued consumption through foreign and domestic borrowing failed and created an exceptionally severe debt problem. In the last years of the 1980s, the Government's response to a failing economy was to increase expenditures and borrow from the domestic banking system. This led, in turn, to monetary expansion and inflationary pressures.

The consequences of the past policies have been a per capita GDP which is now one-third of what it was in 1978 in real terms, an inflation rate which peaked in 1989 at 113 percent, and a foreign debt level of about \$900 percapita (\$7 billion) which is among the highest in the world.

In early 1992, the GRZ agreed to sweeping and dramatic Policy Framework Papers (PFP) with the IMF and the World Bank, installing effective stabilization and Structural Adjustment Programs (SAP). The PFP commits the GRZ to macroeconomic stabilization and establishment of the conditions necessary for a vital private sector.

Zambia's social and health sectors have suffered from the failed economic policies of the past. Real expenditures on health have declined steadily for the last several years, and the outlook for improvement in healthcare expenditures is dim given the tightly controlled fiscal policies the GRZ will adhere to as part of the SAP.

B. Problem Statement

The AIDS epidemic in Zambia -- HIV sero-prevalence in Zambia is among the highest in the world -- has the potential to exacerbate the country's economic problems. If the epidemic is

left unchecked, Zambia's weak economy may experience further declines in productivity, and find the scarce funding it has spent on social services and education of its youth wasted. Since the years of highest economic productivity coincide with the age groups with the highest infection rates, Zambia can expect to see a large portion of its work force succumb to the disease just as it is about to enter its most productive years. The AIDS problem has rapidly evolved from a medical anomaly into an economic threat.

Of particular importance is that in Zambia, like other African nations, the more educated, better trained and wealthier segments of society tend to have higher HIV-infection rates than the general population. This fact has important consequences for Zambia whose economic progress is already hindered by a significant shortage of trained personnel across all sectors.

The GRZ established a Sentinel Surveillance System in 1990 to monitor trends of HIV infection among the population. It operates at nine sites using unlinked, anonymous testing methods. Although the epidemiologic data concerning HIV/AIDS are not comprehensive and, at times, conflicting, the sentinel surveys conducted in 1990 reflect an HIV-positive rate of over 25 percent among urban/peri-urban ante-natal clinic attendees. They also found the HIV-positive male/female ratio to be 1.04:1, indicating that heterosexual intercourse is the most significant method of transmission.

Anecdotal reports suggest that the real infection rate may be even higher. The guidelines on AIDS diagnosis were not always available at district hospitals and health centers, and the reporting forms were not consistently used. In spite of this, by 1989, 35 percent of all consecutive hospital admissions were AIDS related. Blood donor data reflected a 22 percent HIV-positive rate among university students in Lusaka in 1990. HIV sero-prevalence rates from the rural areas have been steadily increasing and it is anticipated that in many rural areas rates will be comparable to urban rates in 2-3 years.

The GRZ has recently reported over 5,843 cases of AIDS and 18,676 AIDS-related cases greatly exceeding the 2,000 reported in July 1989, and this is thought to be widely underestimated. Indeed, some experts are now estimating HIV seropositivity at numbers that range from 200,000 to 400,000 among the general population. The vulnerability of the country's future is heightened when one considers the fact that a young population (over 50% is under 16 years of age) is seriously threatened, along with the devastating economic effects of an infected workforce.

Zambia has experienced an economic decline over the past several years and its health system, like most other

governmental services, has deteriorated as a result. An important aspect of the deterioration of the health infrastructure, in light of the HIV/AIDS crisis, is the lack of trained Zambians available for the development, implementation and supervision of HIV-related activities. Zambia has instituted economic reforms which may, over time, increase the ability of the Zambian government to provide more adequate health services to its population. However, expected economic benefits which would strengthen the government's ability to provide effective preventive and curative health services to the general population are not expected to occur within the timeframe necessary to lessen the consequences of the ongoing HIV/AIDS epidemic.

A decade ago, Zambia's annual health expenditures were comparable to those of other African countries - both on a per capita basis and as a percentage of total government spending.² While total government expenditures for health have continued to increase in the last several years, there has been a sharp decline in the real value of the expenditures due to high rates of inflation, currency devaluation, and continuing high population growth. From 1970 to 1984, total GRZ health expenditures increased from K27.2 million to K73.2 million. In 1989, government expenditures for health reached K875 million, or about 7% of the government's overall budget. But during this same period, real per capita expenditures for health declined dramatically. In the decade from 1976 to 1985, government per capita expenditures for health declined by 57% in real terms - with per capita expenditures for capital projects declining by over 90%. In 1989, total government expenditures for health were about \$4 per capita.

The continuing erosion of financial support for health services has been reflected in a decline in expenditures for drugs, transport and maintenance with an increased proportion of spending being directed toward personnel costs, increasing from 39% in 1981 to as high as 61% in 1987.³ From 1981 to 1985, the number of doctors in government employment declined by 37%, with current vacancies estimated at 40% (340/850) of the authorized positions. The ratio of physicians to population dropped from 13 to 7:100,000 by 1986. The most critical shortages are in various medical specialties. Many doctors have left government service for more lucrative positions overseas. Currently there are 245 private clinics in Zambia, 114 of which are located within industry, excluding the mines. To complicate matters, Zambia has become increasingly dependent on expatriate physicians, with only

² Freund, P: "Health Care in a declining Economy: The Case of Zambia," Soc Sci Med 23:875-888, 1986

³ ODA: "Zambia: Health and Population Sector Review" April 1989

32% of MOH doctors being Zambian in 1987. Zambia's general shortage of health resources is further accentuated by extreme emphasis placed on curative rather than preventive services.

C. GRZ Strategy

The GRZ officially recognized AIDS as a public health problem in Zambia in 1986, and immediately established a National AIDS Surveillance Committee. In January 1988, the MOH, working closely with the World Health Organization/Global Program on AIDS (WHO/GPA), developed a Medium Term Plan (MTP) for the prevention and control of AIDS for the period 1988 - 1992. The GRZ initiated a National AIDS Prevention and Control Programme (NAPCP) to carry out the activities proposed in the MTP.

Under NAPCP, the MOH established and staffed a Program Management Unit and an AIDS Secretariat. The Management Unit coordinates the AIDS program through six functional sub-units which are headed by MOH or UTH professionals. The sub-units under the NAPCP are: Information, Education and Communication; Counseling; Home-based Care; Epidemiology, Surveillance and Research; Laboratory Support and Blood Transfusion Safety; and Clinical Care Services. The NAPCP program is comprehensive. It attempts to: maintain low-risk behavior or modify behavior of the general population, improve the quality of life of those infected, monitor trends of the epidemic and its impact on development, prevent the transmission through blood and blood products, and improve case management of HIV-infected individuals.

A review of the NAPCP in April 1991 indicated some degree of success in gathering information on the epidemic, but also identified several concerns. Some of the more important review recommendations concerning AIDS prevention were:

There is a need for a National (as opposed to MOH) policy on AIDS;

Program materials and supplies need to be more consistently available;

AIDS education materials should be translated into local languages;

Collaboration with NGOs needs to continue;

There is a need to improve condom distribution with more aggressive marketing and better delivery;

Training of clinical counselors needs to be upgraded;

Operational research on high risk behavior should be intensified;

Sentinel Surveillance activities should be consolidated and expanded;

The procurement and distribution of HIV testing kits needs to be improved;

Standardized kits should be used to ensure proper evaluation and quality control;

Refresher courses and on-the-job training in the use of kits need to be an on-going exercise; and

All blood screening centers in the country, including the Medical and Education Trust hospitals and private laboratories, should be linked to a reference center for quality control.

Even though the GRZ strategy for combating AIDS was developed before the MOH drafted its National Health Policies and Strategies, the AIDS strategy is consistent with the overall policies and new reforms being proposed to restructure the nature of health care delivery and finance in Zambia. The MOH has established the nation's overall goal in health as "equal access to effective quality health care as close to the family as possible." It has adopted a primary health care⁴ strategy as the most appropriate method of achieving its goal. The strategy focuses on decentralization of health care management, broad participation in determining the future of Zambia's health care, and the development of health care financing strategies.

In sum, the GRZ recognizes the AIDS epidemic, has done an excellent job of designing a program for prevention, monitoring, and care of HIV/AIDS related diseases, and has a progressive national health strategy with the objective of a financially sound program of health for all. Unfortunately, the GRZ health sector is under-funded and in many instances short of the experienced technical skills required to implement the necessary programs. Over 30 percent of the country's health funding comes from international donors, which the MOH acknowledges as too high in terms of long-run sustainability. In spite of the plans for early scrutiny and radical overhaul of Zambia's health care financing, the GRZ needs continued donor assistance for its health sector in general, and with AIDS prevention in particular.

⁴ The GRZ has defined primary health care as promotive, preventative, curative, and rehabilitative efforts within and outside the health sector.

D. USAID Strategy

Recognizing the need for assistance, the GRZ has requested A.I.D. support for its AIDS prevention program. This Project proposes to respond to the request because of the critical nature of the epidemic and the desire of the U.S. Government to be responsive to international requests, especially in Africa, for assistance in controlling the HIV/AIDS.

1. Project Strategy

The Mission has had several teams of consultants and A.I.D. direct hire experts examine the nature and status of the epidemic in Zambia and the GRZ strategy for combating it. Because of the shortage of funding in Zambia for AIDS prevention, the extent of the disease, and the scarcity of Zambian professionals with experience in combating the disease, the consultants and the Mission have concluded that support for the GRZ's AIDS program is a priority. They have also recommended, since there is no cure for AIDS, that the Mission adhere to a Project strategy which supports the GRZ's prevention activities.

As a consequence, the Project proposes to improve public health education, provide greater access to condoms, provide greater availability to medications to reduce STDs, and develop national and workplace AIDS education activities. Given the extent of the epidemic and a lack of international consensus on what works (i.e. cost-effective ways to bring about behavior change), the Mission and GRZ have decided to limit most Project activities to efforts at reducing and closely monitoring the incidence of infection in priority target groups.

The monitoring and evaluation of the Project's activities on the target populations will be tightly controlled and closely scrutinized for statistical accuracy. GRZ and USAID concurrence on the necessity for correct and culturally appropriate HIV-testing is expected to provide the GRZ and the region with dependable surveillance data on the disease and a reliable evaluation of Project impact.

2. AID Program Strategy

The Project strategy is consistent with the Mission's overall program, the Africa Bureau's directives, and Congressional objectives. The Project's Goal and Subgoal Statements were taken from the Mission's preliminary Program Log Frame. The Project indicators at the Subgoal and Goal level will be part of the program indicators the Mission will monitor. The Project is also a direct result of Africa Bureau planning. The Bureau's strategy for Africa concentrates funding for HIV/AIDS on "Emphasis" countries which includes Zambia because of the prevalence of HIV and probable potential for its transmission.

The Project strategy also adheres to Bureau guidance by concentrating on prevention, emphasizing surveillance, emphasizing local leadership, promoting low-risk behavior, and mobilizing private and voluntary sector institutions to sustain on-going activities to prevent the spread of AIDS. Congress has expressed its concern over the global HIV/AIDS epidemic by: earmarking \$65 million of the \$345 million for health, child survival and AIDS specifically for AIDS; directing \$30 million of the \$65 million earmark to the World Health Organization's Global Program on AIDS (WHO/GPA) and \$1 million of the \$65 million for UNICEF's AIDS prevention advocacy program; and setting a DFA target of \$50 million to support HIV/AIDS prevention and control programs. This Project will draw on the special Congressional earmark.

E. Other Donors

Zambia has numerous donors providing assistance for health care activities, especially for AIDS projects. Annex G provides a detailed description of their contributions. Since the AIDS Prevention Project was designed with GRZ collaboration and will work through the NAPCP, every effort has been made to prevent redundancy and increase the impact of donor support.

As a final safeguard against redundancy, the Project will include a covenant requiring the GRZ to establish a National Health Commission as provided for under Zambia's public health laws. A primary function of the Commission is to coordinate donor and NGO health care activities throughout Zambia.

III. PROJECT DESCRIPTION

A. Project Goal and Subgoal

The Goal of the Project is market-oriented, sustainable, broad-based economic growth. This is the Mission's overall Program Goal which is fully consistent with the objectives of the GRZ. The Project's Subgoal is to facilitate the development of a socially stable, economically productive population. This is a requisite to broad-based, economic growth. As described above (see II.B.), the AIDS epidemic is a serious constraint to Goal and Subgoal achievement because of its capacity to devastate Zambia's economically productive population.

B. Project Purpose

The Project Purpose is to reduce the incidence of HIV transmission in target populations. It is expected that by the End of the Project, the GRZ will have reduced the incidence in specifically identified and targeted high-risk populations by 15 percent, and by 30 percent in low-risk populations.

The Project will provide technical assistance, training, commodities, and small grants to and through the Ministry of Health and various non-governmental organizations (NGOs). The Project will achieve the Project Purpose with activities in five components: Public Health Education, Voluntary Testing and Counseling, Condom Social Marketing, STD Control, and Policy and Small Grants.

C. Project Components

1. Public Health Education

a. HIV Prevention in the Workplace

Workers represent a large, easily accessible target population which has already been infected with the HIV virus. Benefits resulting from workers' modification of their behavior extend not only to workers as individuals and to their partners and children, but to their communities, to their companies, which will be able to maintain a healthy and productive work force, and to Zambia, which will be able to base its economic recovery upon its workers. Worker sexual behavior is determined by in part by the social pressures of the workplace. Workers are at high risk given their relative wealth and ability to move. The workplace is a controlled setting in which these pressures can be redirected and used to help modify individual behavior through the use of peer pressure.

Under this activity, the MOH Education Unit will compile a list of accessible workplaces and stratify them into groupings based on similar characteristics. It will then rank the groupings by mutually agreed upon criteria that will identify those companies where the benefit-cost ratio of Project-funded activities is expected to be highest.

A Project-funded HIV-Testing and Survey Team operating out of the Voluntary HIV-Testing and Counseling center (See Section III.C.2.) will then conduct a baseline survey on the first grouping of companies. It will HIV-test blood⁵ specimens from a statistically significant sample of the population, and interview the sampled population to ascertain their knowledge about STDs/AIDS and their sexual practices. The sampled employees will be paid a per diem if they participate in the research. This team will prepare a profile of the types of problems and issues to be addressed in designing an education program for workplaces sampled. The MOH and USAID will use the baseline survey to classify the grouped population as high- or low-risk targets.

⁵ See III.B.2. for more information on the voluntary nature of the testing.

A separate Project-supported team operating out of the Ministry of Health Education Unit will prepare a curriculum and work plan for the first group of companies based on the profiles. The MOH Health Education Unit will draw on Population Services International (PSI), one or more Non-Governmental Organizations (NGO), and the STD Control Program to supply personnel to assemble a Health Education Team. This team will develop or buy instructional materials for their presentations. If videos are deemed appropriate, the MOH will use Project funds to purchase videos already prepared, many of which were developed with A.I.D. and other donor funding.

The Health Education Team will provide STD screenings, training for peer group trainers, and workshops on AIDS prevention for employees at their worksites. PSI will work with management to establish condom social marketing at the workplace. Finally, the Health Education Team will provide management with a compilation of company policies on illness in the workplace and discuss the appropriateness of specific policies that they may wish to adopt, if they have not already done so. While the policies will not be AIDS specific, the policies will provide guidance to employees, supervisors, and managers in how to support employees in the workplace who have life-threatening or chronic illnesses, and in managing these complex situations.

After the Health Education Team has left, the work place visited will have a work specific AIDS program in place that the employer and employees can maintain. The Health Education Team will finish the first group of companies and meet to review and evaluate their own work. The Director of the Health Education Unit will provide a written report to the MOH and USAID and the results of the teams findings and make suggestions, if necessary, on revising the procedures. The teams will repeat the process throughout the life of the Project. The HIV-Testing and Survey Team will return to the selected workplaces at appropriate times during the Project to update the HIV tests and surveys into attitudes and behavior, and ascertain if further activities should be pursued.

Zambia is long on companies with an HIV/AIDS problem. The MOH will ask employers and employees if they wish to participate in the workplace program prior to sending in the HIV-Testing and Survey Team. If an employer or its employees do not wish to participate, the MOH will solicit the next employer on the list. The MOH will present the prospective companies with a simple engagement letter that explains the work place program, the responsibilities of the parties, and principles of confidentiality that will be exercised for both the company and the employees. Preliminary estimates suggest that there is a strong willingness on the part of companies and employees to participate.

Zambia's military maintains thousands of young, mobile recruits. Based on data from other countries, it is suspected that the military probably has infection rates higher than the national average. The workplace program will be open to the military as a whole or by military units. If the military wishes to participate in the program, the MOH will include them in the stratification and ranking with other workplaces. The MOH and the testing units will be receptive to military wishes for extra precautions concerning the handling of results and profiles.

By the end of the Project, the MOH will have initiated HIV/STD programs in approximately 60 workplaces covering a workforce estimated at 30,000.⁶ By training 30 to 35 workplace clinical staff and peer trainers per company, the targeted workplaces will have approximately 2,000 trained trainers in place.

The Project will provide the MOH Education Unit with an expert in health education for three years (for all activities under this component), vehicles, office equipment, per diems for field work, and resource materials. The estimated cost of these inputs will be approximately \$1.2 million.

b. Traditional Healers

It is estimated that 80% of Zambians consult traditional healers either as a first source of treatment or when "western" medicine proves ineffective. The Traditional Healers Practitioners Association of Zambia (THPAZ) has over 10,000 registered members. However, it is assumed that there are many more traditional healers who are not registered with the Association.

The lack of adequate resources for medicines, staffing and facility upkeep result in traditional healers playing an increasing role in preventive and curative health care. In an attempt to establish bonds with traditional healers and to utilize them as an existing resource in Zambia, the MOH has conducted a series of workshops with traditional healers to involve them in primary health care.

However, to date, traditional healers have not been sufficiently utilized in HIV-prevention efforts. Indeed

⁶ Estimate based on company profiles prepared by the Zambia Privatization Agency on 60 companies to be privatized. Average employee population of 800 was reduced to 500 to take into account reductions in the workforce after privatization, and to adhere to a policy of conservatism when making projections.

at times, they have proven to be a negative force by stating that they have cures for AIDS or medicines to prevent HIV infection. As traditional healers provide a significant portion of the health care in Zambia, and as it is increasingly important to prevent negative information concerning cures or preventions from being publicized, this Project will work with traditional healers to "upgrade" their skills in the area of HIV and STD prevention and treatment, as well as working with the "western" health system to establish a better working relationship between the two groups.

Given the HIV epidemic and the decreasing quality of the formal "western" health system in Zambia, the rationale for including traditional healers in the HIV and STD prevention includes:

GRZ health services, especially those relating to STD prevention and control, have inadequate numbers of personnel, inadequate facilities and a continuing lack of STD medications;

Traditional Healers have the numbers and distribution needed to serve the population; and have started to strengthen themselves organizationally by forming a traditional healers association;

For a variety of reasons, traditional healers want to improve their skills and collaborate closer with the formal health system, and are represented in the MOH through a traditional healer unit; and,

Most importantly, traditional healers have the cultural acceptability to communicate with and to educate the general population.⁷

In Zambia, traditional healers are present in the community while public health centers are sparse and difficult to access given insufficient personnel and transport. Moreover, public health centers often lack the proper medications and trained medical personnel to administer to patients. As a result, many turn to traditional healers even if they also visit a health center. This has made traditional healers an important influence in the daily life of most Zambians. The fact that the MOH contains a traditional healer unit is an official acknowledgment of their importance in Zambian society. Their

⁷ See Green, E et al: Traditional Health Beliefs and Practices Related to Child Diarrheal and Sexually-Transmitted Diseases, Research Report & Communication Strategy, Mozambique, 1991.

formation of an association attests to their recognition of the influence they wield.

Implementation of the Project-funded activities for traditional healers will follow the procedures established for HIV/AIDS education in the workplace. The Traditional Healer Unit at the MOH will compile to the best of its ability a list of traditional healers by rural and urban health districts or some other geographic zones acceptable to the MOH and USAID/Zambia. It will stratify and rank the districts by priority areas.

The Project-funded HIV-Testing and Survey Team operating out of the anonymous testing center will select a sample of traditional healers from the first priority zone. The MOH Traditional Healer Unit will solicit the selected traditional healers' participation in the Program. Those entering the sample will be paid for a specified period to keep day-sheets of their patients, recording information such as age, occupation, and diagnosis/complaint.

The HIV-Testing and Survey Team will interview all the participating traditional healers to determine characteristics that will maximize their impact in HIV/AIDS prevention. It will also select a patient population from the day sheets, contact the patients and ask them if they wish to volunteer for the baseline survey. The HIV-Testing and Survey Team will pay a per diem to those consenting to participate in the Program for their time and expenses. It will HIV test from a statistically significant sample, and interview the sampled population to ascertain their knowledge about STDs/AIDS and their sexual practices. The HIV-Testing and Survey Team will assemble profiles of the different types of patients utilizing traditional healers and of the traditional healers participating in the Project. It will provide these profiles to the MOH Traditional Healer Unit. Again, the MOH and USAID will use the baseline survey to classify the grouped population as high- or low-risk targets.

The evaluation team's profiles will provide information on: current practices of traditional healers concerning the prevention and control of HIV/AIDS and STDs; the way traditional healers function within the community(s); health seeking behavior of identified population groups concerning traditional healers only, and concerning health seeking behavior that involves both traditional healers and the formal "western" health system; the concerns of traditional healers relating to establishing an ongoing relationship with the Project and identification of what traditional healers hope to gain from such a relationship; and, what contributions traditional healers believe they can make to HIV and STD prevention.

The team operating out of the MOH Traditional Healer Unit, PSI, NGOs, and the STD Control Program will prepare a curriculum and work plan for the first group of sampled traditional healers based on the profiles. The team will create workshops, training exercises, and supporting materials for the participating traditional healers to: increase their ability to counsel HIV-positive/AIDS patients and their families concerning care and behavior modification; facilitate traditional healers to become community educators promoting risk-reduction behavior including promoting and distributing condoms; ensure that traditional healers use safe methods in their day-to-day practice so that HIV will not be transmitted during patient care; and ensure that traditional healers do not claim that they can cure or prevent AIDS with traditional healing techniques.

The team will then evaluate the results from their work with the first group of traditional healers. The Director of the Health Education Unit will provide a written report to the MOH and USAID with the results of the teams findings and make suggestions, if necessary, on revising the procedures. The teams will repeat the process throughout the life of the Project with subsequent groups of traditional healers. The HIV-Testing and Survey Team will return to survey the traditional healers and update HIV tests and surveys of patients participating in the Project sample.

The traditional healers will continue to send their day sheets into the MOH Traditional Healers Unit where they will be entered into a Traditional Healer Health Information System. The objective of the system is to ascertain the predominant diagnoses/complaints and improve the traditional healers delivery of service, especially as it relates to STDs and high risk behavior. While the design of the information fields and reports will require some technical assistance, the software will be a commonly used and easily accessible database package.

By the end of the Project, the MOH is expected to have trained 2,000 traditional healers in AIDS/STD prevention in all the priority geographic zones, traditional healers are expected to be marketing condoms, and the MOH will have established a Traditional Healer Information System.

The Project will provide the MOH Traditional Healer Unit with vehicles, training and curriculum materials, per diems for traditional healers and unit staff doing field work, a computer system with software, and short-term technical assistance in curriculum development and computer system set up. These inputs will cost approximately \$636,550.

c. HIV Prevention Youth

Youth represent the single largest target group for HIV-prevention activities. Approximately 50% of Zambia's population is under the age of fifteen. At present, youth is relatively unexposed to HIV infection. However, this relative unexposure is rapidly changing. Evidence that youth is sexually active at an early age includes high rates of teen-age pregnancy, data derived from various Knowledge, Attitudes, and Practices (KAP) surveys, and HIV/AIDS surveillance data showing a high percentage of HIV-infection among girls age 20-24 (which means that they were infected during their teen-age years).

Youth is not, however, a completely homogeneous group. For purposes of this Project, youth is divided into four categories: in-school youth (urban and rural); university and post-secondary school students; urban out-of-school youth; and rural out-of-school youth. The Project will focus on the latter three categories as activities already exist for in-school youth (e.g. Anti-AIDS Clubs).

An increasing percentage of youth is leaving school at an early age. In 1990, 69% of students in Grade 7 do not go on to Grade 8. Only 50% of students in Grade 9 went on to Grade 10. The school day consists of 3 hours daily for Grades 1-4 and 5 1/2 hours for Grades 5-7. The increasingly high rate of school drop outs and poor economic conditions, in general and especially among youth, help to make youth a very vulnerable group to high risk sexual behavior, and therefore for acquiring HIV.

Rural out-of-school youth represent a particular target population. They are important to reducing the rate of transmission since they are likely to be those who migrate to urban areas and will be at greatly increased risk for HIV infection. When rural youth first migrate, they tend to adopt the sexual behaviors of the area to which they migrate and therefore quickly become at higher risk for HIV infection.

Despite the fact that youth is at an increasingly high risk for HIV infection, very little is known about their sexual behaviors or their HIV status. Slightly more is known about boys than about girls as boys are a partially visible element of street life. Although some are marginally employed as street vendors, the majority are unemployed. Almost nothing is known about out-of-school girls. They are an almost totally invisible group. Their lives are frequently confined in the domestic compounds where they live as young wives or dependents, and where they work as domestic servants performing labor for which they may be or may not be paid.

Using Project funds, the MOH will work with one or more of the NGOs and the Ministry of Community Development and Youth to identify out-of-school youth and develop a way to

reach them. Once identified, the HIV-Testing and Survey Team will HIV test and survey from a representative population of youths. The Project will pay the youths consenting to the research a per diem for their time and efforts.

The HIV-Testing and Survey Team will provide the implementing NGO with summary profiles of the problem and behavior patterns of out-of-school youth. The implementing NGO will coordinate with the MOH Health Education Department, the STD Control Program, and PSI to develop workshops and training sessions for the youths in HIV/AIDS prevention. The HIV-Testing and Survey Team conducting the baseline survey will re-visit the sampled youths to determine the impact of the workshops.

By the end of the Project, the NGO in charge of this activity is expected to have completed research on out-of-school youths, educated 800 out-of-school youths, and developed a condom marketing program for this targeted population.

The Project will provide the NGO with a vehicle, training and curriculum materials, per diems for field work, a computer system with software, and short-term technical assistance in curriculum development. These inputs will cost approximately \$295,000.

d. HIV Prevention Media

Work with professionals in the print and electronic media has demonstrated that journalists, reporters, and their editors often lack the specialized training for adequate and accurate reporting on complex health issues and lack access to networks of information about health. These factors frequently limit their interest in the subject, as well as their ability to select and present information in a manner that best serves the public interest. Previous experience has shown that training and support for the media can lead to positive changes in the quality and quantity of reporting on health issues.⁸

Discussions with journalists, editors, and medical personnel indicate that although there has been coverage of HIV-related issues, limitations still exist in the range and reliability of this coverage. Opportunities for expanding the depth and coverage of information on HIV/AIDS and STDs can however build on the generally positive reaction to earlier programs. The current radio drama series, Nshilakamona, evoked strong positive reactions. An earlier television series "Talking

⁸The current column on Health Matters in the Times of Zambia was started following a regional workshop for journalists on health reporting.

AIDS," produced from 1990-91 by the Copperbelt Health Education Project (CHEP) was also well received.

Events around World AIDS Day are prominently covered in all media. Prominent medical personnel have spoken out frankly about the cultural context of sexual behavior on such regular programs as "Face to Face." There is a sense that an opportunity exists to increase coverage on health-related topics, and to change the perception of health news as boring and unimportant.

Existing channels for discussing health-related issues include Topic, Kwacha Good Morning, and Face to Face; the twice-weekly radio program Doctor's Corner, produced by the Ministry of Health; and such regular columns as Health News in the Times. However, inherent limitations exist to the expansion of health and AIDS-related reporting. Neither the print nor electronic media assigns staff to cover health as a specific "beat" and there are no trained health reporters. In designing the Project, the following problems and needs were identified:

Although most AIDS reporting is factually accurate, articles still appear that promulgate serious misinformation.

Reporters do not completely understand medical concepts and information, resulting in limited ability to critically review new information and research studies.

AIDS is seen as remote and abstract compared to such issues as cholera or malnutrition.

Coverage should be expanded to include analysis and comment, feature coverage, and human dimension stories. Reporting on HIV/AIDS needs to be broadened to investigate such issues as the impact of AIDS on the economy and the family, including such topics as the impact of AIDS on development, the status of women and its relationship to behavior modification and pressures to have sex, AIDS orphans, cultural norms of shame and how these relate to denial of the impact of the disease.

Reporters and editors communicate poorly between each other on issues of importance and specific coverage of stories.

Reporters do not have access to reliable, updated information on AIDS, specifically research studies and updates on activities from Ministry of Health, medical officials, research institutions, and local NGOs.

There have been periods of intense interest in AIDS, which then die down.

There is virtually no coverage of STDs and its relationship to AIDS.

Health reporting is not interesting, lively, and meaningful to readers, listeners, and viewers.

Opinions about the ability to discuss sensitive topics and the likelihood of external pressure from religious organizations to limit discussion were mixed. Most individuals thought that discussion had become open. Condoms have been discussed in both print and electronic media, and some prominent figures have taken the lead in making direct comments on sexual behavior and disease. Nevertheless, there is a strong element of self-censorship on the part of reporters which still acts as a barrier to open discussion.

To address the shortfalls in media coverage, the MOH Health Education Unit and the Zambia Institute for Mass Communication will sponsor quarterly workshops/press briefings. The objectives of the workshops will be to: enhance the skills of all media in identifying and presenting accurate news and information about HIV/AIDS; foster a supportive attitude among media decisionmakers that facilitates an increase in quantity and depth of HIV/AIDS related media coverage; and strengthen the media's motivation to support communities in HIV prevention, and to increase public understanding of the impact of the epidemic, and draw public attention to the context of and need for behavior modification. By the end of the Project, the quantity and quality of reporting on AIDS and STDs is expected to increase significantly.

The Project will provide the MOH Health Education Unit and the Zambia Institute for Mass Communication with briefing materials such as press handouts, a resource library for the MOH and press to use, and short-term technical assistance in establishing the library and developing the original press kits. These inputs will cost approximately \$278,000.

2. Voluntary Testing and Counselling

Testing for HIV in Zambia is quite limited. Much of the current HIV testing in Zambia is undertaken to screen blood prior to transfusions, to diagnose AIDS in a clinical setting, or for surveillance/research purposes. Not only is the access to voluntary testing services restricted, but the conditions under which the testing is offered to a select proportion of the Zambian population, are often not conducive for in-depth counseling on the implications of the test results. Private clinics provide screening at very high costs and with little or no education or counseling.

In spite of the costs and shortage of facilities, the demand for testing is growing. Many patients are visiting STD clinics and requesting an HIV test whether or not they have an STD. There has also been an increase in the number of blood donors and percentage of blood donors requesting the results of their HIV test. Private clinic testing is expensive for the average Zambian, ranging from \$10 to \$50. Yet, many appear to be willing to pay it to avoid arranging a test at a public facility and wait several weeks for the results.

Even though pre- and post-test counseling is acknowledged and promoted by MOH policy, some health professionals are reportedly not informing their HIV-positive patients of their sero-status. Even patients ill with AIDS are often not told that they have AIDS or that the illnesses from which they suffer are a consequence of AIDS. The population most interested in testing is considered to be more often than not in the high risk group. This includes sexually active men and women who want to know their HIV status and partners of HIV-positive people.

In response to the constraints Zambians have in learning their sero-status, the Project will help to establish one voluntary counseling and testing center in Lusaka and possibly a second in the Copperbelt. The demand for this service is further indicated by: (1) over 90 percent of the clients/patients who are offered HIV testing at the University Teaching Hospital (UTH) STD clinic want to know their results; and (2) the estimate that at least 20 percent of the blood donors who donate blood at UTH each day are doing so to find out their HIV status.

The testing centers will be operated by one of the NGOs in Zambia. Both Kara Counseling and the Family Health Trust have expressed an interest in operating voluntary testing centers. The NGO(s) which will participate in the program have counseling programs already in place. The Project will expand their programs with staff and facilities to counsel greater numbers of beneficiaries and provide testing to the public at an affordable cost; that is, the NGO(s) will charge all patients at least a nominal fee for the tests.

The Voluntary HIV-Testing and Counseling center in Lusaka will also be the location for the Project's HIV-Testing and Survey Team. They will conduct the HIV-tests and surveys for all the Project's health education activities, and prepare the profiles and analyses for the health educators to use in designing their curriculum and work plans. In addition, they will randomly sample, survey, test and follow-up on walk-in beneficiaries to evaluate the effectiveness of the Voluntary HIV-Testing and Counseling Center.

Testing under this Project is strictly voluntary. The Project-funded teams will inform those selected to be in a representative sample (employees in the workplace, traditional healers, patients, youth, and walk-ins) that their participation is totally voluntary. The teams will respect the right of individuals to reject the offer. All volunteers will be asked to sign consent forms, or otherwise indicate that they are participating freely.

The testing team will structure the sample size sufficiently large enough to account for those not wishing to participate. The HIV tests are free to the selected volunteers, and the HIV-testers will offer Project-funded per diems to all volunteers for the time and costs they may incur in participating. Volunteers will be allowed to obtain the results of their HIV test if they so choose. The HIV-Testing and Survey team will de-link the names of the sampled participants from their survey questionnaires and blood samples at the point of testing. Only the team leader of the testing unit will have the ability to link a result to its donor. He/she will be held accountable for any breach of confidentiality.

Condom promotion will be an integral part of the pre- and post-test counseling, and the risk reduction education and counseling process. The counselors will work closely with the sub-contractor responsible for the condom social marketing component to outline a logistics management system for the supply of condoms through Pharmaceutical Society of Zambia's condom social marketing program.

Up to four Project-funded advisors will be assigned to the Lusaka testing facility to work with Zambian counterparts. The team will most likely consist of an epidemiologist, a social scientist, a statistician, and a laboratory technician. They will also be supported with short-term technical advisors as needed.

The MOH and the Mission consider the monitoring and evaluation done by the testing team in the voluntary testing center to be critical to the Project's success, and the development of AIDS programs elsewhere. The contractor in charge of designing baseline surveys, follow-up surveys, statistical sampling, and testing will be independent from the Health Education Unit and the contractor providing advisors assisting with the HIV/AIDS awareness and education. The MOH and the Mission will closely scrutinize the contractors adherence to professional standards. The Project will require the contractors to be open to peer review of all procedures and standards in testing, surveying, and evaluating. The MOH and A.I.D. experts will be included in the peer reviews if they so desire.

By the end of the project, the anonymous testing centers are expected to have counseled and tested 25,000 paying beneficiaries. They will also have surveyed and tested approximately 2,000 sampled individuals from the Project's workplace program, traditional healer program, and youth program. The estimated cost of establishing and expanding the operations of two voluntary testing and counseling centers and providing the technical expertise for project evaluation is \$4.1 million.

3. Condom Social Marketing

The contraceptive prevalence rate among married women of reproductive age (15-49) was recently calculated at 1%. According to recent calculations of contraceptive use, condoms, the only effective means of preventing sexual transmission of HIV, are used by less than 1% of the sexually active population. Although surveys indicate high levels of acceptance of the concept of contraception for family planning, inadequate contraceptive supplies and cumbersome procedures for obtaining them have limited their use by the general population.

Efforts at condom promotion and distribution have been demonstrably inadequate. Condoms have been provided by donors to a wide array of public and private sector distributors. However, neither the public nor private sector distributors have been able to adequately distribute and promote condoms to the general population or to specific target groups. Condoms are erratically procured, lost in transit, and poorly warehoused. At present, there are few condoms available in commercial outlets. WHO has a reported stockpile of 4 million condoms for distribution to health centers, but has encountered logistic difficulties in deliveries. Other NGOs have been able to sporadically obtain condoms for their specific activities. Although the Pharmaceutical Society of Zambia (PSZ) has been designated by the Ministry of Health to lead social marketing activities, donor funds, primarily from FPIA, have dried up.

Population Services International (PSI) submitted an unsolicited proposal to the Mission during the design of this Project for Condom Social Marketing. The MOH and Mission have agreed to accept and incorporate the PSI proposal into this Project. The basic objective of the proposal is to reduce the sexual transmission of HIV and STDs by making condoms widely available and affordable, and to promote their proper use to target consumers.

The social marketing project expects to sell a minimum of 30 million condoms over the five year period. Initially the project will concentrate on achieving distribution in urban areas and along the line of rail which hold nearly 50% of the population, and because the high concentration of commercial, transport, tourist and educational centers has a high

presence of target populations such as students, workers, transport drivers and commercial sex workers. This will serve as a natural springboard to expand to the rural areas as the project expands.

PSI along with its counterpart, Pharmaceutical Society of Zambia (PSZ), will market a new condom brand to a wide array of formal and informal retail outlets, ranging from pharmacies and private health clinics to non-traditional outlets. The price of the condom has been set to be affordable to the lowest income groups.

The sensitivity to condom advertising, while not specifically banned by law, will be closely monitored. Condom advertising by media will not be implemented in the first year and a half of the project to better assess sensitivities and determine future policies. During the first year and a half of the Project, advertising and promotion will be in the form of point of sale material and consumer premiums (e.g. free pocket calendars containing AIDS/STD information) as giveaways. After six months promotion teams will begin conducting targeted promotional activities such as bar promotions, rock concerts, condom songs, neighborhood audio-visual shows and retailer conferences. Additionally, PSI/PSZ will work closely with the MOH with the Health Education Component of this Project, the NGOs with the Project's voluntary testing and counseling, the STD clinics with their Project-funded activities, and other NGOs in their educational efforts.

By the end of the Project, PSI/PSZ are expected to have: sold 30 million condoms; sustained distribution in a minimum of 3,000 retail outlets, STD clinics (private and public), all targeted workplace sites, traditional healer sites, and NGOs involved in HIV-prevention activities under this Project; increased the level of condom brand awareness to 80% among target consumers; and established via PSZ, a sustainable private-sector based social marketing infrastructure that can continue the condom distribution program.

The Project will provide PSI/PSZ with technical assistance, equipment and supplies, advertising, training, and commodities under a Cooperative Agreement. The estimated Project cost is \$7.4 million.

4. STD Control Program

Recent studies have documented that the presence of sexually transmitted diseases (STDs), particularly genital ulcer disease, greatly facilitate the heterosexual transmission of the HIV virus. Of the approximately 170,000 cases seen yearly at the 47 STD clinics under the STD Control Program, an estimated 55-75% of the patients are HIV positive. Since the MOH began the

STD Control Program in 1986, 54 STD clinics have been established. Of the 54 clinics, 37 have been strengthened with diagnostics.

Typically, the staff at the STD clinics include an STD Control Clinical Officer, a nurse (usually trained in counseling), and a laboratory assistant. The STD Control Program faces many constraints: lack of medications; lack of private space for counseling and time constraints of clinic staff result in clients receiving only rudimentary prevention and risk reduction education, if any; lack of educational materials; lack of staff with skills in counselling; limited or no program to contact infected partners; and, uncertain supplies of condoms.

The budget constraints and movement to cost recovery in health care is expected to make the constraints worse for the STD clinics. In an effort to maximize the best use of resources, the Project will fund a pilot program in three STD clinics. The residents in the geographic areas served by the clinics will be entitled to one free series of medications ("clean-up") and be given counseling on HIV/AIDS prevention. Repeat patients will be charged full cost to clear any subsequent infections.

The goal of this component is to reduce the number of future cases of STDs and to reduce HIV transmission by improving the resource allocation of the STD program. To carry out the pilot program, the Project will provide the clinics with diagnostics, supplies, computers with database software, up-dated training in counseling, and most importantly, medications. To assist the STD program to support the other components of the Project, the Project will provide the STD program with vehicles, office equipment and supplies, and audiovisual equipment (TV/video, tape recorders, and/or slide projectors). The expected cost of the component is \$1.5 million.

5. Policy Development

The active support and commitment of key influential persons throughout all sectors is essential for the implementation of an effective and comprehensive HIV/AIDS prevention and control program. HIV/AIDS programs are shaped by political, economic and social factors, including the policies and policy-related practices of leaders within Zambia. These individuals (found in the government, business, unions, voluntary organizations, religious organizations and the international donor agencies) can have a profound impact on the course of the epidemic and the success of prevention programs.

Preliminary discussions with individuals from NGOs, government, and donor agencies, indicate that most people do not believe HIV/AIDS is a sufficiently high priority on the

government agenda. Specifically, many people said that they hope that President Chiluba will publicly discuss AIDS; since most people feel that leadership from the President and other political leaders is essential and will have a significant impact on the population.

Yet, with the current economic situation and the drought, the President and other political leaders have had to direct their attention to economic issues and sudden disease outbreaks, such as cholera. Given the continued urgency of these other problems, some people are pessimistic about top leaders focussing on AIDS. To assist leaders in addressing HIV/AIDS, it is critical to provide them with information about sound policies and programs, especially related to prevention.

While HIV/AIDS is one of the top priorities of the MOH, the Ministry is faced with the challenge of addressing a wide variety of other health problems that affect many Zambians. Recent MOH documents listing national health goals indicate that reductions in malaria, malnutrition, TB, and STDs and HIV transmission are the top priorities (in order of listing). Similarly, when the public was asked to rank health priorities, those listed in order of priority were malaria, child-related illnesses, cholera, and then AIDS.

The objective of this component is to raise HIV/AIDS on the agenda of policymakers and to help facilitate the development of effective HIV/AIDS policies and programs. This goal will be accomplished by providing policymakers with the information and incentives necessary to support and develop policies and policy-related practices conducive to reducing HIV transmission.

To accomplish this, the Project will provide approximately \$150,000 for policy analyses requiring projections of the economic impact of the AIDS epidemic, and a workshop to present the policy analysis' findings.

There is a significant need in Zambia for a fund which can be quickly mobilized to provide small amounts of resources to new and ongoing activities. In general, the approval process and time delays are the same when requesting small grants as when requesting grants of several hundred thousand dollars. In addition, because of the extensive documentation involved, many donors tend not to make small grants. The rapid response fund will help fill this need by rapidly providing resources for a variety of HIV-prevention activities.

To accommodate NGOs and community groups doing AIDS small prevention projects, the Project will provide \$220,000 in a small grants fund. This funding will provide small grants

as requested for a wide range of HIV-prevention activities including, but not limited to, rapid behavioral research studies; workshops; short-term travel/training including international (maximum of 7 days), and community-based pilot programs. The amount of funding will generally be limited to \$10,000. The A.I.D. Project Manager and MOH counterpart will recommend requests for funding and present them to USAID/Zambia.

A single organization will not be funded for more than one activity during any fiscal year. However, upon successful completion of an activity funded under this component, the organization can again submit a request for funds in a subsequent calendar year, and that request will be considered on its merits.

The duration of activities funded under this mechanism is not defined. However, preference will be given to activities that can be completed in six months or less.

The procedure for receipt of funding under this component will be initiated by submission of a 1-2 page proposal containing an outline of the proposed activities, budget and approvals from the national AIDS control program and provincial/district officials (if required). Monthly progress reports will be submitted, and a final 2-page technical report with a final accounting and photocopies of all receipts will be submitted within 30 days of completion of the activities.

6. Project Management and Support

The Project will fund a long-term PSC Project Manager and Administrative Assistant/Secretary. The A.I.D. Project Manager will be based in the A.I.D. Mission and will work collaboratively with the MOH and the technical advisors. The estimated cost of the Project Manager with assistant for five years is approximately \$515,000.

The Project will also provide for four evaluations and up to two audits. Because of the Project's on-going HIV testing and surveying, the evaluations will concentrate on Output level indicators, contractor performance, MOH collaboration, and USAID project management. Progress in achieving Purpose level indicators will be forthcoming throughout the life of the Project from the HIV-Testing and Evaluation Team. The expected cost of evaluations and audits is \$350,000.

IV. PROJECT MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

A. Financial Plan

The Project will have a total budget of \$19.7 million. A.I.D. will contribute the entire amount, subject to availability

of funds and progress in achieving Project Purpose and Covenants. The Mission has requested and received a Section 110 waiver of the host country counterpart. Zambia qualified for a waiver as it is a "relatively least developed country" on the U.N. General Assembly list and a low-income country on the Development Assistance Committee (DAC) list of the OECD.

The country is characterized by poverty, limited infrastructure, and limited administrative capacity to implement basic human needs growth strategies. Financial constraints inhibit the Government from meeting the requirement for a 25 percent contribution, particularly at a time when the country is facing the effects of the worst drought in living memory.

The standard tables to the financial plan indicate the overall allocation of financial responsibilities and the sources from which each individual project element will be financed. Detailed costing of the Project appears as Annex F. An inflation and contingency factor of approximately 15 percent was applied to the total Project cost.

Sustainability is a difficult issue for this Project. To date, there is no cure for AIDS. The only way to resolve the AIDS crisis is through behavior modification; that is, through the maintenance of safer sexual practices, the use of condoms, and/or the control of STDs. The objective of the Project, and of AIDS efforts worldwide, is to modify the behavior of a critical mass in the population to a point where the rate of HIV/AIDS transmission is reduced and stabilized. If the epidemic is reduced to a point where the relationship between long-term behavior change and increased health is apparent, then the behavior changes should perpetuate with minimal publicly-funded reinforcement.

Until that time, continued government support for public health education, HIV-testing, control of STDs, and condom social marketing will be necessary. Furthermore, given the current economic situation in Zambia, the GRZ will continue to be dependent on external resources in the near and mid-term for all social sectors.

The Project addresses the issue of how to pay for adequate health care needs, including HIV/AIDS, by requiring the GRZ to draft a health care financing plan that recommends sustainable funding sources as a Covenant to the Project. The Project will also initiate a pilot cost recovery program in up to three STD clinics.

Some of the Project activities do lend themselves to sustainability. The workplace activities will encourage employers to extend HIV/AIDS education and counselling beyond Project supported activities. HIV/AIDS education by the more

progressive private employers will be sustainable as the cost of doing business. Commercial condom distribution has already proven itself sustainable elsewhere in the world where subsidies are no longer necessary. This is the ultimate goal of the Condom Social Marketing Component. Finally, the MOH, traditional healers, and NGO trainers will maintain and use the Project-taught teaching and counselling skills long after the PACD.

If the effort to curtail the epidemic is not successful, sustainability will be moot. The AIDS epidemic in Africa has the potential of rivaling the Black Death of medieval Europe. At the moment, the existing tax base and private resources necessary to fund private and public health programs is meager. If the AIDS epidemic goes unchecked, the potential decline in productivity will erode the economic base even further. To do nothing to slow the spread of the disease because the GRZ may not be able to sustain it is simply not an option.

Summary Cost Estimate (US\$ 000)

Type of Expenditure	A.I.D. FX	A.I.D. LC	GRZ	TOTAL
Technical Assistance	6,408	2,251		8,659
Training	203	71		274
Commodities	5,438	1,911		7,349
Audit & Evaluation	167	58		225
Grants Fund	259	91		350
Inflation/Contingency	2,125	718		2,843
Total	14,600	5,100	0	19,700

Projections of Expenditures by Fiscal Year (US\$ 000)

Fiscal Year	A.I.D.	GRZ	TOTAL
FY 93	3,963		3,963.00
FY 94	4,744		4,744.00
FY 95	4,557		4,557.00
FY 96	3,731		3,731.00
FY 97	2,705		2,705.00
TOTAL	19,699.00	0.00	19,699.00

AIDS Prevention Project
 USAID/Zambia
 Project 611 – 0221

COSTING OF PROJECT BY INPUTS AND OUTPUTS
 PROJECT OUTPUTS

PROJECT INPUTS	WORK PLACE	TRADITIONAL HEALERS	YOUTH	MEDIA	TESTING COUNSEL	CONDOM SOC MKTG	STD	POLICY & GRANTS	A.I.D. MGMT	INFLATION CONT	TOTAL
AID APPROPRIATED											
TECHNICAL ASSISTANCE	889,000	364,000	130,000	208,000	3,513,000	2,735,000	130,000	175,000	515,000		8,659,000
TRAINING	71,000	67,000	29,000	0	0	107,000	0				274,000
COMMODITIES	261,000	206,000	136,000	70,000	635,000	4,642,000	1,399,000				7,349,000
GRANTS								225,000			225,000
AUDIT/EVALUATION									350,000		350,000
INFLATION/CONTINGENCY										2,843,000	2,843,000
SUBTOTAL	1,221,000	637,000	295,000	278,000	4,148,000	7,484,000	1,529,000	400,000	865,000	2,843,000	19,700,000

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B. Implementation and Mission Management Plan

1. Implementation Plan

An implementation schedule of major events appears below. Based on past experience, the GRZ will rapidly comply with the standard Conditions Precedent to this Project. Since the Cooperative Agreement with PSI was drafted during the design of the Project, the GRZ and Mission will initiate Condom Social Marketing immediately. The Mission will also begin the search for a Personal Service Contract Project Manager after obligation.

2. Implementation Schedule

Activity	Action	Date
Project negotiated with GRZ	PDO	09/92
Pro Ag drafted	PDO	09/92
Pro Ag signed	GRZ/DIR	09/92
PIO/T Cooperative Agrmt	PDO	10/92
PIO/T inst. contractor completed	PDO	10/92
PIO/T PSC completed	PDO	10/92
PIO/T S-T consultants completed	PDO	11/92
CBD notice and RFP for 2 inst. contractors drafted	PSC/RCO	11/92
PIO/T admin assist. completed	PSC	11/92
PIO/C USAID proj procurement	PSC/GDO	01/94
PIO/T 1st evaluation	PSC	01/94
PIO/T 2nd evaluation	PSC	01/95
PIO/T 3rd evaluation	PSC	01/96
PIO/T 4th/final evaluation	PSC	01/97
PIO/T 1st audit	PSC/CONT	06/94
PIO/T 2nd audit	PSC/CONT	06/96

The MOH and the institutional contractors will be required to submit annual workplans to USAID, indicating the expected dates for achieving Project indicators.

3. Mission Management Plan

Management responsibility for this project will reside in the USAID Assistant Directors Office. The Assistant Director will continue to act in the capacity of the Mission's HPN Officer. First echelon implementation responsibility for the project will reside with a PSC Project Manager, assisted by a locally recruited administrative assistant/secretary. The PSC Project Manager will serve to support the Mission with any other AIDS-related health, nutrition, and population initiatives of the Mission.

This Project will utilize two institutional contracts for the greatest portion of the technical assistance to

be provided under this Project. The Mission will award the first contract under full competition for the health education component of the Project. The Mission will limit the competition for the second contract for the HIV-Testing and Survey team to an American Black Historic College. Both institutional contractors will be responsible for all consultant support services such as house rentals and travel arrangements, and the procurement of commodities, except for vehicles and household furnishings.

With a personal service contracted Project Manager and an institutional contractor for most of the technical assistance, the Mission management burden will be sustainable.

C. Monitoring and Evaluation Plan

The HIV-Testing and Survey Team will provide on-going monitoring and evaluation of the target groups. Prior to any Project-funded activities, the HIV-Testing and Evaluation Team will conduct a baseline survey that will provide social information on the target groups such as knowledge of AIDS, attitudes towards the disease, and sexual practices. More importantly, it will also determine the level of HIV seropositives as baseline information in the target populations.

The HIV-Testing and Survey Team will complete follow-up HIV tests and surveys on the target population during the Project, and in so doing, provide the MOH and USAID with the unique ability of having on-going information on Purpose level achievement. The determination on whether the incidence of HIV transmission is decreasing will be similar to attribute testing (yes or no).

Analysis of target group changes in the incidence of HIV transmission will also be an on-going monitoring function. The Project provides for sufficient short-term technical assistance to analyze the changes for causality as they happen. This is part of the Project, and not will not be left to periodic evaluations.

As stated in the Project Description, the evaluations will concentrate on Output level indicators, contractor performance, MOH collaboration, and USAID project management. These will be annual evaluations in March of each year beginning in 1994.

D. Procurement Plan

An itemized Procurement Plan appears as Annex H. The Mission will maximize procurement from U.S. sources in accordance with recent AID/W policy emphasis. USAID and the MOH will select two institutional contractors to provide long- and short-term technical assistance, and supply certain commodities. The

Mission will prepare a Project Implementation Orders for Technical Services (PIO/T) to request the Regional Contracting Officer to seek out the services of two institutions for the Health Education and HIV/Testing requirements of the Project.

The Mission expects the Health Education contract to be for \$3,000,000 and estimates \$2.2 million of it to be from A.I.D. Geographic Code 000. The second contract is expected to be for almost \$4.5 million with \$4.3 of it from A.I.D. Geographic Code 000. PSI will carry out the Condom Social Marketing component under a Cooperative Agreement. The Mission estimates \$6.1 million of the \$7.5 expected for Condom Social Marketing will be from A.I.D. Geographic Code 000.

USAID/Zambia will contract for all the Project's A.I.D.-funded technical assistance, commodities, and training not included in one of the institutional contracts, the cooperative agreement, or the Small Grants fund. This will amount to approximately \$4.7 million of which \$2.7 is budgeted for inflation and contingencies. The Mission estimates that approximately \$3.5 million of the \$4.7 be from A.I.D. Geographic Code 000. The recipients of awards under the Small Grants fund will be responsible for procuring under AID guidance their own off-the-shelf items and being reimbursed. In total, the Mission estimates almost \$16.3 million of the Project will have its source and origin in the United States.

VI. PROJECT ANALYSES

A. Social Soundness Analysis

This Project will operate in a complex social and cultural environment currently undergoing rapid change which will preclude the implementing entities from adopting a standardized approach to promoting HIV/AIDS education. Zambia is characterized by 73 different ethnic groups and seven major languages. There are many differences among the ethnic groups with respect to belief in sorcery or spirit possession, bringing up children, marriage, obligations in marriage (part of the society adheres to matrilineal principles), and inheritances.

Close to one half of the country lives in urban areas. The political system is in the process of transforming itself from decades of one-party rule to an open and transparent democracy. Democratization along with the continued urbanization of the country have reduced the importance of tribal chiefs and extended families as well as long-held traditions. New lifestyles are being forged, and former relationships and traditions are now more ambiguous and complicated.

Even with the diversity, certain common trends in sexual behavior have emerged. Polygamy is a valued tradition

practiced in many parts of Zambia. The practice of extra-marital affairs or multiple liaisons has replaced sanctioned polygamy in the cities.

Zambians, whether residing in rural or urban areas, intensely desire children. Fertility is perceived as an indispensable requirement in life. Children are considered an economic asset to the tribal life; they provide security for the parents in their old age; and, their presence ensures that the ancestors will continually be honored. There has been little modification of this value as people migrated to the city. It is still considered a grave misfortune for women to be barren.

Consumption of beer has traditionally been important to Zambians. It has been used in everything from structured ritual ceremonies to leisure-time pursuits. When the majority of men go out to drink for leisure, they do not take their spouses along. Consuming large amounts of beer often culminates in a desire to indulge in sexual intercourse, increasing the tendency to have multiple partners.

Reasonableness is basic to Zambian thinking. It is reasonable to be sexually active within limits. Excessive promiscuity is not favorably regarded, and when committed, it is believed that punishment, illness or death will follow. It is believed to be reasonable to stigmatize those who have been punished with illness caused for not obeying taboos like having sexual intercourse with nursing mothers or women who have had abortions.

Traditionally, Zambians are fatalistic with regard to life and death. Their attitude is that one dies either because of a long illness, a short illness or in a vehicular accident. Denial of anxieties is a common attitude among Zambians. Denial and fear have been instrumental in preventing the acceptance of information about HIV/AIDS.

The Project's prevention activities have to focus on individual behavior which in Zambia is clearly influenced by a wide range of factors and can be unique to small groups. To deal with the changing environment and diverse culture, the Project requires an HIV-testing and survey team to compile site and target specific profiles before an education activity is introduced.

It is essential that the group delivering the education be cognizant of local cultural, social, and religious traits of the target audiences. To ensure this, the Project's contractor selection process will evaluate the prospective firms for their ability to incorporate language, social, and cultural expertise into their proposals. The selected firm will then be required to ensure that the local Zambian institutions or teams working with

HIV/AIDS in the workplace, with traditional healers, and out of school youths are also capable of adapting their work to fit the cultural environment of the target population. Finally, the Project's rigorously controlled monitoring and evaluation system will identify the effectiveness of Project-funded activities and determine when social considerations need more attention.

The Zambian public has been aware of the existence of AIDS for several years now. In an A.I.D.-funded survey in the Copperbelt and Northern Province⁹, 95 percent of the respondents had heard of AIDS. Over 75 percent of these had known about AIDS for more than two years. Yet, when asked about the most serious diseases, AIDS ranked fourth. The majority of persons interviewed knew that AIDS could be transmitted through sex and that being celibate or sticking to one partner provides protection. With these high levels of knowledge about the disease, it was surprising that only eight percent of those sampled mentioned the use of a condom as a means of protection.

The high level of awareness about AIDS has several implications for the Project. The condom social marketing component of the Project needs to rapidly inform Zambians that condoms can prevent HIV transmission. The education activities have to concentrate on behavior change from the premise that just telling people about the threat and the ways to avoid it is not enough. Zambians already know it exists and it kills.

The status of women in Zambia plays a fundamental role in the spread of AIDS. Women who are monogamous and married to a man who has multiple sexual partners are becoming infected with HIV. The risk factor in these cases is not behavior, but powerlessness to influence a husband's sexual behavior. Men are much more likely to determine the who, when, where, and how of sexual intercourse. The perceived inability to modify a husband's behavior is reinforced in child rearing and even validated at kitchen parties when young brides-to-be are educated on their connubial duties.

For many women, victimization begins early and is tied to economic necessity. Many young girls are sought after by older, more affluent men who are willing to pay school fees and other necessities in exchange for sex. This same situation holds true for out-of-school girls who are economically and educationally impoverished. These liaisons start a cycle of premarital sexual adventures with a number of different partners over a lifetime. For many of these girls formal marriage is perceived as less attractive than maintaining multiple liaisons.

⁹ Yoder PS, Liskin L, and Chirwa B, Knowledge of AIDS in Copperbelt and Northern Provinces Zambia, AID - AIDSCOM, 1992.

The entities providing the HIV/AIDS prevention education will incorporate the "women as victims" into their message and attempt to change women's perceptions of their ability to protect themselves and their family from irresponsible spousal behavior. The attempt to improve the control women can exercise in avoiding HIV contamination will not be limited to changing personal perceptions. The Project will also fund policy activities which will examine wide-ranging, non-traditional areas that may have an impact on the susceptibility of women to HIV transmission. These topics could include the laws governing property distribution after divorce, inheritance rights, and legal penalties against the use of economic rights for sexual harassment.

B. Environmental Analysis

This Project received a Categorical Exclusion, which excludes it from further environmental review (see ANNEX B).

C. Administrative Analysis

Implementation of the Project will involve both public and private sector institutions. The MOH will coordinate the education and counselling activities through its Health Education Unit. The Health Education Unit is a small office with four full-time professionals. The institutional contractor will locate a long-term advisor at the Health Education Unit to assist with coordination and management of the Project's activities.

Annex N provides a partial list and description of NGO's and other institutions most likely to participate in the Project's education and counselling activities. There is no comprehensive directory of NGOs involved in HIV/AIDS prevention, but a preliminary list being developed indicates 162 as being involved in health-related activities. The most notable NGOs are active in HIV/AIDS education, home-based care, counselling, and community support. While there is supply of institutions to provide HIV/AIDS education and care is long, there is no critical evaluation of the quality and impact of their work. The Project will fill this administrative void.

Administratively, the MOH and the NGOs have been involved with the NACPC for over four years. Better coordination of NGO and donor HIV/AIDS activities has been an annual recommendation for improved effectiveness and utilization of resources. Recognizing the need to improve institutional coordination, the Mission made the establishment of a National Health Council to coordinate NGO and donor activity a covenant. With the Project-funded technical assistance and Project covenant, the Mission expects the Project's institutional requirements to be met.

D. Technical Analysis

Because there is no prospect of a "cure" for HIV infection, the technical feasibility and appropriateness of the Project is to a great degree determined by A.I.D. and other donor experience to date. The three main routes of transmission are: contact with infected blood or blood products via transfusions, transplants, or shared needles; sexual contact with an infected person; and infection of infants born to an infected mother. The solution to preventing transmission via blood and blood products is to establish HIV screening for blood transfusion services and promote the use of clean needles. The solution to preventing transmission via sexual contact and perinatal transmission is to implement education programs about HIV and AIDS, encourage fewer sexual partners and more safe-sex practices, and promote and distribute condoms.

The MOH and other providers are screening the blood supply sufficiently well enough that no USAID assistance is required. USAID assistance, however, is warranted in attempting to slow the transmission via sexual contact. The prevalence in Zambia has spread through sexual contact to such an extent that it is probably impossible to eradicate. Even if an effective vaccine were to be devised within the next few years, technical and financial obstacles probably will limit its use in Zambia and, thus, its impact on the spread of the disease. A.I.D. has concluded that education and counselling are the only adequate alternatives to slowing the transmission through sexual contact.

The challenge in slowing the transmission through sexual contact is to bring about behavior modification primarily through education and counselling. This is not easy. The more complex the behavior, the greater the challenge to education and counselling programs to change knowledge, attitudes, beliefs, and practices. Fertility and sexuality are at the core of being human, especially in the social context of Zambian values. The behavior change required has to be long-term, and unlike a one-time vaccine, requires continuous and repetitive actions. Thus, an objective and thorough behavioral analysis for each audience prior to introducing a Project activity is crucial for HIV prevention. The analysis should examine current practices, reasons why a given practice persists and how alternative behavior can be introduced, encouraged, and maintained over time.

The Testing and Survey Team will assist in determining the content and direction of the Project-funded education activities based on the incidence, prevalence and distribution (i.e., within various geographic or ethnic/tribal locations and among populations subgroups in those locations) of HIV infection, and on the information obtained from their surveys. It will be imperative that the Testing and Survey team gather this information and compile profiles for the educators prior to their

determination of the content of the education. The educators have to be prepared to accommodate variations in the target audiences.

Counselling will be tried as part of the Project although the extent to which education and counselling have been effective elsewhere is still a subject of research and debate. Several studies in developed countries have shown no difference in risk reduction between tested and untested gay men. A study in Zaire found that HIV-seropositive women actually had higher fertility rates following testing and counselling than did seronegative women. The implication was that the women's sexual partners needed to be included in the counselling. Preliminary results from an evaluation in Uganda tend to show post-test changes in behavior among women who seek voluntary testing, but no change in behavior among men. The Project will fund voluntary testing and counselling, but under strict on-going surveillance to measure its impact. This Project expects to add solid findings to the debate on the efficacy of voluntary testing and counselling. The counselling will be offered by one or more of the NGOs that has experience in Zambia with HIV/AIDS counselling. As explained in III.C.2. the Zambian demand for voluntary testing is high.

Condom social marketing represents an underutilized strategy for combating the spread of HIV/AIDS in Zambia. The survey on AIDS knowledge in the Copperbelt and Northern Province tested public knowledge about condoms. About three-quarters of the sampled population were able to recognize a condom. When asked why people use condoms, 57 percent of those who had seen a condom before said to protect against disease and 28 percent said to avoid pregnancy. Only 13 percent said to protect against AIDS. Approximately 28 percent of the survey agreed with the statement that condoms were against their religion, and 38 percent agreed with the statement that married people should never use them. Based on the survey, few Zambians use condoms for protection against AIDS.

Consequently, the Project will rely on formative research to ensure the effectiveness of all elements of the condom social marketing strategy. Brand name and packaging have already been selected based on a series of 16 focus groups. The price has been set at a level affordable to even the lowest segment of the population. Because of the complex social structure, condom education and promotion will include popular theater, songs, condom education conferences, condom evenings and point-of sale promotions. The condom education conferences will be held to educate groups such as health workers, pharmacists, industrial workers, NGOs and students on correct condom usage and HIV prevention strategies.

Eventually, condoms will be advertised in the mass media. In Zambia, three out of four households have a radio and one out of four have access to a television. Experience in Zaire demonstrated that radio and television broadcasts reached 85 percent of the population in urban areas. In the first year, the Project-funded advertising will stress the need for protection against HIV/AIDS. Explicit condom advertising will be developed slowly to stay within cultural constraints.

Logistics is the most immediate barrier to increased use of condoms in Zambia. Condoms have tended to be warehoused and distributed under last-in, first-out method of inventory control. By the time the warehouses began working down stocks, the shelf life of the condoms would have expired. One WHO/Population Council consultant estimated a 30 percent breakage rate of condoms in Zambia, due in part to inadequate distribution and quality control. The technical solutions to quality control of packaging and storage are well known and will be followed under the Project.

Technically, one of the best places to have an impact on slowing the rate of transmission, especially as it pertains to the problems women face, is through STD control. Attendees at STD clinics have significantly higher seropositivity rates than that of the general population. Beside the tendency for these patients to engage in high risk sexual behavior, they are thought to be at risk for HIV because of they generally have ulcerative diseases which provide the virus with an entry. The Zambia National STD Control Program noted a seroprevalence rate of 42.5 percent among male and 54.5 percent among female attendees of its STD/HIV clinics.

A demographic model for the U.S. demonstrates that a five percent reduction in the duration of STDs in urban areas would result in a two percentage drop in seroprevalence levels by 2015. STD control may be the only defense for women who have no control over the where and when of sexual intercourse. A genital ulcer on the vaginal wall that can rupture from the friction of intercourse may afford HIV access to the bloodstream.

Unfortunately, STD control is expensive. Diagnosing STDs requires testing equipment and supplies. Clearing up STDs requires drugs which are hard for Zambians to purchase and properly utilize. Even penicillin at 10 cents per dose is too expensive to treat everyone in poorer countries who needs it. Improper utilization also increases the potential for drug resistant strains to develop. Recognizing the problems associated with STD control, the Project proposes to appropriately address the utilization and cost issues of STD control on a pilot basis.

Based on the Project's design which builds on AIDS prevention experience in 39 African countries, the Project activities are technically feasible and appropriate. Even with consistent success of all the Project's measures, the long-range outlook is not encouraging. The trend in HIV/AIDS cases in Zambia through the mid-1990s will continue to be upward. By the mid- to late-1990's, AIDS will probably become the leading cause of death in Zambian adults between the ages of 15 and 49, and will probably cause more deaths in children under the age of five than either malaria or measles.

E. Economic Analysis

This economic analysis is presented using a non-traditional approach. Rather than estimate several epidemiological scenarios resulting from the Project and then present the Project as having a high, medium, and low benefit-cost ratio, this analysis identifies the minimum decrease in the national HIV transmission rate necessary to for the Project's benefit-cost ratio to just exceed one. Given the humanitarian aspects of the Project and the Congressional mandate for HIV/AIDS prevention efforts in Africa, the economic test for this Project is to be extremely confident that at a minimum the benefits from the Project will be greater than the costs. The Mission fully expects a high benefit-cost ratio but, considering the nature of the Project and the difficulty in assigning impact values to the education activities, sees no need to develop and fine-tune elaborate epidemiological and economic projections.

The costs and benefits of the Project are presented in a simple model (see Annex L for detailed calculations) that projects AIDS deaths with and without the Project (see Exhibit 1). The source for the baseline level of HIV infections by year up to 1992 is Epi Model¹⁰, a simple computer program for short-term projections of AIDS cases. With the assumption that Zambia currently (1992) has 300,000 citizens infected with the virus, Epi Model interpolated the timing and rate of past infections. Approximately 300,000 current infections is reasonable as current estimates range between 200,000 and 400,000.

The annual growth rate in the cases of HIV infections was estimated at 4.5 percent for 1993 with an annual decrease of 0.1 percent thereafter to reflect the generally held belief that the epidemic will plateau out on its own in the long-term. Four and a half percent growth is conservatively estimated when compared to the seven to nine percent growth rate suggested in the Epi Model calculations. The analysis used the Epi Model conversion table to calculate the number of HIV cases converting

¹⁰ Epi Model was developed by staff and consultants at the World Health Organization's Global Program on AIDS.

EXHIBIT 1

USAID/ZAMBIA
HIV/AIDS PREVENTION PROJECT
PROJECT NO: 611-0221

Analysis of Reasonableness of Project Costs
Reduction in rate of transmission for Project to have a benefit-cost ratio > 1

	(a) NEW HIV W/O PROJ	(b) AIDS NEW	(c) DEATH NEW b after 1 yr	(d) COST PER AIDS DEATH	(e) COST W/O PROJ c x d	(f) NEW HIV W PROJ	(g) AIDS NEW	(h) DEATH NEW W PROJ	(i) COST PER AIDS DEATH	(j) COST W PROJ c x d	(k) COST DIF W/ PROJ
1992	60,068	12,726	11,160								
1993	62,771	16,157	12,726			60,068	12,726	11,160			(17,660,467)
1994	65,533	19,775	16,157			62,681	16,157	12,726			
1995	68,351	23,472	19,775			65,345	19,775	16,157			
1996	71,222	27,170	23,472			68,057	23,469	19,775			
1997	74,142	30,855	27,170			70,813	27,158	23,469			
1998	77,107	34,520	30,855	1,816	49,343,305	73,610	30,829	27,158	1,816	49,322,276	21,029
1999	80,115	38,184	34,520	1,851	57,124,747	76,444	34,472	30,829	1,851	57,076,445	48,302
2000	83,159	41,799	38,184	1,887	65,154,990	79,311	38,106	34,472	1,887	65,064,170	90,820
2001	86,236	45,336	41,799	1,924	73,473,232	82,206	41,682	38,106	1,924	73,322,665	150,567
2002	89,340	48,761	45,336	1,962	81,998,701	85,124	45,171	41,682	1,962	81,767,022	229,678
2003	92,467	52,066	48,761	2,000	90,668,341	88,061	48,538	45,171	2,000	90,337,902	330,439
2004	95,611	55,220	52,066	2,039	99,420,175	91,011	51,777	48,538	2,039	98,964,880	455,295
2005	98,766	58,212	55,220	2,079	108,229,550	93,969	54,857	51,777	2,079	107,628,318	601,231
2006	101,927	61,047	58,212	2,119	117,025,781	96,929	57,765	54,857	2,119	116,255,591	770,190
2007	105,087	63,746	61,047	2,161	125,774,805	99,885	60,509	57,765	2,161	124,810,593	964,212
2008	108,239	66,338	63,746	2,203	134,478,064	102,832	63,107	60,509	2,203	133,292,621	1,185,443
2009	111,378	68,859	66,338	2,246	143,168,079	105,762	65,587	63,107	2,246	141,731,952	1,436,126
2010	114,497	71,349	68,859	2,290	151,902,940	108,671	67,987	65,587	2,290	150,184,332	1,718,608
2011	117,588	73,859	71,349	2,335	160,760,819	111,550	70,346	67,987	2,335	158,725,486	2,035,333
2012	120,645	76,384	73,859	2,380	169,833,884	114,395	72,716	70,346	2,380	167,445,041	2,388,843
2013	123,661	78,921	76,384	2,427	179,250,235	117,198	75,095	72,716	2,427	176,477,205	2,773,030
				2,474	189,010,505	119,952	77,479	75,095	2,474	185,821,176	3,189,329
Sum of benefits											18,388,476
Cost of Project											17,660,467
Benefit cost ratio											1.04
Decrease in national transmission rate necessary for the Project to have a benefit cost ratio greater than 1.											3.33%
Total HIV cases with Project											1,646,907
Total HIV cases without Project											1,679,965
Total HIV to be averted for Project to have a benefit cost ratio greater than 1.											33,058

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to AIDS by year. Once converted to AIDS, the analysis assumed the patient would die within one year.

The average age at the time of death was estimated at 35 years. This is considerably higher than actual because it conservatively does not factor in the AIDS infants that pass away before the age of five. The estimated life span for those not infected and reaching 35 is estimated at 65. Since the average age at death from AIDS is probably lower than 35, 30 lost productive years are understated.

The analysis forecasts per capita GDP in 1997 to be \$400 and the cost of direct treatment per AIDS patient to be \$50. Real GDP is expected to grow at two percent per year and the discount rate is estimated at four percent. The model then assumes that a life protected from an HIV infection will generate surplus earnings of at least 20 percent per year for 30 years. Surplus earnings are defined as the amount not spent on maintenance of self and family.

These economic, demographic, and epidemiological assumptions are conservative and supportable. For instance, the direct cost per AIDS patient is probably higher; one recent study put it at \$400. The surplus earnings is probably much greater than 20 percent; one A.I.D. economist suggested 50 percent as more reasonable.

Using these extremely conservative assumptions, the minimum decrease in the national HIV transmission rate needed to justify the Project was calculated to be 3.33 percent (see Exhibit 1). That is, if the Project reduces the growth rate in the transmission of HIV by approximately 3.3 percent, the Project's benefit-cost ratio will be greater than one. For example, in a single year such as 1995, the Project would be expected at a minimum to reduce the annual growth in HIV transmission from 4.5 percent to 4.35 percent.

A 3.3 percent reduction in the growth rate is the equivalent of approximately 45,000 fewer HIV cases over a 22 year period, or on the average, 2,000 cases per year. The Project's condom social marketing component alone is expected to generate an annual demand for at least 7.5 million condoms. Since the number of HIV cases averted per million condoms sold is estimated to be 400, condom sales alone will generate a positive benefit cost ratio.

The Project's health education activities are expected to reach approximately 25,000 individuals per year during the life of the Project. Half of these are expected to have self selected themselves to be at risk for HIV infection. Behavior modification is necessary in: only one quarter of those receiving the Project-funded message in the early years of the Project;

and, because the prevention message is expected to be passed on to larger numbers of recipients in the out years, in smaller and smaller percentage of the population at risk in the ensuing years.

While admittedly a simple model, the analysis demonstrates that it is reasonable to assume that the Project will bring about a decrease in HIV transmission rate capable of making the Project investment worthwhile. As a final assurance of economic justification, the Project has a tightly controlled monitoring and evaluation aspect to it which will evaluate the impact of the education activities in target groups using HIV tests to ensure accuracy. If reductions in the transmission rate are not evident, the Project's education activities will be redesigned or terminated, assuring that Project funds are not spent on efforts with no economic justification. Based on the nature of the Project, the high degree of confidence that the Project will have a positive internal rate of return, and the evaluation safeguard built into the design, the Project is considered to be economically sound.

VII. NEGOTIATING STATUS, CONDITIONS, AND COVENANTS

USAID/Zambia and the MOH have jointly developed the Project. The Project also includes the advice and recommendations of various Zambians outside the government. With this setting, USAID/Zambia expects no problems in negotiating a Grant agreement.

The Grant Agreement will include the usual initial conditions precedent requiring a specimen signature an authorized representative for the Project.

The Government of the Republic of Zambia shall covenant that, unless A.I.D. otherwise agrees in writing, it will:

provide appropriate office space, equipment, supplies and support personnel required for the effective operation of the HIV/AIDS Prevention Project;

establish a National Health Council to improve the coordination of Non-Governmental Organization and donor health care activities in Zambia; and

draft a health care financing plan that recommends sustainable funding sources in Zambia which might pay for an adequate level of care for Zambians.

Project Logical Framework

AIDS Prevention Project
611-0221

Narrative	Indicators	Means of Verification	Assumptions
Goal: Market-oriented, sustainable, broad-based economic growth	Improved GNP Increased tax revenues Improved balance of trade and current account Interest payments to service debt decreased	Central Bank reports IBRD/IMF country reports Project monitoring GRZ reports	Political and social stability maintained Global copper prices decline moderately (10%-15%) Legal and regulatory reforms implemented
Subgoal: Socially stable, economically productive population	Agricultural, industrial, and commercial productivity remains constant or improves	Central Bank reports IBRD/IMF country reports Project monitoring GRZ reports	
Purpose: To reduce the incidence of HIV transmission in target populations	End of Project Status: Reduce incidence of HIV by 15% in high risk target group Reduce incidence by 30% in low risk target groups Incidence of HIV demonstrated to be lower in target population than in population in general	Project-funded baseline and follow-up testing & surveys Project-funded baseline and follow-up testing and surveys Project-funded baseline and follow-up testing & surveys	

Project Logical Framework

AIDS Prevention Project
011-0221

Narrative	Indicators	Means of Verification	Assumptions		
Outputs:					
1. Public Health Education Component					
<u>HIV Prevention in the Work Place</u>					
Stratification and ranking of companies by selected criteria	1	Site visits Project Implementation Letters MOH Quarterly Reports Mission Reports			
Baseline survey of HIV seroprevalence in the workplace (by Phases)	4				
Workplace curricula developed	4				
Workplace HIV/STD screening programs	80				
Workplace clinical/peer staff trained in HIV prevention counselling	2,000				
Workplaces with established HIV policies	80				
Condoms distributed through workplace program	405,000				
<u>Traditional Healers</u>					
Identification, stratification and ranking of traditional healers by priority areas	1				
Baseline survey of HIV seroprevalence among patients of selected traditional healers (in Phases)	4				
Curricula developed for traditional healers	8				
Trained peer trainers	400				
Trained traditional healers in prevention and counselling	8,000				
Condoms marketed through traditional healers	1,500,000				
Traditional healer health information system	1				
<u>HIV Prevention Youth</u>					
Survey into sexual behavior	1				
Trained youth educators	500				
Youth condom marketing program	1				
<u>HIV Prevention Media</u>					
Program of quarterly briefings and review of journalism standards in reporting on AIDS and related health topics	1				
2. Volunteer Testing and Counseling					
Counselled and tested beneficiaries in surveys	1,820				
Counselled and tested beneficiaries	38,000				
3. Condom Social Marketing					
Condoms distributed through non-Project specific channels	28,085,000				
4. STD Control Program					
Pilot Cost Recovery Program	1				
5. Policy and Grant Fund					
Policy paper	1				
Small grants fund	1				
6. Management and Evaluation					
Interim evaluations	3				
Final evaluation	1				
Project audits	3				

Annex A

Project Logical Framework

AIDS Prevention Project
011-0221

Narrative	Indicators			Means of Verification	Assumptions
Inputs:	Aid	GRZ	TOTAL		
	(\$US000)				
1. Technical assistance	\$8,650,000		\$8,650,000	Contractor quarterly reports A.I.D. Disbursement Records A.I.D. Audit Reports	Commodities and TA arrive in timely fashion.
2. Training	274,000		274,000		
3. Commodities	7,340,000		7,340,000		
4. Audit & evaluation	225,000		225,000		
5. Grants fund	350,000		350,000		
6. Inflation & contingency	2,843,000		2,843,000		
Total	\$10,700,000		\$0 \$10,700,000		

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INITIAL ENVIRONMENTAL EXAMINATION OR CATEGORICAL EXCLUSION

Project Country: Zambia Project Number 611-0221
 Project Title: AIDS Control and Prevention Sub-project
 AIDSCAP/ZAMBIA
 Funding: FY (s) 1992-1995 \$19,750,000
 IEE Prepared by: USAID/Zambia PDO: Peter Downs
 Environmental Action Recommended:

Positive Determination _____
 Negative Determination _____

Categorical Exclusion: _____ X _____

AIDSCAP/Zambia (number 611-0221) is a bilateral sub-project under the centrally funded AIDS Technical Support Project (number 936-5672). AIDSCAP provides for a variety of short term-training experiences, workshops, Social Condom Marketing, and STD/HIV educational and clinical interventions in Zambia. Funds are included for evaluation and planning. No financing of construction is provided for in this project, nor is any financing provided for any activity which would directly affect the environment. Protocols concerning the handling of syringes, and other materials involved in work with actual or potential HIV infected persons will be strictly adhered to.

This activity meets the criteria for Categorical Exclusion in accordance with Section 216.2 (2) (i) and (iii), and is excluded from further review because the proposed sub-project consists of the financing of activities listed below which will have no direct impact on the environment:

- (1) training designed to change activities and attitudes which contribute to the increased incidence of STD/HIV infections; examples of target populations are out-of-school youths and other potential sexually active males and females;

- (2) information dissemination campaigns directed toward policy makers in the private and public sectors;
- (3) institutional strengthening of selected parts of the Zambia STD network;
- (4) program to incorporate traditional healers into STD/HIV control efforts;
- (5) voluntary counseling and testing centers
- (6) condom marketing and distribution program.
- (7) minor physical improvements to office space and clinical facilities may be made pursuant to specific architectural and engineering plans, and specifications deemed necessary by the cognizant A.I.D. technical office.

Concurrence:

[Handwritten Signature]

Bureau Environmental Officer

APPROVED

[Handwritten Signature] 4/22/92

DISAPPROVED

Clearance:

GC/AFR MA Klevyan Date 5/4/92

drafter: *[Handwritten Signature]* Jackson; 4/1/92

CLEARANCES:

ADO, John Foster

[Handwritten Signature]

PRM. John Wiehler

[Handwritten Signature] 4/3/92

A/DIR, Bruno Kotheleff

[Handwritten Signature] 4/2/92

All communications should be addressed
to the Permanent Secretary
Telephone: LUSAKA 211991, 211348, 211589
211747, 250497



In reply please quote
No. NCDP/101/7/68

REPUBLIC OF ZAMBIA
OFFICE OF THE PRESIDENT

NATIONAL COMMISSION FOR DEVELOPMENT PLANNING
NATIONALIST/MBITA ROAD
P.O. BOX 50268
LUSAKA

SEP 28 1992

28th September, 1992

Dr. Fred E. Winch,
Mission Director,
USAID/Zambia,
2365 Katunjila Road,
LUSAKA
Zambia

ACTION FEW	DUE DATE 10/5
TRANSFER JW	INFO
ACTION TAKEN JAW	
DATE 9/28	INITIALS JAW

Dear Dr. Winch,

On behalf of the Government of the Republic of Zambia, I hereby request the Agency for International Development (A.I.D) to provide a grant of nineteen million seven hundred thousand United States Dollars for the HIV/AIDS prevention efforts in Zambia. This grant will be used over the next five years to address the constraints to reducing the rate of transmission of HIV in target groups.

We understand that the Ministry of Health will take an active role in implementing and co-ordinating grant-funded activities. The Government of the Republic of Zambia welcomes the assistance from A.I.D, and we look forward to an Agreement covering the requested assistance.

Yours sincerely,


M. M. LISWANISO
PERMANENT SECRETARY
(DEVELOPMENT CO-OPERATION)
OFFICE OF THE PRESIDENT

c.c Dr. K. Kamanga,
Permanent Secretary,
Ministry of Health,
LUSAKA

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Annex D

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH CHECKLIST UP TO DATE?

1. Host Country Development

Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage developments and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

- (a) N/A
- (b) N/A
- (c) N/A
- (d) N/A
- (e) Project hopes to reduce the incidence of HIV in Zambia's productive workforce.
- (f) Same as (e).

2. U.S. Private Trade and

Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. consulting firms and advisors will assist the GRZ in implementing the Project. The Project will fund the purchase of U.S. vehicles and pharmaceuticals. As much procurement as possible will come from the U.S.

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3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

A Congressional Notification was sent to Congress as required. It expired without objection on June 30, 1992.

b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided with a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575 (b) (3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000 will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonable firm estimate of the cost to the U.S. of the assistance?

a) Yes

b) Yes

5. Legislative Action (FAA Sec. 611(a) (2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

The GRZ does not require legislative approval of the obligation.

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6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575 (b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? N/A
8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A
9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to:
- (a) increase the flow of international trade; (a) N/A
 - (b) foster private initiative and competition; (b) N/A
 - (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (c) N/A
 - (d) discourage monopolistic practices; (d) N/A
 - (e) improve technical efficiency of industry, agriculture and commerce; (e) Project hopes to reduce the incidence of HIV in Zambia's productive workforce. (f) Same as (e).
 - (f) strengthen free labor unions.
10. **U.S. Private Trade** (FAA Sec. 501(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). U.S. consulting firms and advisors will assist the GRZ in implementing the Project. The Project will fund the purchase of U.S. vehicles and pharmaceuticals. As much procurement as possible will come from the U.S.

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11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

N/A, Zambia has received a Section 110 waiver.

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

c. Separate Account FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

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(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A

12. Trade Restrictions

a. **Surplus Commodities** (FY 1991 Appropriations Act. Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and in such assistance likely to cause substantial injury to U.S. procedures of the same, similar or competing commodity? N/A

b. **Textiles (Lautenberg Amendment)** (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? N/A

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c) (3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? (a) No
(b) No

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14. **Sahel Accounting** (FAA Sec. 121(d)): If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

N/A

15. **PVO Assistance**

a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

16. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Mission will comply when date of signing is confirmed.

17. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the

No. Most procurement will be for computers, office equipment, and vehicles.

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extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

No. In Zambia, the male/female infection rate is 1.04 to 1. Project attempts to reduce the rate of transmission in target populations which are expected to be evenly distributed.

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No.

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

N/A

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

N/A

b. Will any funds be used to lobby for abortion?

N/A

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperative, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

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22. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

U.S. does not have excess holdings of kwacha.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

The U.S. does not own excess Zambian currency.

23. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Small businesses are expected to supply commodities.

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?

Yes.

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminated against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

N/A

d. Non-U.S. agricultural procurement (FAA Sec. 604 (e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those

N/A

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countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. **Cargo preference shipping (FAA Sec. 603):** Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No.

g. **Technical assistance (FAA Sec. 621(a)):** If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes.
Yes.

h. **U.S. air carriers (International Air Transportation Fair Competitive practices Act, 1974):** If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

i. **Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504):** If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes, standard clauses.

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- j. Consulting services** (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? **Yes.**
- k. Metric conversion** (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? **N/A**
- Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? **N/A**
- l. Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? **Yes.**
- 24. Construction**
- a. Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? **N/A**
- b. Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? **N/A**

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- c. Large projects, Congressional approval (FAA Sec. 620(k)):** If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional presentation), or does assistance have the express approval of Congress? N/A
- 25. U.S. Audit Rights (FAA Sec. 301(d)):** If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A
- 26. Communist Assistance (FAA Sec. 620(h)).** Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.
- 27. Narcotics**
- a. Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops eradicated? Yes.
- b. Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes.

Annex

28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? **Yes.**
29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? **Yes.**
30. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? **Yes.**
31. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? **Yes. Even though DFA procurement rules apply, Project will purchase U.S. vehicles.**
32. **Military Personnel** (FY 1991 Appropriations Act. Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? **Yes.**
33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act. Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? **Yes.**
34. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) transfer of FAA funds to multilateral organizations for lending)? **Yes.**
35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? **Yes.**

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36. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human rights? Yes.

37. **Publicity or Propaganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No.

38. **Marine Insurance** (FY 1991 Appropriations Act Sec. 5633): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a Yes.

No.

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Annex D

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers? N/A
2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits? N/A
3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Yes, Project will use HIV tests, to the extent possible, that are appropriate to incomes of the poor. Condoms will also be priced so as to be accessible by the poor.
4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government. The Project was designed in close collaboration with the GRZ.

Annex D

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes. Project's subgoal is directed at protecting the nation's productive labor force.

6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

a) N/A

b) N/A

c) N/A

d) N/A

e) N/A

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

No. This Project qualified for a Section 110 waiver.

8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes, Project includes an monitoring and evaluation activity to ensure beneficiary impact.

Annex D

9. **Abortions** (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? N/A

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? N/A

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? N/A

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? N/A

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? N/A

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? N/A

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? N/A

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Annex D

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes

11. **Disadvantaged Enterprises** (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? Projected to be between 15% and 20% of total Project cost.

12. **Biological Diversity** (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N/A

13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):

a. **A.I.D. Regulation 16**: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Yes.

b. **Conservation**: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent N/A.

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N/A

feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watershed and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss or degradation; (9) conserve biological diversity in foresty areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. Government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

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c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

N/A

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

Project received a categorical exclusion.

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14. **Energy** (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. **Sub-Saharan Africa Assistance** (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks,

a) Yes

b) N/A

c) Yes

d) Yes

e) Yes

f) N/A

Annex D

to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

18. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

Annex D

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? Yes.

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A

d. Exports to United States (FAA Sec. 629(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries? 1) N/A
2) N/A
3) N/A
4) N/A
5) N/A

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20. Agriculture, Rural Development and Nutrition, and Agricultural research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor, or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. Nutrition: Describe extent which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

N/A

c. Food security: Describe extent to which activity increases national security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of

Project will improve the integrated delivery of services at existing clinics, health posts, and workplaces with multi-skilled teams: health educators, STD representatives, NGO counsellors, and condom sales-persons.

Annex D

mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collected and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources, energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

Project will operate a pilot program at STD clinics, develop a information system for traditional healers, and tightly survey and HIV test target populations.

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

N/A

Annex D

- c. research into, and evaluation of, economic development processes and techniques; N/A
- d. reconstruction after natural or manmade disaster and programs of disaster preparedness; N/A
- e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; N/A
- f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. N/A
24. Sahel Development (FAA Secs. 120-21): If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). N/A

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ACT: AID-3 INFO: AMB DCM

VZCZCESA106BCA206
 PP RUEHLS
 DE RUEHC #1844 2182031
 ZNR UUUUU ZZH
 P 052030Z AUG 92
 FM SECSTATE WASHDC
 TO AMEMBASSY LUSAKA PRIORITY 2336
 BT
 UNCLAS STATE 251844

ACTION BAL	DUE DATE 8/11
TRANSFER	INFO
ACTION TAKEN	
DATE	INITIALS

AIDS/174

LOC: 156 430
 06 AUG 92 0602
 CN: 63165
 CHR: AID
 DIST: AID

611-0221

AUG 06 1992

AIDAC, NAIROBI, FOR REDSO RLA

E.O. 12356: N/A

TAGS:

SUBJECT: ZAMBIA - AIDS PREVENTION PROJECT (611-0221) -
 PROGRAM CONCURRENCE

REF: (A) AIDS STRATEGIC PLAN FOR ZAMBIA (B) LUSAKA 3129

1. PROGRAM CONCURRENCE IS HEREBY PROVIDED FOR DEVELOPMENT OF THE SUBJECT PROGRAM BASED ON THE QUOTE PID - LIKE DOCUMENT UNQUOTE COMPRISED OF REFS A AND B. REFS WERE REVIEWED IN AID/W AND NO OBJECTIONS WERE RAISED TO THE MISSION'S PROPOSED PROGRAM.

2. THE FOLLOWING ISSUES WERE IDENTIFIED FOR MISSION CONSIDERATION IN DEVELOPMENT OF THE PROPOSED PROGRAM:

(A) PROCUREMENT WAIVERS: ALTHOUGH SPECIFIC WAIVERS ARE NOT REQUIRED FOR VEHICLES PROCURED WITH DFA FUNDS, MISSION IS REQUESTED TO ENSURE THAT CODE 000 BE USED TO THE MAXIMUM EXTENT PRACTICABLE. SHOULD NON-US PROCUREMENT BE NECESSARY TO ACHIEVE PROJECT OBJECTIVES, MISSION SHOULD FULLY JUSTIFY REASONS FOR NON - U.S. PROCUREMENT IN THE PROJECT FILES. NON-AVAILABILITY IN TERMS OF INAPPROPRIATE SPECIFICATIONS, LACK OF SPARE PARTS AVAILABILITY OR MAINTENANCE CAPABILITY ARE POSSIBLE JUSTIFICATIONS. FOR

PHARMACEUTICALS, U.S. PROCUREMENT IS REQUIRED FOR PUBLIC HEALTH REASONS IN ACCORDANCE WITH HB 18, CHAPTER 4C3, WHICH ALSO HAS WAIVER PROVISIONS REQUIRING CONCURRENCE OF MS/OP/COMS/M. CURRENT PROCUREMENT POLICY IS DETAILED IN AA/AFR CHARLES L. GLADSON TO AFRICA FIELD POSTS MEMORANDUM, DATED APRIL 4, 1988 (SEE SECTION C (2) (D) AND SUBSECTION (E)). THOUGH THIS GUIDANCE IS STILL IN EFFECT, GROWING SUPPORT IN CONGRESS FOR PROPOSED BUY AMERICA LEGISLATION REINFORCE NEED FOR CLEAR AND COMPELLING REASON AND STRONG JUSTIFICATION FOR ANY PROCUREMENT WAIVERS PROPOSED. IT IS UNDERSTOOD THAT PROJECT-FINANCED CONDOM PROCUREMENT WILL BE FROM THE U.S.

(B) COUNSELING AND TESTING COMPONENT: WHILE WIDESPREAD TESTING AND COUNSELING SEEM INTUITIVELY CORRECT AND APPEAL TO THE BASIC SENSE OF ONE'S QUOTE RIGHT TO KNOW UNQUOTE, IN THE CONTEXT OF THE AIDS EPIDEMIC, ONE NEEDS TO CONSIDER THE LIMITATIONS OF SUCH AN INTERVENTION. IN THE ABSENCE

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OF ANY MEDICAL TREATMENT TO MITIGATE THE EFFECTS OF HIV/AIDS, THE PREVENTION IMPACT OF TESTING AND COUNSELING IS CONSIDERABLY WEAKENED. THE ACCOMPANYING COSTS HOWEVER, WILL BE GREAT AND THE DEMAND CREATED BY TESTING WILL BE EXPENSIVE FROM AN INFRASTRUCTURE AS WELL AS A MANAGEMENT PERSPECTIVE. THERE IS NO EVIDENCE THAT TESTING AND COUNSELING HAS RESULTED IN QUOTE SAFER UNQUOTE BEHAVIOR. ANECDOTAL EVIDENCE SUGGESTS THAT IN SOME CASES, THERE HAS BEEN AN ADVERSE EFFECT ON SUCH BEHAVIOR MODIFICATION. CONSEQUENTLY, IT IS RECOMMENDED THAT THE MISSION PROCEED WITH CAUTION IN THE DESIGN AND IMPLEMENTATION OF TESTING AND COUNSELING PROGRAMS AND THAT SUCH DESIGN INCLUDE A COMPREHENSIVE EVALUATION COMPONENT. THE EVALUATION COMPONENT WILL PROVIDE THE BASIS FOR MODIFICATION OF THE PROGRAM AS NECESSARY. EVALUATION DATA AND FINDINGS WILL ALSO BE OF INTEREST AND IMPORTANCE TO THE AIDS PREVENTION COMMUNITY AT LARGE AND A CRITICAL CONTRIBUTION TO THE AIDS PREVENTION KNOWLEDGE BASE.

3. MISSION AUTHORITY TO APPROVE AND AUTHORIZE THE PROJECT IN AN AMOUNT OF DOLS 19.7 MILLION SHALL BE EXERCISED UNDER THE TERMS AND CONDITIONS OF DOA 551 AND IN ACCORDANCE WITH THE MISSION'S PROPOSAL IN REF DOCUMENTS AND THE GUIDANCE PROVIDED HEREIN.

4. AN IEE (CATEGORICAL EXCLUSION) NEEDS TO BE ARRANGED BY THE BUREAU ENVIRONMENTAL OFFICER FOR THIS ACTIVITY.

5. IS PSI PROPOSING A CONTRACT OR AN ASSISTANCE INSTRUMENT? IF A CONTRACT IS INTENDED THE MISSION SHOULD BE AWARE THAT THE FAR STANDARDS FOR ACCEPTING AN UNSOLICITED PROPOSAL FOR A CONTRACT ARE VERY DIFFICULT TO MEET, AND THE MISSION SHOULD CONSULT WITH A CONTRACTING OFFICER AND RLA AT AN EARLY POINT.

5. BUDGET ALLOWANCE IS IN PROCESS AND WILL BE PROVIDED BY SEPTEL. EAGLEBURGER

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COSTING OF PROJECT BY INPUTS AND OUTPUTS

PROJECT INPUTS	PROJECT OUTPUTS										
	WORK PLACE	TRADITIONAL HEALERS	YOUTH	MEDIA	TESTING COUNSEL	CONDOM SOC MKTG	STD	POLICY & GRANTS	A.I.D. MGMT	INFLATION CONT	TOTAL
AID APPROPRIATED											
TECHNICAL ASSISTANCE	889,000	637,000	589,000	278,000	4,148,000	2,735,000	1,529,000	175,000	515,000		11,495,000
TRAINING	71,000	637,000	589,000	278,000	4,148,000	107,000	1,529,000				7,359,000
COMMODITIES	261,000	637,000	589,000	278,000	4,148,000	4,642,000	1,529,000				12,084,000
GRANTS								225,000			225,000
AUDIT/EVALUATION									350,000		350,000
INFLATION/CONTINGENCY										2,843,000	2,843,000
SUBTOTAL	1,221,000	1,911,000	1,767,000	834,000	12,444,000	7,484,000	4,587,000	400,000	865,000	2,843,000	34,356,000

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For Detailed Budgets see corresponding note in Annex F

Workplace – see note 1

Traditional healers – see note 2

Youth – see note 3

Media – see note 4

HIV Testing & Counsel – see note 5

Condom Social Marketing – based on budgets in PSI unsolicited proposal

STD – see note 6

For short- and long-term technical assistance costs – see note 7

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NOTE 1
 Workplace

<u>HIV Prevention in the Work Place</u>	<u>QTY</u>	<u>COST</u>	<u>TYPE</u>	<u>TOTAL</u>	<u>FY93</u>	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>CHECK</u>
1 Stratification and ranking of companies by selected criteria										
Vehicle	2	28,000 C		56,000	56,000					0
Spares (13%)	0.15	C		8,400	8,400					0
Shipment & insurance (25%)	0.25	C		14,000	14,000					0
Operation	5	1,500 C		7,500	1,500	1,500	1,500	1,500	1,500	0
Maintenance	5	600 C		3,000	600	600	600	600	600	0
Computer	1	2,500 C		2,500	2,500					0
Laser printer	1	1,750 C		1,750	1,750					0
Software	3	500 C		1,500	1,500					0
U P S	1	500 C		500	500					0
Supplies	10	225 C		2,250	2,250					0
Shipping (15%)	0.15	C		300	300					0
Facsimile	1	750 C		750	750					0
Office furniture	5	1,500 C		7,500	7,500					0
VCR/TV	1	1,500 C		1,500	1,500					0
2 Baseline survey of HIV seroprevalence in the workplace (by Phases) Cost of lab and survey										
Phase I Companies	300	50 C		15,000	15,000					0
Phase II Companies	300	50 C		15,000		15,000				0
Phase III Companies	300	50 C		15,000			15,000			0
Phase IV Companies	300	50 C		15,000			15,000			0
Per Diems	240	15 C		3,600	1,200	1,200	1,200			0
ST TA to compile & analyze		a								
3 Workplace curriculums developed										
Books/journals/supplies	3,000	5 C		15,000	5,000	5,000	5,000			0
Ads/pamphlets/videos	15,000	5 C		75,000	25,000	25,000	25,000			0
Curriculum/Occupational health advisor w/ HQ support	3	279,000 TA		837,000	279,000	279,000	279,000			0
4 Workplace HIV/STD screening programs										
5 Workplace clinical/peer staff trained in HIV prevention counselling										
Workshop sessions	50									
Trainers - per diem	250	15 TR		3,750	1,125	1,125	1,500			0
Clinical/peer trainers	2,000	15 TR		30,000	9,000	9,000	12,000			0
Workshop materials	2,000	10 TR		20,000	6,000	6,000	8,000			0
Workshop facilities	50	350 TR		17,500	5,250	5,250	7,000			0
6 Workplaces with established HIV policies										
ST TA to compile comprehensive manual & train staff in use	2	26,000 TA		52,000	26,000	26,000				0
7 Condoms distributed through workplace										
c										
TOTAL				\$1,221,300	\$471,625	\$374,675	\$370,800	\$2,100	\$2,100	0

NOTE 2
 Traditional Healers

<u>Traditional Healers</u>	<u>QTY</u>	<u>COST</u>	<u>TYPE</u>	<u>TOTAL</u>	<u>FY93</u>	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>CHECK</u>
1 Identification, stratification and ranking of traditional healers by priority areas										
ST TA in compiling population list	1	26,000 TA		\$26,000	26,000					0
Vehicle	2	28,000 C		56,000	56,000					0
Spares (15%)	0.15	C		8,400	8,400					0
Shipment & insurance (25%)	0.25	C		14,000	14,000					0
Operation	5	1,500 C		7,500	1,500	1,500	1,500	1,500	1,500	0
Maintenance	5	600 C		3,000	600	600	600	600	600	0
2 Baseline survey of traditional healers and their patients										
Cost of lab and survey										
Phase I	400	50 C		20,000	10,000	10,000				0
Phase II	100	50 C		5,000		5,000				0
Phase III	100	50 C		5,000			5,000			0
Phase IV	100	50 C		5,000			5,000			0
Per Diems	240	15 C		3,600	1,030	1,540	1,030			0
3 Traditional Healer curriculum developed										
Books/Journals/Pamphlets		C		2,000	800	800	400			0
Pamphlets	50,000	1 C		50,000	10,000	20,000	20,000			0
ST TA Curriculum & Workshops	10	26,000 TA		260,000	104,000	104,000	52,000			0
4 Traditional Healer training in HIV prevention counselling										
Workshop sessions	40									
Trainers - per diem	200	15 TR		3,000	860	1,290	850			0
Traditional healers trained	2,000	15 TR		30,000	8,570	12,860	8,570			0
Workshop materials	2,000	10 TR		20,000	5,710	8,570	5,720			0
Workshop facilities	40	350 TR		14,000	4,000	6,000	4,000			0
5 Condoms marketed through traditional healers										
6 Traditional Healer Health Inf System										
Computer	1	2,500 C		2,500	2,500					0
Laser printer	1	1,750 C		1,750	1,750					0
Software	3	500 C		1,500	1,500					0
U P S	1	500 C		500	500					0
Supplies	10	225 C		2,250	2,250					0
Shipping (15%)	0.15	C		300	300					0
Facsimile	1	750 C		750	750					0
Office furniture	5	1,500 C		7,500	7,500					0
Payment for day sheet recording	600	15 C		9,000	3,600	3,600	1,800			0
ST TA System setup & data analysis	3	26,000 TA		78,000	31,200	31,200	15,600			0
TOTAL				\$636,550	\$303,320	\$206,960	\$122,070	\$2,100	\$2,100	\$0

0

NOTE 3
 HIV/AIDS Prevention for Youth

HIV Prevention Youth	QTY	COST	TYPE	TOTAL	FY93	FY94	FY95	FY96	FY97	CHECK
1 Identification of population										
ST TA	1	26,000	TA	\$26,000		26,000				
2 Baseline survey of youth										
Cost of lab and survey										
Phase I	400	50	C	20,000		20,000				
Phase II	100	50	C	5,000			5,000			
Per Diems	240	15	C	3,600		2,880	720			
ST TA - Curriculum development	2	26,000	TA	52,000		52,000				
3 Training in HIV prevention counselling										
Workshop sessions	20									
Trainers - per diem	100	15	TR	1,500		1,500				
Trained youth	800	15	TR	12,000		12,000				
Workshop materials	800	10	TR	8,000		8,000				
Workshop facilities	20	350	TR	7,000		7,000				
ST TA - Workshop	2	26,000	TA	52,000		52,000				
Program operations										
Vehicle	2	28,000	C	56,000	28,000	28,000				
Spares (15%)	0.15		C	8,400	4,200	4,200				
Shipment & insurance (25%)	0.25		C	14,000	7,000	7,000				
Operation	5	1,500	C	7,500	750	1,500	1,500	1,500	2,250	
Maintenance	5	600	C	3,000	300	600	600	600	900	
Computer	1	2,500	C	2,500	2,500					
Laser printer	1	1,750	C	1,750	1,750					
Software	3	500	C	1,500	1,500					
U P S	1	500	C	500	500					
Supplies	10	225	C	2,250	2,250					
Shipping (15%)	0.15		C	300	300					
Facsimile	1	750	C	750	750					
Office furniture	5	1,500	C	7,500	7,500					
VCR/TV	1	1,500	C	1,500	1,500					
Youth Condom Marketing										
TOTAL				\$294,550	\$58,800	\$222,680	\$7,820	\$2,100	\$3,150	
				0						

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NOTE 5
 Voluntary HIV Testing and Counseling

	<u>QTY</u>	<u>QOST</u>	<u>TYPE</u>	<u>TOTAL</u>	<u>FY93</u>	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>CHECK</u>
1 HIV Testing and Survey Team										
Technical Assistance										
Workplace										
ST TA Statistics – sampling baseline/workplace	2	26,000 TA		\$52,000	52,000					0
Traditional Healers										
ST TA – Statistical analysis traditional healers	5	26,000 TA		26,000	26,000					0
ST TA Statistics – sampling traditional healers	1	26,000 TA		26,000	26,000					0
Youth										
Survey into sexual behavior of youth Development of sample size/survey Survey takers	2	26,000 TA		52,000		52,000				0
	300	20 TA		6,000		6,000				0
LT TA Epidemiologist	3	279,000 TA		837,000	139,500	279,000	279,000	139,500		0
LT TA Statistician	3	258,000 TA		774,000	129,000	258,000	258,000	129,000		0
LT TA Social Researcher	3	258,000 TA		774,000	129,000	258,000	258,000	129,000		0
LT TA Lab Technician	2	258,000 TA		516,000	86,000	172,000	172,000	86,000		0
ST TA Follow-up survey & analysis	10	30,000 TA		300,000	65,000	130,000	130,000	65,000		0
Lab Equipment	1	75,000 C		75,000	75,000					0
HIV – tests for paying patients	36,000	2 C		72,000	12,000	24,000	24,000	12,000		0
HIV – tests for sampled patient										
HIV Spot test (10%)	3,600	50 C		180,000	30,000	60,000	60,000	30,000		0
Lab Supplies	3	35,000 C		105,000	78,750	26,250				0
Rent	3	14,400 C		43,200	7,200	14,400	14,400	7,200		0
Counsellors	12	5,000 TA		60,000	10,000	20,000	20,000	10,000		0
Office Supplies & Stationary	3	5,000 C		15,000	2,500	5,000	5,000	2,500		0
Computer	1	2,500 C		2,500	2,500					0
Laser printer	1	1,750 C		1,750	1,750					0
Software	3	500 C		1,500	1,500					0
U P S	1	500 C		500	500					0
Supplies	10	225 C		2,250	2,250					0
Shipping (15%)	0.15	C		300	300					0
Facsimile	1	750 C		750	750					0
Office furniture	5	1,500 C		7,500	7,500					0
Vehicle	3	28,000 C		84,000	84,000					0
Spares (15%)	0.15	C		12,600	12,600					0
Shipment & insurance (25%)	0.25	C		21,000	21,000					0
Operation	5	1,500 C		7,500	1,250	2,500	2,500	1,250		0
Maintenance	5	600 C		3,000	500	1,000	1,000	500		0
TOTAL				4,148,350	1,004,350	1,308,150	1,223,900	611,950	0	0

NOTE 6
 STD Component

	<u>QTY</u>	<u>COST</u>	<u>TYPE</u>	<u>TOTAL</u>	<u>FY93</u>	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>CHECK</u>
Office Supplies & Stationary	3	5,000	C	15,000	15,000					0
Computer	1	2,500	C	2,500	2,500					0
Laser printer	1	1,750	C	1,750	1,750					0
Software	3	500	C	1,500	1,500					0
U P S	1	500	C	500	500					0
Supplies	10	225	C	2,250	2,250					0
Shipping (15%)	0.15		C	300	300					0
Facsimile	1	750	C	750	750					0
Office furniture	5	1,500	C	7,500	7,500					0
HIV - tests for paying patients	108,000	2	C	216,000	36,000	72,000	72,000	36,000		0
HIV - tests for sampled patient										
HIV Spot test (10%)	10,800	50	C	540,000	90,000	180,000	180,000	90,000		0
Vehicle	3	28,000	C	84,000	84,000					0
Spares (15%)	0.15		C	12,600	12,600					0
Shipment & insurance (25%)	0.25		C	21,000	21,000					0
Operation	5	2,250	C	11,250	1,875	3,750	3,750	1,875		0
Maintenance	5	900	C	4,500	750	1,500	1,500	750		0
ST TA Health Education	5	26,000	TA	130,000	26,000	52,000	52,000			0
AV Equipment	5	4,000	C	20,000	20,000					0
Diagnostic Equipment	3	15,000	C	45,000	7,500	15,000	15,000	7,500		0
Medications			C	412,748	68,791	137,583	137,583	68,791		0
TOTAL				1,529,148	400,566	461,833	461,833	204,916		0

NOTE 7

A. LONG-TERM TECHNICAL ASSISTANCE (2 YEAR PERIOD)

Estimated costs of long term technical assistance are based on a two-year tour (24 person months) for one advisor with a spouse and two children, one in high school and the other in grade school. One child is studying in the U.S. while the other is at post. The post assignment is assumed to be Lusaka, Zambia. The estimated average long-term technical assistance cost per year is approximately \$276,000.00

	PSC AMOUNT	INSTITUTIONAL AMOUNT	MID LEVEL AMOUNT
1. Salary (FS 1/14 @ \$320.00 per day)	170,515	170,515	100,000
2. Post Differential (15% of #1)	25,577	25,577	15,000
3. Contingency on Salary & Post Differential (3%)	2,720	2,720	1,595
4. Cost of Living Allowance (4.2%)	7,162	7,162	4,200
5. Life insurance	1,000	1,000	1,000
Medevac insurance	2,000	2,000	2,000
6. FICA (6.2% of the first \$55,500)	3,441	3,441	3,441
7. Medicare (1.45% of the first \$125,000)	1,813	1,813	1,813
8. Travel to and from Post (est. \$4,000/traveller * 4)	32,000	32,000	32,000
9. Air Freight to and from Post (\$6 * 700 lbs net)	8,400	8,400	8,400
10. Sea Freight to and from Post (\$4 * 7200 lbs gross & POV)	28,800	28,800	28,800
11. Consumable Allowance (\$2.5 * 2500 lbs net)	6,250	6,250	6,250
12. Storage (est. \$1500 per year)	3,000	3,000	3,000
13. Education Allowance (in-country - \$6000 per child)*			
Away from post: \$26,900 per annum	53,800	53,800	53,800
At post: 7000 p/a per child	14,000	14,000	14,000
14. Educational Travel: US - Lusaka rt (two tnps)	8,000	8,000	8,000
15. R & R Traveller (est. \$3000 per traveller)	12,000	12,000	12,000
16. In-country Travel	4,000	4,000	4,000
Airfare 20 tnps * \$200/tnp			
Per Diem \$170 * 3 days * 20 tnps	14,200	14,200	14,200
17. Temporary lodging (\$170 * 15 days)	2,550	2,550	2,550
18. Furnishings (PIO/C)	12,000	12,000	12,000
19. Furnishings (PIO/C) - Security improvements	7,500	7,500	7,500
20. Utilities (est. \$ 200/mo)	4,800	4,800	4,800
21. Rent (\$ 2500/mo)	60,000	60,000	60,000
22. Residential maintenance (est. \$ 260/mo)	6,240	6,240	6,240
23. Guard Service (est. \$763/mo for 24 months)	18,312	18,312	18,312
24. FAAS (PIO/T - Logistic Support)	0	0	0
25. Health Insurance (Family)	3,995	3,995	3,995
26. Communications	500	500	500
27. Miscellaneous Costs (Physical Exam, Visas, etc.)	600	600	600
28. Subtotal	515,174	515,174	429,996
29. Inflation (5%) (Lines 1 to 27)	0	0	0
30. Contingency (7%) (Lines 28 and 29)	0	0	0
31. Contractor multiplier on salary	0	42,629	25,000
25%			
Total Estimated Cost for 24 months (lines 1 to 30)	515,174	557,803	454,996
Per year cost	257,587	278,902	227,498
Total estimated amount for Foreign Exchange	412,140	446,243	363,997
Total estimated for Local Currency	103,035	111,561	90,999

B. SHORT-TERM TECHNICAL ASSISTANCE COSTS

The estimated average short-term technical assistance cost for one person month is approximately \$42,500.00

Budget Item/Descriptions

1. Salary (20 days @ \$320/day)	6,400
Fringe Benefit (20% of salary)	1,280
Overhead (95% of salary & fringe benefit)	7,296
Airfare travel - US - Lusaka rt	4,000
2. Per Diem @ \$165 * 30 days	4,950
3. Defense Base Insurance - 3.3% of salary)	211
4. Travel	
in-country transportation	700
Miscellaneous	382
Visa	100
Communications	700
Total estimated cost for one person month	25,999

Other Donor Activity

The following is a summary by donor of their health sector and HIV/AIDS activity in Zambia.

NETHERLANDS

The Netherlands is the leading donor agency in the health sector in Zambia, with a total annual budget of \$8,060,000 in 1992. The main focus of support has been a large PHC programme in Western Province, and the sponsoring of 23 Dutch doctors serving at district level primarily in Western and Northern Provinces. Another large-scale PHC program is starting in Northern Province. The Netherlands has provided substantial support to the TB/Leprosy Control Programme of the MOH. Import support for TB drugs in 1991 was approximately \$450,000, and the Dutch will provide substantial funding for TB drugs in 1992. Two TB physician specialists will be seconded to the Ministry of Health TB/Leprosy Control Programme in 1992.

The Netherlands' main channel for AIDS support is through WHO/GPA, to which they donated approximately \$3,750,000 in 1991.

Small scale financing is now being considered in the areas of HIV/AIDS operational research and the "children in distress" project.

SWEDEN - SIDA

The Swedish International Development Authority is a major contributor to the health sector in Zambia, with a total budget of about \$6.3 million in 1992. SIDA has a long-term commitment to the development of the Planning Unit of the Ministry; development and financing of the Essential Drugs Programme; the SIDA transport programme; the National Nutrition Surveillance Programme; construction and maintenance of rural health centers; PHC training; and support of AIDS control.

SIDA has supported the AIDS program of the MOH since 1986. The areas of support have been in health education, counseling, purchase of HIV test kits and support to home care services. SIDA also provides funds for the procurement of anti-TB drugs. In 1992 SIDA will extend support to NGOs and other organizations working at the grass roots level in HIV/AIDS education activities. An AIDS epidemiologist seconded by SIDA will join the MOH under the NAPCP in 1992. The annual budget for AIDS support is approximately \$750,000 in 1992. Of this, \$167,000 is for test kits, \$133,000 for counselling and home care activities and \$83,000 for TB drugs. The remainder will finance evaluation, research, printing and direct support to NGOs.

Other Donor Activity

The Essential Drugs Program includes condoms in drug kits which are supplied to all rural health centers, serving nearly half of the population of Zambia. About half a million condoms are thereby made available annually to the rural sector. A reported one-third of the health facilities actually manage to distribute the condoms.

A national survey on the social and economic impact of HIV/AIDS will be financed by SIDA in 1992. This activity lies outside of the health sector support program, and is budgeted at \$350,000. Terms of reference for the study have not yet been drafted.

Funding from the Swedish government is provided for research and training to the International Health Care Research Unit of Karolinska Institute. IHCAR works in collaboration with the Ministry of Health, IAS, UTH, and UNZA School of Medicine. A number of ongoing research projects in Zambia are of relevance to the Project: TB and HIV in children; Teenage pregnancy and abortion; Community capacity - social, behavioral and cultural aspects of AIDS/HIV (a three-year interdisciplinary project, budget - \$500,000); Adolescent fertility: knowledge, attitudes and social situation of young pregnant adolescents in Zambia; Health services and control of STD in three districts in Zambia; Contact tracing in HIV/AIDS and STD.

NORWAY - NORAD

NORAD has an annual bi-lateral grant to the AIDS programme in Zambia. The total grant in 1991 was \$825,000 and was allocated for support to NGO activities. A grant of \$800,000 was requested for 1992. The main focus of NORAD's assistance is health education, training and home care and is channelled through NGOs.

NORAD assists the CMAZ home-based care program; educational materials development for the Anti-AIDS Project; scholarship and consultancy costs for CHEP; construction and secondment of a NORAD volunteer to Kara Counseling; Family Health Trust receives support for administrative and home care activities, and under the umbrella of FHT, the Children in Distress Project and Teachers Education Project on AIDS have received limited support. Small grants have been provided to the Northern Province Health Education Project on AIDS, Salvation Army Hospital, Chikankata, Zambia Red Cross Livingstone, the Second National NGO Conference on AIDS and the Health Education Unit, MOH.

NORAD finances small-scale studies and evaluation activities, including a study presently underway on the impact of AIDS on women and children. NORAD provides support to NGOs with a focus on women, including the Women's Lobby Group, Zambian Association for Research and Development and the NGO Coordinating Committee.

Other Donor Activity

Bilateral support from NORAD to WHO/GPA is \$820,000 for 1992.

GREAT BRITAIN - ODA

Support to the health sector by ODA has primarily taken the form of providing overseas staff to the government health system. Twenty-six medical posts held by British doctors have been supported by ODA, although this program is now being rationalized to concentrate the support on fewer posts.

ODA support to HIV/AIDS prevention has primarily been through the GPA, to which ODA contributed \$1,725,000 in 1992. Locally ODA assists NGOs in HIV-related activities. Through their small project scheme, ODA has assisted the Anti-AIDS project, Family Health Trust and Kara Counselling.

ODA is funding a three-year study on the economic implications of adult disease in Monze District, in cooperation with the London School of Hygiene and Tropical Medicine. The research programme has a particular focus on the cost of care for HIV-positive/AIDS patients.

Small-scale support to a number of mission hospitals and rural health centers is provided on a request basis. ODA expects to increase the level of their support to the health sector in the future.

FINLAND - FINNIDA

FINNIDA's main activities in Zambia are in the areas of educational materials production, agriculture, cooperatives, energy and transport.

FINNIDA has been providing NGOs with small scale support for AIDS prevention activities, such as theater groups. They are initiating plans for a project on female commercial sex workers and AIDS. The project will be implemented by NGOs and will lie outside of the FINNIDA country frame. FINNIDA contributes to WHO/GPA.

BELGIUM

Belgium has supported a project on Health Manpower Development since 1984 through Chainama College of Health Sciences. The project is presently phasing out. Currently there is ad hoc support provided to the Essential Drugs Programme. Belgian support to the health sector has ranged from \$500,000 - \$1,000,000 per year during the past five years.

DENMARK - DANIDA

Other Donor Activity

Danida provides limited development assistance to Zambia. This may expand considerably if Zambia becomes a Danida program country. At present some modest support is provided to the Anti-AIDS project and some indirect support to a clinic in Mazabuka which will, among other things, assist AIDS orphans. Minor project funds of up to three million kwacha (\$24,000) for support of small projects is available for NGO AIDS activities.

JAPAN - JICA

JICA is implementing a five year Infectious Diseases Project at the UNZA School of Medicine (1989-1994). Four Japanese experts and three trainees are attached to the project. A virology laboratory has been recently built at UTH.

CANADA - CIDA

CIDA has budgeted \$11,900,000 for AIDS projects, over 5 years throughout the active SADCC. Through the Canada fund, which finances projects of maximum \$48,000, CIDA has been supporting HIV/AIDS activities through PPAZ, Chikankata Home Care project and Kara Counseling.

EEC

The EEC is funding a three-year project aimed at reduction of HIV transmission through strengthening of blood transfusion services. An improved national blood transfusion service will be created at UTH, to be extended to provincial capitals and central hospitals. The blood bank will become a separate department of the MOH.

The \$4,239,000 project will be focused on technical assistance, consumables and equipment. The EEC would welcome partners in blood bank support. HIV testing will be a component of the project, including not only standard test kits but also some specialized tests.

The project will implement a new strategy of safer donor recruitment. A manual will be developed, which will form the basis for a blood transfusion/blood bank policy. The director of the project is Dr. Muyinda at UTH blood bank.

The EEC provided \$50,000 in 1991 for import support of TB drugs. EEC counter value funds have been provided to support NGO activities on AIDS including \$280,000 to the Family Health Trust and \$60,800 to the Anti-AIDS project in 1992.

UNDP

UNDP is financing a two-year \$600,000 community-based program

Other Donor Activity

focused on assistance to HIV/AIDS patients and their families. The program is carried out by UN volunteers based in Mansa, Lusaka and Livingstone. The volunteers are organized in teams consisting of a home-based care specialist, a community development worker and an IEC specialist. In addition to providing conventional home care and counseling inputs, families are assisted in initiating income generating activities to assure a more certain economic future in the event of the death of a breadwinner. A full-time program officer coordinates the project from UNDP Lusaka.

UNDP works closely with the MOH and NGOs. They have an interest in influencing government policy on HIV/AIDS.

UNFPA

UNFPA has no direct AIDS activities, although there is an AIDS education component in their Family Planning Service Providers 14-week training program. UNFPA supports the training of demographers at UNZA, Department of Demography. It has been suggested that graduates could be enlisted to assist in studies on the demographic impact of AIDS in Zambia.

UNICEF

UNICEF has a large program in the health sector, mainly focused on the Universal Child Immunization Programme and related maternal and child health activities in the areas of safe motherhood, control of diarrheal diseases and nutrition. UNICEF also supports efforts in other sectors such as education and agriculture which have a direct bearing on the situation of women and children.

In the area of AIDS, UNICEF has provided support primarily on an ad hoc basis to NGOs and the government. This has focused on the social needs of families and children affected by HIV/AIDS and education activities targeted for youth. Implementation is largely through community based organizations.

Approximately \$20,000 has been provided to CINDI to support research, workshops, computer equipment and to finance a study tour. Family Health Trust has received consultancy support. Several NGOs have obtained UNICEF funding for production of educational materials. UNICEF recently financed a series of studies on street children by the Ministry of Education. A number of theater groups have been sponsored through UNICEF's Education Section.

UNICEF co-sponsors meetings, workshops and seminars on AIDS and has sponsored delegates attending international meetings.

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Other Donor Activity

Technical support has been provided to AIDS review team delegations.

UNICEF has assisted the STD Control Program through their Safe Motherhood Project. RPR kits are provided to the STD clinics and silver nitrate to Obstetrics Departments. UNICEF also sponsors STD training seminars for clinical officers, and financed the production of the manual on STD management.

An indirect input in AIDS prevention is the provision of needles, syringes, sterilizing equipment and protective gloves to all health facilities for the UCI programme.

Although UNICEF does not have a separate AIDS program at present, this could evolve in the near future. The focus of a future AIDS prevention program is expected to target youth. Involvement in new UNICEF international programs, such as Girl Child, may have particular relevance for AIDS prevention. Ongoing social mobilization efforts and support of empowerment of women can be broadened to incorporate AIDS-related components. UNICEF works actively in the areas of advocacy and policy in collaboration with government and other institutions.

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Annex H

AIDS Prevention Project
US AID/Zambia
Project 811-0221

Procurement Plan

	QTY	COST	TYPE	TOTAL	PROBABLE SOURCE/ORIGIN		941	935	USA 000
					PROC AGENT	LOCAL 811			
Workshop materials	1		10 TR X	20,000		20,000			
Workshop materials	1		10 TR X	20,000		20,000			
Workshop materials	1		10 TR X	8,000		8,000			
Workshop facilities	1		350 TR X	14,000		14,000			
Workshop facilities	1		350 TR X	17,500		17,500			
Workshop facilities	1		350 TR X	7,000		7,000			
VCR/TV	1		1,500 C X	1,500					
VCR/TV	1		1,500 C X	1,500				1,500	
U P S	1		500 C X	500				1,500	
U P S	1		500 C X	500					500
U P S	1		500 C X	500					500
Trainers - per diem	5		15 TR X	3,000		3,000			500
Trainers - per diem	25		15 TR X	3,750					
Trainers - per diem	125		15 TR X	1,500					
Trained youth	1,000		15 TR X	12,000					
Traditional healers trained	8,250		15 TR X	30,000		30,000			
Supplies	10		225 C X	2,250			2,250		
Supplies	10		225 C X	2,250			2,250		
Supplies	10		225 C X	2,250			2,250		
ST TA to compile	2		28,000 TA X	52,000					
ST TA System setup & data analysis	3		28,000 TA X	78,000					52,000
ST TA in compiling population list	1		28,000 TA X	28,000					78,000
ST TA Health Education	5		28,000 TA X	130,000					28,000
ST TA Curriculum & Workshops	24		28,000 TA X	624,000					130,000
ST TA - Workshop	5		28,000 TA X	130,000					624,000
ST TA - Curriculum development	2		28,000 TA X	52,000					130,000
ST TA	1		28,000 TA X	28,000					52,000
ST TA	8		28,000 TA X	208,000					28,000
Software	3		500 C X	1,500					208,000
Software	3		500 C X	1,500					1,500
Software	3		500 C X	1,500					1,500
Shipping (15%)	0.15		C X	300					1,500
Shipping (15%)	0.15		C X	300				300	
Shipping (15%)	0.15		C X	300				300	
Resource materials	1		50,000 C X	50,000				50,000	
Payment for day sheet recording	600		15 C X	9,000					
Pamphlets	50,000		1 C X	50,000					
Operation	5		1,500 C X	7,500		9,000			
Operation	5		1,500 C X	7,500					
Operator	5		1,500 C X	7,500					
Office furniture	5		1,500 C X	7,500					
Office furniture	5		1,500 C X	7,500			7,500		
Office furniture	5		1,500 C X	7,500			7,500		
Maintenance	5		800 C X	3,000			7,500		
Maintenance	5		800 C X	3,000					
Maintenance	5		800 C X	3,000					
Laser printer	1		1,750 C X	1,750					
Laser printer	1		1,750 C X	1,750					1,750
Laser printer	1		1,750 C X	1,750					1,750
Facsimile	1		750 C X	750					
Facsimile	1		750 C X	750				750	
Facsimile	1		750 C X	750				750	
Curriculum/Occupational	3		279,000 TA X	837,000					
Computer	1		2,500 C X	2,500					837,000
Computer	1		2,500 C X	2,500					2,500
Computer	1		2,500 C X	2,500					2,500
Clinical/peer trainers	40		15 TR X	30,000					
Books/journals/supplies	3,000		5 C X	15,000		30,000			
Books/journals/Pamphlets			5 C X	2,000					15,000
AV Equipment	5		4,000 C X	20,000					2,000
AIDS briefing materials	20		1,000 C X	20,000				20,000	
Aids/pamphlets/videos	15,000		5 C X	75,000					
Subcontracts w/ NGOs & Subcontractors			X	343,600		343,600			37,500
Total HIV/AIDS Health Education Contract				3,000,000		658,350	28,250	78,150	2,230,250

Annex H

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Annex H

AIDS Prevention Project
USAID/Zambia
Project 611 - 0221

Procurement Plan

	QTY	COST	TYPE	TOTAL	PROBABLE SOURCE/ORIGIN			USA 000	
					PROC AGENT	LOCAL 611	941		935
U P S.	1	500 C	Y	500				500	
Survey takers	300	20 TA	Y	6,000		6,000			
Supplies	10	225 C	Y	2,250			2,250		
ST TA Statistics - sampling	0.5	26,000 TA	Y	13,000				13,000	
ST TA Statistics - sampling	0.5	26,000 TA	Y	13,000				13,000	
ST TA Follow-up survey & analysis	1	26,000 TA	Y	26,000				26,000	
ST TA - Statistical analysis	1	26,000 TA	Y	26,000				26,000	
Software	3	500 C	Y	1,500				1,500	
Shipping (15%)	0.15	C	Y	300					
Rent	3	14,400 C	Y	43,200		43,200		300	
Phase IV Companies	300	50 C	Y	15,000				15,000	
Phase IV	100	50 C	Y	5,000				5,000	
Phase III Companies	300	50 C	Y	15,000				15,000	
Phase III	100	50 C	Y	5,000				5,000	
Phase II Companies	300	50 C	Y	15,000				15,000	
Phase II	100	50 C	Y	5,000				5,000	
Phase II	100	50 C	Y	5,000				5,000	
Phase I Companies	300	50 C	Y	15,000				15,000	
Phase I	400	50 C	Y	20,000				20,000	
Phase I	400	50 C	Y	20,000				20,000	
Per Diems	240	15 C	Y	3,600		3,600			
Per Diems	240	15 C	Y	3,600		3,600			
Per Diems	240	15 C	Y	3,600		3,600			
Operation	5	1,500 C	Y	7,500		7,500			
Office Supplies & Stationary	3	5,000 C	Y	15,000			15,000		
Office furniture	5	1,500 C	Y	7,500			7,500		
Maintenance	5	600 C	Y	3,000		3,000			
LT TA Statistician	3	258,000 TA	Y	774,000				774,000	
LT TA Social Researcher	3	258,000 TA	Y	774,000				774,000	
LT TA Lab Technician	2	258,000 TA	Y	516,000				516,000	
LT TA Epidemiologist	3	279,000 TA	Y	837,000				837,000	
Laser printer	1	1,750 C	Y	1,750				1,750	
Lab Supplies	3	35,000 C	Y	105,000				105,000	
Lab Equipment	1	75,000 C	Y	75,000				75,000	
HIV Spot test (10%)	0	50 C	Y	180,000				180,000	
HIV Spot test (10%)	0	50 C	Y	540,000				540,000	
HIV - tests for paying patients	36,000	2 C	Y	72,000				72,000	
HIV - tests for paying patients	108,000	2 C	Y	216,000				216,000	
Facsimile	1	750 C	Y	750			750		
Development of sample size/survey	1	26,000 TA	Y	26,000				26,000	
Counsellors	12	5,000 TA	Y	60,000		60,000			
Computer	1	1,950 C	Y	1,950				1,950	
Totals for HIV/Testing and Survey Contract				4,475,000		130,500	24,750	1,050	4,318,700

Annex H

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Annex H

AIDS Prevention Project
USAID/Zambia
Project 611-0221

Procurement Plan

	QTY	COST	TYPE	TOTAL	PROBABLE SOURCE/ORIGIN			USA 000	
					PROC AGENT	LOCAL 811	941		
Vehicle	2	28,000 C	Z	56,000				56,000	
Vehicle	2	28,000 C	Z	56,000				56,000	
Vehicle	3	28,000 C	Z	84,000				84,000	
Vehicle	3	28,000 C	Z	84,000				84,000	
Vehicle	2	28,000 C	Z	56,000				56,000	
U P S.	1	500 C	Z	500				500	
Supplies	10	225 C	Z	2,250			2,250		
Spares (15%)	0.15	C	Z	8,400				8,400	
Spares (15%)	0.15	C	Z	12,600				12,600	
Spares (15%)	0.15	C	Z	8,400				8,400	
Spares (15%)	0.15	C	Z	8,400				8,400	
Spares (15%)	0.15	C	Z	12,600				12,600	
Software	3	500 C	Z	1,500				1,500	
Small Grants			Z	225,000		225,000			
Shipping (15%)	0.15	C	Z	300				300	
Shipment & insurance (25%)	0.25	C	Z	21,000				21,000	
Shipment & insurance (25%)	0.25	C	Z	14,000				14,000	
Shipment & insurance (25%)	0.25	C	Z	21,000				21,000	
Shipment & insurance (25%)	0.25	C	Z	14,000				14,000	
Shipment & insurance (25%)	0.25	C	Z	14,000				14,000	
PSC Project Manager			Z	515,000				515,000	
Policy Paper			Z	175,000		175,000			
Operation	5	2,250 C	Z	11,250		11,250			
Office Supplies & Stationary	3	5,000 C	Z	15,000			15,000		
Office furniture	5	1,500 C	Z	7,500			7,500		
Medications		C	Z	412,748				412,748	
Maintenance	5	900 C	Z	4,500		4,500			
Laser printer	1	1,750 C	Z	1,750				1,750	
Inflation/Contingencies			Z	0					
Facsimile	1	750 C	Z	750				750	
Evaluations			Z	0				0	
Diagnostic Equipment	3	15,000 C	Z	45,000				45,000	
Computer	1	2,500 C	Z	2,500				2,500	
Audits			Z	150,000		150,000			
Total USAID Procurement				2,040,948 0		585,750	24,750	85,050	1,365,393
PSI Cooperative Agreement				7,484,000		1,047,700		299,400	6,136,900
Inflation and Contingencies				2,700,052		381,550	12,508	73,323	2,232,672
Total Project Procurement				19,700,000 0		2,783,850	91,258	534,973	16,289,920

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PSI Proposal for Condom Social Marketing

I. PURPOSE

The purpose of the project is to reduce the incidence of HIV transmission in target groups by making condoms widely available and affordable in Zambia. This project will increase the availability and affordability of condoms in private commercial outlets throughout Zambia over a five-year period.

III. DESCRIPTION OF ACTIVITIES

Population Services International (PSI), a registered U.S. PVO, in cooperation with the Pharmaceutical Society of Zambia (PSZ), a private Zambian organization, will perform the activities under this project as described herein.

A. Specific Objectives and Performance Indicators

The specific objectives and performance indicators for the five-year project are:

1. To increase use of condoms among the sexually active population. Minimum sales objectives are 30.6 million (4 million in Year 1, 5 million in Year 2, 6 million in Year 3, 7.2 million in Year 4 and 8.4 million in Year 5);
2. To increase condom distribution to achieve coverage in all of Zambia's urban and periurban areas. This coverage will include 95% of pharmacies and private health clinics, 90% of wholesalers, 80% of state stores, 75% of hotels, major bars/clubs and private stores, and as many non-traditional outlets as possible;
3. To achieve a high level of brand awareness for the social marketed condom brand and strong consumer recall of the specific benefits associated with the brand. Consumer studies will demonstrate an 80% level of brand awareness for the project-sponsored condom by the end of the project;
4. To increase the awareness and practice of HIV prevention measures among the general population and high-risk target groups. Levels of awareness of appropriate HIV prevention behavior will reach 50% by project mid-term

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PSI Proposal for Condom Social Marketing

and 80% by the end of the project among certain target populations. Similarly, levels of prevention awareness will reach 30% by mid-term and 50% by project end among the general population;

5. To strengthen the capacity of PSZ to operate a sustainable private sector-based social marketing infrastructure that can be utilized to distribute additional health care and family planning products. This will be accomplished through on-the-job training of a marketing and management staff as well as formal training workshops. In addition, a Management Information System using a computerized database will be established by the end of Year 1.

B. Distribution

Distribution to pharmacies, private health clinics, and general retail outlets will be handled by PSZ with strong technical support and supervision by PSI. PSZ has experience in contraceptive selling for family planning and is equipped with the necessary logistical resources (distribution network, sales staff, delivery, warehousing and accounting) to achieve national distribution. Assessments by PSI field personnel have revealed areas where PSZ's capabilities need to be strengthened and the project envisions that these will be addressed and treated over the course of the five years.

Anticipated national coverage targets for urban areas and major commercial centers are as follows:

	<u>YR 1</u>	<u>YR 2</u>	<u>YR 3</u>	<u>YR 4</u>	<u>YR 5</u>
Wholesalers	75%	85%	90%	90%	90%
Pharmacies	90%	90%	95%	95%	95%
Private Health Clinics	50%	95%	95%	95%	95%
State Stores	50%	75%	80%	80%	80%
Private Stores	15%	30%	60%	70%	75%
Hotels	30%	50%	60%	70%	75%
Major bars/clubs	25%	50%	60%	70%	75%

It is important to note that 100% distribution is not likely to be achieved. This is due to the probability that there will always be some cases of credit/payment problems with certain clients, establishments that will object to carrying the product on religious or moral grounds, and outlets that are too small to be economically viable as a direct client. It is expected,

PSI Proposal for Condom Social Marketing

however, that more outlets will be covered beyond this initial five-year period.

C. Condom Brand

A series of 16 focus groups were conducted in Lusaka, the Copperbelt and Livingstone in April in order to determine a culturally acceptable brand name, marketing concept and package design. The results show that the name "MAXIMUM" is the most universally acceptable and that the concept of the dual benefit of maximum protection and maximum pleasure is credible and attractive. The package design most favored is that of a black silhouette of a couple with a bright yellow background.

Condoms will be packaged in attractive boxes (4 condoms to a box) to increase consumer appeal. Counter dispensers (12 boxes to a dispenser) will also be produced to provide an instant display vehicle for retail outlets.

The preferred condom, if sourced in the U.S., is the "Blue and Gold" presentation manufactured by Ansell Corporation, the AID contractor for condom supplies.

D. Pricing

Setting prices for social marketed products is a critical aspect of the planning process. It is imperative that the consumer price be affordable to even the lowest income segment of the population. There are several considerations that go into deciding the best price for a social marketed condom including the retail prices of other mass marketed goods (soft drinks, cigarettes, beer), costs of local public transportation, minimum wages, the lowest and most common monetary unit, government pricing laws, and traditional wholesale and retail margins. The suggested pricing structure for Zambia is:

	Price/4 Condom Pack	% Margin
To Wholesaler:	K13.50	10
To Retailer:	K15.00	25
To Consumer:	K20.00	-

Margins for wholesalers and retailers have to be kept high enough to motivate them to buy, merchandise and promote the condom despite the low consumer price relative to other pharmaceutical products. This financial incentive is also necessary because wholesalers and retailers will realize substantial volume and profit only after a period of intensive promotional and educational campaigns to generate consumer

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PSI Proposal for Condom Social Marketing

demand, a phenomenon which has been universally experienced in other social marketing projects worldwide.

Because the 20 kwacha note is very common in Zambia, the consumer price of K20 will facilitate quick purchases. This is critical to the marketing of a product of a private and personal nature such as condoms which can be a source of embarrassment to the purchaser. Given the highly inflationary nature of the Zambian economy, and further devaluation of the Kwacha, the consumer price will be reviewed at least once a year, in order to maintain a constant real product price.

E. Summary Sales Targets

PSI has set very optimistic sales objectives for this project: 4 million in year 1, 5 million in Year 2, 6 million in Year 3, 7.2 million in Year 4 and 8.4 million in Year 5, for a total of 30.6 million. These sales objectives, if achieved, would make Zambia the most successful condom social marketing project ever in Africa, with per capita sales of .86 units at the end of five years. The most successful CSM project in Africa to date was Zaire which reached .48 per capita sales in 1991, its fourth year of operation.

F. Marketing

1. Target Consumers

As it is virtually impossible to determine how many individuals in the sexually active population are at risk of HIV infection by sexual transmission, all sexually active adults should be considered as target consumers.

Certain high-risk target populations can be identified such as prostitutes, truck drivers, mobile traders, migrant labor, soldiers and students. There is reason to believe that multiple partner relationships as well as polygamous activity among presumed monogamous couples is widespread and therefore subject to the same considerations as the target populations mentioned. Moreover, large clusters of workers can also be reached at their workplaces, thus providing a good venue for concentrated educational, promotional, and sales activities.

Promotional efforts will therefore be directed primarily to the above-mentioned groups and secondarily to the general public.

2. Education and Promotion

A wide variety of targeted educational and promotional activities will be implemented. These will include popular

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PSI Proposal for Condom Social Marketing

theater, songs, condom education conferences, condom evenings and point-of-sale (POS) promotions and product sampling.

Popular theater and songs will be developed in conjunction with local arts groups to disseminate AIDS prevention messages and promote condom usage. These materials will be used both for local promotion in nightclubs, bars, workplaces and community groups and also recorded for radio or TV broadcast.

Condom education conferences will be held to educate target groups such as health workers, pharmacists, industrial workers, NGOs and students on correct condom usage and HIV prevention strategies. Booklets and other educational materials will be developed for distribution at these conferences. Whenever possible, the project will enlist the help of, and coordinate with, local organizations in conducting educational conferences and developing educational materials.

A less formal version of the condom educational conference, the condom evening, will be utilized in night clubs and in bars where high risk groups are likely to congregate. In these condom evenings, door prizes will be awarded, and the cooperation of bar owners and workers will be enlisted. Demonstrations of correct condom use will be conducted with wooden models and question-and-answer sessions will be encouraged. These efforts will be conducted by the project's sales and promotional teams.

Point-of-sale materials will be utilized wherever MAXIMUM condoms are sold. These will consist of posters, decals, product displays, educational leaflets, and consumer and trade promotional incentives such as calendars, key chains, T-shirts, coasters, car stickers, etc. Specific promotions will be spaced so that there is always something new and exciting connected with selling and buying MAXIMUM for both consumers and the trade, i.e., "free pocket calendar with purchase of MAXIMUM condoms."

Samples of MAXIMUM will be given away at special events such as condom education conferences and condom evenings to promote trial and build awareness of the MAXIMUM brand image. Sample giveaways will be accompanied by educational leaflets stressing AIDS prevention practices and correct condom usage.

The project will coordinate its activities with the other components of the larger HIV/AIDS prevention project which will start sometime in 1993. Here are some of the ways PSI will integrate its activities into the larger project:

- **HIV Prevention in the Workplace:** PSI will contribute personnel to a Health Education Team which will do presentations on HIV/AIDS prevention in the targeted workplaces.

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PSI Proposal for Condom Social Marketing

PSI will also work with management to establish condom social marketing at the worksites.

- **Traditional Healers:** Similarly, PSI will supply individuals for a Traditional Healer Health Education Team which will conduct workshops and training exercises and provide supporting materials for the traditional healers.

- **Voluntary HIV-Testing and Counseling:** Condom promotion will be an integral part of the pre- and post-HIV test counseling and the NGO counselors will work closely with PSI to outline a logistics management system for the supply of condoms.

- **STD Control Program:** PSI will work with the STD Control Program to assure promotion and distribution of condoms to all STD clinics.

3. Mass Media/Advertising

Drawing on PSI's mass media experience in other countries, PSI will implement a series of campaigns designed to increase awareness of the need to adopt protective behavior against HIV/AIDS, promote condom use and safe sex practices, and promote the benefits of MAXIMUM.

This mass media campaign will be implemented by the project director through the combined efforts of local advertising agencies and the short-term technical assistance of PSI's experts based in Washington.

PSI has substantial experience in developing and implementing mass media campaigns, and in validating the effectiveness of mass media as an integral part of social marketing efforts. Data from a number of PSI projects show a direct relationship between mass media promotion and a dramatic increase in the demand for condoms.

Critical to the design of mass media campaigns will be attentiveness to public and political sensitivities. While generic condom promotion and brand advertising on TV and radio is not specifically banned by law, the issue is sensitive enough that first year campaigns will stay clear of explicit condom promotion and brand advertising messages. Instead, a range of messages stressing the need for protection against HIV/AIDS will be developed and tested for effectiveness and sensitivity among target consumers, health professionals and policy makers. By pre-testing a range of messages, PSI will be able to develop messages that maximize informational and motivational impact but stay within cultural constraints.

PSI Proposal for Condom Social Marketing

After the project's first year, it is hoped that more explicit campaigns can be aired that directly promote HIV prevention through condom usage and promote the social marketing condom brand. The acceptance of, and sensitivity to, condom promotion will be continuously monitored during the project in order to plan successive campaigns.

G. Effectiveness Measures

Unlike many other projects, social marketing, through sales and distribution data, provides immediate and measurable feedback on progress on objectives. Nevertheless, it is still important to assess regularly the CSM project performance through consumer monitoring and other forms of market research which is crucial to any CSM operation. Market research will provide the basic data to analyze and define all components of the marketing environment and on which to define project plans. The following applied research activities will be conducted.

1. **Baseline Data** - Baseline data will be compiled from existing studies that have been done in Zambia. This will save both time and money in implementing the project quickly. If existing baseline data prove inadequate, additional research will be conducted.
2. **Knowledge Attitudes Behavior and Practices (KABP) Studies** - KABP studies will be conducted at the end of the second and fifth years to measure knowledge of HIV/AIDS and use of condoms, and to identify areas in the marketing strategy that may need to be strengthened. These data will be compared with the initial baseline data in order to measure knowledge, attitudes and behavior modification.
3. **Intercept Studies** - Intercept studies of condom purchasers will be conducted at the end of each year to identify user profiles, and to determine when, why and with whom condoms are used. These consumer intercept studies will be carried out in retail establishments, using short-term technical assistance from PSI/Washington.
4. **Sales Monitoring** - Sales and distribution data will be closely analyzed to measure effectiveness of the project's sales efforts

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PSI Proposal for Condom Social Marketing

in reaching the maximum number of target consumer and its cost efficiency.

5. Communication Tests - These will be utilized to assess comprehension and motivational impact of advertising and promotional campaigns.
6. Final Evaluation Report - This will be submitted at the end of the project. This will include the results of the above-described KABP studies which will measure changes in knowledge of AIDS and condom usage, as well as tendencies toward behavior modification; sales and distribution data, results of campaign specific evaluation; program implementation problems and opportunities; an assessment of the local distributor's capabilities to carry on the program with minimum supervision; cost-benefit analysis; and strategies for the future.

H. Management Information System

In order to determine the degree to which the program is being successfully implemented, project staff will develop a Management Information System that will track these data:

1. Product Inventory Status - Number of condoms on order, in shipment, in warehouse, at packaging state, in distribution pipeline and monthly sales.
2. Product Performance (Sales) - Number of condoms sold by outlet type and by region; average wholesale and retail prices.
3. Distribution Performance - Number of condoms sold by outlet type and region; average wholesale and retail prices.
4. Financial Reports - A PSI/PSZ balance sheet, statement of changes in fund balances, and statement of support, revenue, and expenses.

PSI is experienced in conducting these monitoring activities and will be responsible for their execution.

I. Organization

PSI Proposal for Condom Social Marketing

PSI, a U.S.-registered PVO, will be responsible for the overall implementation and management of the project. PSI is responsible for management of all project funds, fiscal reporting, invoicing and records. PSI will enter into a separate agreement with PSZ describing collaborative arrangements applicable to this project.

1. Staffing, Facilities and Equipment

PSI will provide an expatriate resident advisor who will have ultimate responsibility for overall project management and for ensuring the project's success. He will ensure a proper delegation of responsibilities and adequate staff training take place in order to enhance Zambian staff development which is vital to the project's sustainability. He is required to produce quarterly activity and financial reports to USAID/Zambia, PSI/Washington and PSZ and must ensure that all mechanisms for the monitoring and evaluation of the project are in place. The resident advisor represents PSI on all matters and will maintain close and frequent communication with USAID/Zambia on all aspects of the project as well as any other matters that affect the project, including financial and administrative matters.

The project will need to expand significantly the PSZ staff to handle the increased workload. The newly-enlarged staff will include the following positions of which six are already filled:

- 1 marketing manager
- 1 finance/administration manager
- 1 accounting clerk
- 1 sales/promotion manager
- 3 sales/promotion agents
- 1 warehouse manager
- 1 warehouse clerk
- 2 secretaries
- 4 drivers
- 6 packers
- 3 guards'
- 1 messenger

PSI will be in charge of ordering condoms and packaging to be delivered to the project's warehouse where they will be repackaged. PSI will take charge of ensuring delivery of these products to clients and for their proper storage.

The project will purchase four vehicles for use by the project team. Vehicle procurement will be in concert with USAID regulations and approved by USAID/Zambia prior to finalization. These vehicles will be used for sales deliveries, administrative functions and for general field work.

PSI Proposal for Condom Social Marketing

PSI will rent office and warehouse facilities for its resident advisor and other project staff.

2. Commodities

PSI will procure the condoms directly for the project. The preferred condom is the "Blue and Gold" manufactured by Ansell Corporation, the AID contractor for condom supplies. PSI will follow all AID regulations regarding the source and origin of the commodities as well as shipment regulations on the utilization of U.S. flag carriers. PSI has extensive experience purchasing commodities and purchases U.S.-sourced condoms for its USAID-funded social marketing project in Burundi.

Condom shipments for the first two years will be delivered by air to Lusaka because of the expected bottlenecks at Tanzania and South African ports overwhelmed by food relief. PSI will monitor the port situation closely and ascertain if ship or air will be used after the first two years. USAID/Zambia approval will be secured prior to every air shipment. PSI will try to route every sea shipment via Durban to minimize risk of shipment loss because PSI has a resident manager in Durban who will facilitate transshipment to Lusaka. PSI will submit budget amendments as necessary to reflect cost differences between air and sea shipment.

3. Use of Sales Revenue

All revenues generated from condom sales will be deposited in a separate bank account. Initially the revenues will be applied as follows:

- (1) 5% will support PSZ;
- (2) The next 10% will be used to support operations/administrative expenses; and
- (3) The remaining 85% will be reinvested for activities addressing sustainability issues.

4. Technical Assistance and Administration

Technical assistance, project monitoring and administrative support will be provided through the PSI Washington office. Executive oversight and technical assistance to the project will be provided by PSI's President, Director of Research and Communications, Southern Africa Program Manager, Director of Marketing Projects, Program Officer for Logistics, Controller and others as needed.

PSI Proposal for Condom Social Marketing

PSI will provide technical assistance to PSZ and operational direction to the project in the following major areas:

- Training support for PSZ sales and accounting staff (including the development of a training manual and training materials).
- Expansion planning and product development.
- Commodity logistics management.
- Management Information System development.
- Monitoring (including financial controls, audit and project impact).
- Development, testing and finalization of sales training project (on process and products).
- Supervision of market research.

The Finance/Administration Manager within PSZ, as well as PSI's financial staff, will provide PSZ with assistance in establishing or upgrading any financial, accounting and/or administrative procedures that may be necessary for the project, and through the quarterly financial reports PSI will assess that these procedures are in effect and provide corrective actions, if necessary.

The technical assistance team to be fielded by PSI represents expertise in marketing management, consumer and pharmaceutical marketing, market research, advertising and communications, accounting, social marketing, project management and development.

5. Management Considerations

PSI's management approach in the CSM project will be directed at anticipating technical issues in the field to assure that resources are available in critical disciplines to support and encourage appropriate social marketing strategies that are flexible and responsive to consumer needs.

The PSI staff will assist PSZ with cost control, including costs incurred, billing and reporting. The PSI administrative staff will assist in logistics planning and will provide needed support to the CSM project to handle communications and reporting.

J. Implementation Plan

PSI Proposal for Condom Social Marketing

Year 1 implementation of the Condom social Marketing Project will involve the following key steps to be undertaken by PSI in collaboration with PSZ:

- Establish office and warehouse
- Hire staff
- Order equipment and vehicles
- Promotion messages and materials development and pre-test
- Launch promotion campaign
- Product launch
- Media message development, production and pre-test
- Media campaign launch
- Sales/promotion training
- Financial/office operations training
- Sales and distribution monitoring
- Consumer intercept
- Establish MIS systems
- Assessment of degree of financial viability

Implementation activities for subsequent years of the CSM project will be similar to that of Year 1.

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Annex J



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

ACTION MEMORANDUM FOR THE DEPUTY ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: Keith Brown, Director, AFR/SA *KWB*

SUBJECT: Waiver of 25% Host Country Contribution to the Zambia AIDS Prevention Project (611-0221)

Problem: Approval is requested to waive the requirement of Section 110 of the Foreign Assistance Act of 1961, as amended (FAA), calling for a host country contribution of at least twenty-five (25) percent of program or project costs for the Zambia AIDS Prevention Project.

Background: HIV sero-prevalence in Zambia is among the highest in the world. The impending impact in terms of increased morbidity and mortality, decreased productivity of the workforce, and the deterioration of social structures underscores the far-reaching nature of this crisis. Although epidemiologic data concerning HIV/AIDS are not comprehensive and, at times, conflicting, the sentinel surveys conducted in 1990 reflect an HIV-positive rate of over 25 percent among urban and peri-urban ante-natal clinic patients. Anecdotal reports suggest that the real infection rate is even higher. Blood donor data reflected a 22 percent HIV-positive rate among university students in Lusaka in 1990. HIV sero-prevalence rates from the rural areas have been steadily increasing and it is anticipated that in many rural areas rates will be comparable to urban rates in 2-3 years.

The Government of the Republic of Zambia (GRZ) has recently reported 5,843 cases of AIDS and 18,676 AIDS-related cases, greatly exceeding the 2,000 reported in July, 1989. This is thought to be widely underestimated. Indeed, some experts are now estimating HIV seropositivity at numbers that range from 200,000 to 400,000 among the general population. With a significant portion of Zambia's young population threatened (over 50 percent of the population is under 16 years old), the economic consequences of AIDS depleting a generation of workers is staggering.

The potential impact of AIDS on the workforce is even more serious to economic development in Zambia since the more educated, better trained and wealthier segments of society tend to have higher HIV-infection rates than the general population. This fact has important consequences for Zambia whose economic

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progress is already hindered by a significant shortage of trained personnel across all sectors.

The GRZ has openly and officially recognized AIDS as a major health problem. The GRZ has an established AIDS Control Program which has developed a national strategy to reduce effects of HIV infection and its associated morbidity and mortality by decreasing the sexual transmission of the disease.

The purpose of the AIDS Prevention Project (Project) is to combat the spread of HIV in Zambia. The Project will do so through several activities primarily focussed on public education and designed to bring about changes in sexual behavior. These include increasing the demand for condoms and reducing the number of sexual partners for individuals; training staff in, and providing diagnosis and treatment of STDs; increasing access to condoms; establishing a policy dialogue with influential individuals and organizations in the private and public sectors; strengthening the Zambian media; training Traditional Healers in STD and HIV prevention; and building effective communication channels with various target populations.

By the end of the Project, it is anticipated that: condom use will have increased four-fold and 30 million condoms will have been sold; there will have been a 15 percent decrease in the number of sexual partners among sexually-active adults and youth; there will have been a decrease in STD prevalence; traditional healers will be actively involved in HIV and STD prevention in their communities; a private sector based social marketing infrastructure will be in place; two Voluntary Counseling and Testing centers will be operational; the capacity of Zambia to develop and implement HIV-prevention activities will have been strengthened; there will be a significant increase in resources available for HIV-prevention activities provided by the private sector; and senior government officials will be actively involved in HIV-prevention activities both in their official and personal capacities.

The GRZ will make a variety of in-kind contributions to the Project. Among these contributions are the following: staff and office space in the Ministry of Health associated with the Project, private sector contributions of time and space used in occupational health activities, and volunteer time and materials on the part of indigenous non-governmental organizations (NGOs). The combined value of these contributions, however, will be insufficient to satisfy the requirements of the FAA for a 25 percent host country contribution to the Project.

Discussion: Section 110 of the FAA provides that: "No assistance shall be furnished by the United States Government to a country under sections 103 through 106 of this Act until the country provides assurances to the President, and the President

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is satisfied, that such country provide at least 25 percent of the costs of the entire program, project or activity with respect to which such assistance is to be furnished, except that such costs borne by such country may be provided on an 'in-kind' basis."

FAA Section 124(d) authorizes a waiver, on a case-by-case basis, of the requirement of FAA Section 110 in the case of a program, project or activity in a relatively least developed country. A.I.D. regulations implementing FAA sections 110 and 124(d) are set forth in A.I.D. Handbook 3, Chapter 2, Appendix 2G. Appendix 2G sets forth general considerations which should be taken into account in determining when a waiver of FAA Section 110 would be appropriate. Considerations relating to financial constraints, host country commitment, nature of the project, and phased contribution form the basis for such a determination. These items are discussed below.

Financial Constraints: Zambia is on the Development Assistance Committee (DAC) list of low income countries and is reported by the World Bank (IBRD) to be in severe budgetary and balance of payments difficulties. In view of this situation, special consideration is merited with regard to the required level of the contribution of the Government of the Republic of Zambia in support of the activities of the AIDS Prevention Project. Since 1989, Zambia has been attempting to stabilize its economic circumstances with the assistance of the International Monetary Fund (IMF) and the IBRD. The impact of economic restructuring in Zambia is complicated by the need to cope with drought-induced staple food supply shortages. This imposes a severe burden upon available budgetary resources which are already limited.

Country Commitment: Given a drought and a fiscal crisis, the GRZ is responding to the AIDS epidemic as best it can. As described above, it has developed and is implementing a national plan to reduce the rate of HIV transmission. Because of inadequate funding and fiscal constraints associated with the economic reform and adjustment program, the GRZ has increased its capability to address the AIDS crisis by using a number of indigenous NGOs to assist it with its efforts. There is strong government support for AIDS prevention in the Ministry of Health, where AIDS is the top priority, as well as the Office of the President.

Nature of the Project: The Project assists the GRZ in addressing what is perhaps the most serious medical problem in Zambia. The AIDS epidemic in Zambia, as well as in the rest of Africa, is a biological disaster, even if it lacks a formal proclamation as such. This is not an area where the principles of cost sharing and matching participation are usually applied.

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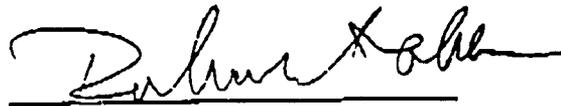
Phased Contribution: This option was not deemed feasible for the Project because Zambia's financial constraints are likely to remain throughout the life of the project. Consequently, the GRZ's ability to financially participate in the Project is not expected to show appreciable improvement over this period. Host country contributions will be limited to in-kind goods and services. While this contribution will be made in all components of the Project and over the entire life of the Project, it will fall short of the 25 percent threshold.

Authority: Section 124(d) of the Act permits a waiver of the Section 110 cooperating country cost sharing requirement of 25 percent on a case-by-case basis for programs, projects or activities in relatively least developed countries. A.I.D. Handbook 3, Chapter 2, Appendix 2G, Section E2b, indicates that the DAC list of low income countries is an acceptable starting point for considering whether a country is eligible for a waiver of the Section 110 requirements. As indicated above, Zambia is on the DAC list. Zambia is also on the United Nations General Assembly list of "least developed countries." Delegation of Authority 403 delegates authority to Assistant Administrators to approve Section 110 waivers, but does not permit it to be redelegated to field posts. You may exercise the authority under your DOA 550 "alter ego" delegation.

For these reasons, and for all of the other reasons described above, USAID/Zambia believes that the initiation and execution of the AIDS Prevention Project (611-0221) would be handicapped by the 25 percent contribution requirement.

Recommendation: That you approve a waiver of the 25 percent cost sharing requirement contained in Section 110 of the Foreign Assistance Act of 1961, as amended, for the Zambia AIDS Prevention Project, provided that Zambia makes the contribution indicated above.

Approved:



Disapproved:

Date:

9/24/92

Clearances:

RLA:MFittipaldi	(draft)	
USAID/ZAMBIA/PPM:JWeibler	(draft)	
AFR/SA:LTaylor	(draft)	Date: <u>9/22/92</u>
AFR/DP:JGovan	(draft)	Date: <u>9/21/92</u>
GC/AFR:MAKleinjan	(draft)	Date: <u>9/21/92</u>

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Draft:USAID/Zambia/PDO,DStraley;AFR/SA,RHarber(9/15-6/92)
AIDS Prevention 25% Waiver Memorandum
ZAIDSWAV.MEM

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Introduction

HIV/AIDS is a pervasive socio-cultural disease causing disability and death across all age groups. Once the virus has been acquired, incubation is impossible to predict with absolute surety. In Zambia the incubation period is often less than ten years. The long latency period between HIV infection and the onset of AIDS makes it easy to underestimate the seriousness of the problem.

For countries with very high infection rates there are no special risk or target groups. Infants can become infected with the disease at birth directly from HIV-positive mothers. Young children, if transfused with tainted blood can acquire HIV. Anyone, particularly those engaged in risky sexual behavior have the potential of acquiring AIDS.

- Persons living in poverty, economic crisis or social deprivation tend to participate in risky behavior. This especially holds true for women who exchange sex for money, food or shelter.
- Better educated Zambian urban residents and sexually active adults (both men and women) are disproportionately infected with the virus in relation to their estimated number in the population. A 1986 study of the Copperbelt mines found that 68% of HIV-positive men were skilled professionals in the copper industry.
- The peak age of Lusaka-Urban residents infected with HIV is 19 - 25 years for women and 30 - 45 years for men. Overall, women are infected at an earlier age than men.
- In 1990, the official GRZ rate reported that 24.5% of all pregnant women receiving antenatal care at UTH tested positive and in general 40% of the children born to HIV-positive mothers will have AIDS.
- A 1989 study found that between 40% to 50% of lorry drivers and between 26% to 36% of their assistants were HIV-positive.

Identification of Target Geographic Areas

The Project will concentrate in four geographic areas: Lusaka, Copperbelt, Central and Southern Provinces. Lusaka Province is

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composed of three districts: Lusaka-Urban, Lusaka-Rural and Luangwa. The Copperbelt Province is composed of eight districts. Based on 1990 population rates, Ndola-Urban is the largest, followed by Kitwe, Chingola, Mufulira, Ndola-Rural, Luanshya, Kalulushi and Chililabombwe. Southern Province is composed of nine districts. Based on 1990 population rates, Choma is the largest, followed by Mazabuka, Monze, Kalomo, Livingstone, Namwala, Sinazongwe, Siavonga and Gwembe. The predominate tribes within these provinces are the Bembas of the Copperbelt; the Nyanjas of Lusaka, and the Tongas of the Southern Province.

Demographic Profile

The 1990 census reports that the population of Zambia is 7.8 million of which 3,975,083 or 50.8% are women and 3,843,364 or 49.2% are men. This represents an average growth rate of 3.2% per year since 1980. 58% of the total population live in the rural areas while 42% are urban dwellers. Approximately 52% of the population is under 15 years of age.

The Copperbelt Province:

The Copperbelt Province has the highest distribution of urban population of all of Zambia. 20.2% of the total population of Zambia or 1,579,542 people, and 43.5% of the total urban population of Zambia reside in this province. This represents a 2.3% population growth rate since 1980. (Table #1) The distribution of women to men is almost equal: 49.4% of the province population are women and 50.6% are men. (Table #2) People living in the Copperbelt urban areas represent 90.5% of the total population of the province. (Table #3)

TABLE #1: POPULATION GROWTH RATES - COPPERBELT, LUSAKA & SOUTHERN PROVINCES

	1980	1990	% Increase
Copperbelt	1,251,178	1,579,542	2.3
Lusaka	691,054	1,295,980	5.6
Southern	671,923	946,353	3.4

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TABLE #2: POPULATION DISTRIBUTION BY DISTRICT AND BY SEX, 1990

	Females	Males	Total
COPPERBELT PROVINCE:			
Ndola-Urban	186,270	190,041	376,311
Kitwe	172,273	176,298	348,571
Chingola	92,254	94,515	186,769
Mufulira	86,874	88,151	175,025
Ndola-Rural	83,359	84,493	167,852
Luanshya	72,117	75,630	147,747
Kalulushi	44,485	46,145	90,630
Chililabombwe	42,521	44,116	86,637
Subtotals:	780,153	799,389	1,579,542
LUSAKA PROVINCE:			
Lusaka-Urban	488,746	493,616	982,362
Lusaka-Rural	103,604	105,714	209,318
Lwangwa	8,497	7,803	16,300
Subtotals	600,847	607,133	1,207,980
SOUTHERN PROVINCE:			
Choma	84,453	80,034	164,387
Mazabuka	78,014	79,710	157,724
Monze	79,267	76,970	157,451
Kalomo	79,267	75,608	154,875
Livingstone	41,652	42,464	84,116
Namwala	42,938	40,478	83,416
Sinazongwe	32,329	30,008	62,337
Siavonga	23,531	22,343	45,874
Gwembe	19,210	16,963	36,173
Subtotals:	481,775	464,578	946,353
TOTALS:	1,862,775	1,871,100	3,733,875

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TABLE #3: POPULATION DISTRIBUTION BY RURAL/URBAN AREAS,
AND BY SEX, 1990

	Urban Areas				
	Female	%	Male	%	Total
Copperbelt	706,916	18.9	721,781	19.3	1,428,697
Lusaka	518,328	13.9	523,145	14.1	1,041,473
Southern	95,717	2.6	94,667	2.5	190,384
Subtotals:	1,320,961	35.4	1,339,593	35.9	2,660,554
	Rural Areas				
	Female	%	Male	%	Total
Copperbelt	73,306	2.6	77,539	2.1	150,845
Lusaka	82,519	2.2	83,988	2.2	166,507
Southern	386,058	10.3	396,911	10.7	755,969
Subtotals:	541,883	14.5	558,438	15.0	1,073,321
TOTAL:	1,862,844	49.9	1,898,031	50.8	3,733,875

All of the copperbelt districts with the exception of Ndola-Rural are large urban areas. Although Kitwe is the most densely populated district in the Copperbelt Province, Ndola-Urban has experienced the most rapid population growth over the past ten years. (Tables #4 & #5) A growth rate of 4.0% in this district over the past ten years has resulted in a population total of 376,311 people of which 186,270 are women and 190,041 are men. Ndola-Urban has the most number of people of any other district in the copperbelt. The slowest population growth urban district was Mufulira which experienced a rate of 1.2%. Population density in the province ranges from a high of 449 persons per square kilometer in Kitwe to a low of 7 persons per square kilometer in the Ndola-Rural district.

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TABLE 4: POPULATION GROWTH RATES IN LARGE URBAN AREAS, 1980 - 1990

	% Growth Rate	Population
LUSAKA PROVINCE:		
Lusaka	2.6	982,362
COPPERBELT PROVINCE:		
Ndola-Urban	4.0	376,311
Kalulushi	3.6	75,197
Chililabombwe	3.4	76,848
Luanshya	2.8	146,275
Chingola	2.5	167,954
Kitwe	2.4	338,207
Mufulira	1.2	152,944
SOUTHERN PROVINCE:		
Livingstone	2.6	146,275

TABLE # 5: POPULATION DENSITY (PERSONS/SQUARE KILOMETER)
BY DISTRICT, 1980 & 1990

	1980	1990
COPPERBELT PROVINCE		
Kitwe	412.2	448.6
Ndola-Urban	255.1	341.2
Luanshya	159.8	182.2
Kalulushi	81.7	125.0
Chingola	87.0	111.3
Mufulira	91.7	106.9
Chililabombwe	60.5	84.4
Ndola-Rural	4.3	7.1

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LUSAKA PROVINCE:

Lusaka-Urban	1488.4	2728.8
	8.0	11.6
	3.3	4.7

SOUTHERN PROVINCE:

Livingstone	50.1	58.9
Monze	22.8	32.4
Mazabuka	16.4	23.1
Choma	17.9	22.5
Siavonga	11.3	17.5
Sinazongwe	8.8	12.6
Kalomo	3.1	5.0
Namwala	2.6	3.8
Gwembe	1.6	2.9

The sex ratio reflects the number of men per 100 women. Except for Ndola-Rural, all other copperbelt districts have experienced a decline of one to 5 percentage points in the sex ratio over the past ten years. there is an average of 102 men to 100 women within the entire province. (Table #6)

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TABLE #6: SEX RATIO GROWTH RATE, 1980 AND 1990

	1980	1990
COPPERBELT PROVINCE:		
Luanshya	107.6	104.7
Chililabombwe	107.0	103.8
Kalulushi	105.8	103.7
chingola	106.1	102.4
Kitwe	107.5	102.3
Ndola-Urban	104.6	102.0
Ndola-Rural	99.4	101.4
Mufulira	104.8	101.3
TOTAL:	105.5	102.4
LUSAKA PROVINCE:		
Lusaka-Rural	102.1	102.0
Lusaka-Urban	104.9	101.1
Luangwa	94.1	91.8
TOTAL:	103.8	101.1
SOUTHERN PROVINCE:		
Mazabuka	99.6	102.2
Livingstone	105.0	101.9
Monze	96.3	95.6
Kalomo	93.5	95.4
Siavonga	89.3	95.0
Choma	93.3	94.8
Namwala	96.6	94.3
Sinazongwe	86.8	92.8
Gwembe	89.3	91.9

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Lusaka Province:

Lusaka Province is the second most populated province representing 15.5% of the total country population, or 1,207,080 Zambians. 31.7% of all urban dwellers live in Lusaka Province. A total of 982,362 people, or 86.2% of all province residents live in the urban area. 488,746 of these urban dwellers or 49.7% are women; 493,616 or 50.3% are men. Lusaka province has experienced a growth rate of 5.6% since 1980. (Tables #1 and #2)

Lusaka-Urban is the most densely populated area of Zambia. Its density has nearly doubled in ten years, reaching 2,729 persons per square kilometer in 1990. Lusaka-Rural and Luangwa districts have a population density of 12 persons and 5 persons, respectively, per square kilometer. (Table #5)

Whereas the urban area has experienced a 6.1% growth rate since 1980, the sex ratio declined to 3.8% during the same period. Although all districts within this province experienced a decline in the number of men to women, the sex ratio within the entire province is now slightly more than parity with 101 men to every 100 women. (Table #6)

Southern Province:

Southern Province is the fourth largest province based upon population distribution of Zambia. 12.1% of the total population of Zambia or 946,353 people reside there. 481,775 (50.9%) of these Southern Province residents are women and 464,578 (49.1%) are men. This province has 5.8% of the total urban population. 20.1% of all its population reside in urban areas. The province experienced a 3.4% population growth during the past ten years.

Livingstone, considered the only large urban area within the province, experienced a growth rate of 2.6% since 1980. It is the most densely populated district in the province with 59 people per square kilometer. The second most densely populated district is Monze with 32 people per square kilometer. The least densely populated district is Gwembe with 3 persons per square kilometer.

The province has a sex ratio of 97 men to every 100 women. From 1980 to 1990, all of the districts except Livingstone, Monze and Namwala experienced a sex ratio increase of between one to 6 additional men per 100 women.

Patterns of Communication Networks among the Bemba, Nyanja and Tonga Tribes:

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There are seven major language groups in Zambia. The three groups that will be the main beneficiaries of the project are the Bemba, tonga and Nyanja groups. Transcommunication occurs across different tribes. For example, the Chewa, Nsenga and Ngoni tribes also speak Nyanja; and, the Lozi, Lenje, Soli and Ila tribes also speak Tonga. the latest figures available are from the 1980 Census. This data serve as a point of reference since when comparing 1980 figures to 1969 figures, a change of less than 1 percentage point occurred. One can assume that a similar change would have occurred from 1980 to 1990.

TABLE # 7: THREE MAJOR LANGUAGE GROUPS

Language Group	1980 - 1990 Total Growth Population
Bemba	36.2
Nyanja	17.6
Tonga	15.1

In 1980, 36.2% of all Zambians spoke Bemba; 15.1% spoke tonga and 17.6% spoke Nyanja. If HIV/AIDS prevention messages are targeted to these three language groups, the potential would exist to reach at least 69% of the total Zambian population.

When comparing transcommunication networks among the three tribes we find that the potential would be less if media messages were limited to English only. Less than 7% of members from all three tribes spoke English as their first language of communication, i.e., mother tongue. In all three groups, men are more fluent in English than women, representing less than 19% of male tribal members as compared to 9.5% of female tribal members.

TABLE # 8: PERCENTAGE OF DISTRIBUTION BY SEX AND
FIRST LANGUAGE OF COMMUNICATION, 1980

Language Group	Bemba	Nyanja	Tonga	English
Males:				
Bemba	86.96	0.69	6.39	
Nyanja	12.08	1.90	6.37	
Tonga	5.53	77.27	5.91	

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Language Group	Bemba	Nyanja	Tonga	English
Females:				
Bemba	87.02	3.45	4.65	3.17
Nyanja	11.41	81.98	2.00	3.08
Tonga	5.22	8.66	80.64	3.26

Socio-Cultural Aspects

Zambia is a nation of approximately 73 different tribal groups and seven major languages. Within this country's cultural pluralism are common themes that are shared across tribes. It is therefore possible to assess several of transcultural themes of the three tribes that will be influenced by AIDS Control Project, the Bembas of the Copperbelt Province, the Nyanjas of Lusaka Province and the tongas of southern Province.

since the advent and expulsion of colonialism, Zambia is attempting to absorb considerable transformation within the social, political and economic structures of its society. while similar changes have occurred over centuries in Europe and the United States, this African nation has attempted to integrate these modern changes within two generations.

Zambian society is in a state of flux and conflict. The gaining of multiparty democracy in November 1991, has yet to completely dismantle the vestige and oppression of one-party politics. Migration to the urban areas has reduced the significance of tribal chiefs and extended families as well as many long-held traditions. As new lifestyles are being forged these former relationships and traditions are more ambiguous and complicated.

Attitudes and beliefs concerning family life, marriage and sexual behaviors, which are more private, have been slower to change as have economic values. Some traditional sentiments have persisted; some have been compromised to meet the changing needs of society; and some remain in conflict with new ideas and attitudes.

The recognition and respect of one's ancestry and extended family, is paramount in Zambian society. This social system provides the individual with an identity and a connection to the rest of society and is a source of guidance, and emotional and material support in times of need. The Bembas, Nyanjas and Tongas are matrilineal tribes. Men from these tribes are responsible for their sisters' children, and within the Bemba tradition, newly-wed bridegrooms are economically dependent on

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their wives' families for a number of years until they prove their worth as husbands and fathers.

Fewer marriages are being traditionally arranged by extended families, especially in the urban areas. Many couples are now choosing their mates which allows for more egalitarian relationships with regard to status and responsibility within the marriage. Without the influence of marital arrangement and bride price, couples have less restrictions to dissolve unsatisfying marriages.

Zambians, whether residing in rural or urban areas, intensely desire children. Fertility is perceived as not only a highly held value, but also as an indispensable requirement in life. Children are considered an economic asset to the tribal life; they provide security for the parents in their old age; and, their presence ensures that the ancestors will continually be honored. There has been little modification of this value as people migrated to the city. It is still considered a grave misfortune for women to be barren.

Once a man has proven to his in-laws to be a worthy husband and father, or as his position within the family group becomes stronger due to his economic independence from his extended family, he has rights over his woman as his childbearer and wife. Women have very little control, power or authority over this aspect of their lives. In the urban areas prior to her marriage, a woman is honored with the tradition of a "kitchen party." At the party she is secluded with the older women of her family and instructed on the attributes of a "good" wife and mother. In the rural areas prospective brides are likewise instructed in their wifely duties by a Nyanja "apoogu" or a Bemba "bana chimbusa" who may be the bride's grandmother or elder aunt, or a close female friend of the bride's mother. Both urban and rural brides-to-be are advised that of utmost importance is that she remains respectful, obedient and submissive to her husband and that she never questions his demands upon her if conveyed as his perceptions of a "good" wife.

Historically, rural women are staunch communicators of cultural values and traditions to future generations. As reported in the 1990 census, slightly less than 60% of Zambians reside in the rural areas. Half of these rural residents are women. They wield substantial influence to instill cultural values even after their children have resettled in the cities. As population groups migrate from the rural areas to the cities, as they become better educated and more economically independent from their extended families, there is less acceptance and entrenchment of traditional values. Life in the urban areas will necessitate the modification of long-held traditions and beliefs.

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Most Zambian tribes practice polygamy. It is more economically feasible to practice polygamy in the rural areas where it is perceived as prestigious to have several wives and many children. This practice, though, would be an economic burden to men residing in the urban areas where housing and land is scarce. Likewise, the normal distribution of men to women (101 men to every 100 women in Lusaka-Urban, and 102 men to every 100 women in the urban areas of the Copperbelt) makes polygamy impossible.

what has replaced sanctioned polygamy in the cities is the practice of extramarital affairs or multiple liaisons. Historically, this is customary behavior that sanctioned by society as a result of the decreased numbers of polygamous marriages. Multiple liaisons confer the prestige of polygamy with less permanent financial expense. There are increased opportunities for such behavior in the urban areas and mining towns because of the anonymity of living in a large city, more frequent and natural contacts between men and women, the nature of shift work in the mines, and the widespread attitude that one's spouse is unfaithful.

The number of girls being educated in Zambia is increasing. These girls are becoming more aware of opportunities to develop a new identity modeled on the privileges and power of men and to obtain economic independence.

Young girls are preyed upon by older, more affluent men who are willing to pay for school fees and other necessities in exchange for sex. This same situation holds true for out-of-school girls who are more economically and educationally and educationally impoverished. These men are increasingly attracted to these girls under the wishful impression that they are HIV-negative. Older men and young girls act out a traditional attitude of Zambians, i.e., sex is a normal routine activity. In this society it is acceptable to exchange sex for money or gifts, although it would be humiliating for others to know that no "prizes" were offered. These liaisons at such an early age start a cycle of a long premarital sexual adventures with a number of different partners over a lifetime. for many of these girls formal marriage is perceived as less advantageous than maintaining multiple liaisons of various sorts.

A majority of school-aged girls whether attending in or out of school have yet to fully accept the dangers and responsibility of sexual freedom in an age of HIV infection. these girls need to be educated in risk-reducing behaviors and appropriate role models which will help them to retain an element of freedom from HIV/AIDS.

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Youth is in the process of determining its own values different from traditions that once helped in shaping role identification and behaviors. Urban youth is struggling against traditional ways. By accepting new values and new role models, youth identified less with his/her presumed role in society and lacks a basic trust of the ability or wisdom of their elders to secure a stable future for them.

In addressing this country's health problems, the attitudes and beliefs of its people are important factors that must be considered. Traditionally, Zambians are fatalistic with regard to life and death. The attitude is that one dies either because of a long illness, a short illness or in a vehicular accident, all orchestrated by witchcraft. The belief is that one cannot control one's life or death unless one seeks assistance in preventing bad magic against oneself or one's family, or by paying special homage to one's ancestors through ritual obligations.

Reasonableness is basic to Zambian thinking. It is reasonable to be sexually active within limits. Excessive promiscuity is not favorably regarded, and when committed, it is believed that supernatural or social, e.g., bewitching, punishment of illness or death will follow. It is believed to be reasonable to stigmatize those who have been punished with illness caused for not obeying taboos like, having sexual intercourse with nursing mothers or women who have had abortions. Collaboration with traditional healers in dispelling these myths and enlightening the project beneficiaries with reasonable explanations as to how the disease is acquired and how to curb the spread of HIV infection would coincide with basic Zambian thinking.

Denial of anxieties is a common attitude among Zambians. Denial and fear have been instrumental in not accepting information about HIV/AIDS. This denial is often sublimated by consuming beer and by being sexually indiscriminate. Beer consumption is a vital part of hospitality. Beer-drinking not only produces a sense of fun and conviviality and relieves denied anxieties, but it likewise raises one's status and is an indicator of one's virility particularly if one can drink more than one's companions. Consuming significant amounts of beer usually culminates in a desire to indulge in sexual intercourse and allows the individuals not confront or control problems of sexual impropriety.

There is a need to work equally with Zambian men and women since they both equally share the responsibility of practicing healthy social behavior. The woman's role in this society is very precarious. She is the purveyor of societal values and traditions from generation to generation, particularly if she

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resides in the rural areas. Her urban sister, on the other hand may equivocate traditional values and may be ambivalent about adopting more modern, i.e., Western influences. The role of both rural and urban women will be strengthened by accepting the challenge of HIV/AIDS prevention. Women will then be able to advocate another value within the culture, i.e., the value of safe and healthy sexual behavior.

Changes in male-female relationships need to occur in marital relationships. With the decline in the number of arranged marriages, marriages of choice can serve as a vital reference point. Couples who have negotiated to marry will continue negotiating for the appropriate use of condoms and, in cases of HIV-positivity among women, limiting family size. The Project will attempt to appeal to the reasonableness of Zambian thinking by stressing that HIV-positive babies will be unable to carry on the strength and life of the lineage. Rather than enhancing the viability of the tribes and ensuring the honor of their ancestors, these infected babies will be a grave liability to tribal heritage.

Project Strategies

All sub-project components are strategies for contravening social and traditional obstacles to modifying behavior. Its Policy dialogue and Traditional Healers components will strive to establish relationships with influential leaders in these areas. This effort will help to better define the role that these leaders must play in helping Zambians understand and accept the benefits of HIV/AIDS prevention activities. The project will actively support these leaders' efforts in forging a new set of values and beliefs appropriate to mitigating this epidemic.

Dependence on the extended family network is a powerful influence, particularly in the rural areas. This influence can be an asset in meeting the challenge of HIV/AIDS prevention.

HIV/AIDS cases tend to cluster within families. There are two realities facing Zambian families: they will have one or several members who are AIDS-infected; or they will be affected as an aftermath to an AIDS-related death, either caring for children of their dead relatives or trying to adjust to their familial loss in economic and social terms. A sharing of experience and expertise across various provider groups, e.g., families, health care facilities, is vitally necessary in combating this epidemic. The project will not disregard the significance of social support systems. Their support is needed in promoting appropriate sexual behavior within the family and encouraging the use of preventive activities, like voluntary testing and counseling. This component will validate individuals' anxieties caused by the AIDS

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pandemic, provide emotional relief through counseling, and offer realistic modification of sexual behavior. The Media Information component will seek to enlighten the public on HIV/AIDS prevention.

Project services will be provided by cooperating agencies in Zambia. There will be an attempt to fully incorporate female employees at the level proportionate to their representation in the total population. All Zambian collaborators will be the expert interpreters of the project strategies in a language readily comprehended by the project's beneficiaries. Project interventions will therefore be the least disruptive within the social structures and culture of Zambia.

Undoubtedly, the Project will make demands on Zambians who participate and receive HIV/AIDS prevention services. These demands are vitally necessary to mitigating the prevalence of HIV/AIDS in Zambia. The most significant demands will include:

- accepting control and responsibility over one's life and physical health, and allowing one's partners to do likewise;
- choosing safe sex over risky sex;
- using condoms as a form of protection; and,
- acknowledging the personal risk of acquiring HIV/AIDS.

The Problem of HIV/AIDS as Perceived by Zambians

In a country with such cultural and social diversity as Zambia, one would expect that there would be little consensus regarding the means of becoming infected with HIV and strategies for its prevention. A review of local newspaper articles and letters to the editors dated 1983 through 1986, supports this claim.

The GRZ's reaction to this emergent health problem was cautious. In November 1983, the government announced that it would prevent the "deadly AIDS" from coming to this country by screening all blood donations. At that time there were no reported cases of AIDS in Zambia. A planned AIDS Education Campaign was announced in July 1985.

AIDS was first identified in Lusaka in September 1985, with the announcement of four victims hospitalized at UTH. This was followed by other reports of confirmed cases in January and July 1986. The government officially confirmed the existence of AIDS in Zambia on 15 January 1986. They acknowledged that it was presumed that many people had died from AIDS without specifying

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it as the diagnosis. On 29 January 1986, the then Minister of Health, Pickson Chitambala reported to Parliament that AIDS had arrived to Zambia. He advocated that the diagnosis should be left to doctors and that patients should not be treated as outcasts. He also reported that AIDS could be transmitted through the sharing of toothbrushes, razor blades and other personal items of infected persons, and that the tradition of scarification should be avoided since the instrument used could spread the disease if used by other people. During this month there was also a plea that the government establish a standard diagnostic test specific to Zambia and not to depend on Western-developed AIDS tests.

The public had a number of opportunities to read rebuttals to the AIDS panic. They were told that AIDS was the result of an U.S. experiment in bacteriological warfare; that it was a campaign designed to avoid litigation against companies who had sold contaminated blood to the U.S. and Europe who in turn gave it to Zambia and other African countries; that it was a racist attempt to blame and scapegoat Africa for being the continent of presumed origin of the disease; and, that it was a farce and a hoax, that AIDS patients did not pose any public health risk.

The public was told by the newspapers that AIDS was caused by mosquito bites and bedbug bites; by sharing beer mugs and other utensils used in public places. They were told that the disease could be cured by herbal and other traditional medicines, and by faith healing or prayers. AIDS could be prevented if Zambians confined themselves to true traditions, like polygamy which was meant to protect people from diseases of sexual immorality; if extra-marital sex was discouraged and pre-marital sex prevented; or, if they eradicated prostitution and converted to a Moslem-like state, i.e., regulate the mixing of opposite sexes in certain public places.

Zambian men blamed women and prostitutes for being the carriers of AIDS and other STDs which the men supported by evidence: in May 1985, the first Zambians to be confirmed as AIDS carriers were two women, one, a nursing student in London and the second, a pregnant mother vacationing with her husband in Perth, Australia. Women countered that opinion by placing the responsibility on men.

In March 1986, Minister of Health Chitambala banned all medical officers from issuing statements on AIDS with the exception of the director of Medical Services. He directed UTH and TDRS to spearhead AIDS diagnosis and advocated for educational campaigns on prevention. The little support that was given for this ban centered on the need to save the economy. The opinion was that by not talking about AIDS, investors would remain and Zambia's

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economy would improve. The majority opinion, though, was that the ban might muzzle those who could enlighten the public; that the masses needed to be educated about the disease; and that official silence could only help to spread infection.

Similar to other nations faced with this epidemic, the Zambian public has gone full circle in trying to understand why they are being afflicted with HIV/AIDS. The timing is now right to help them face the challenge of HIV/AIDS prevention.

THE SOCIAL IMPACT OF THE PROJECT

HIV/AIDS is one of the most serious threats to the development of Zambia as it enters the 21st century. Zambia's HIV/AIDS epidemic is causing increasingly high morbidity and mortality rates. The need for acute and chronic hospitalization is overwhelming the health care system rendering. Health care workers are faced with severe and chronic stress which will critically jeopardize their ability to provide effective care.

Without HIV/AIDS prevention activities, Zambia, which has a high seroprevalence among pregnant women, will experience a reversal of expected gains in child survival. The high level of infection among childbearing women imperils their own health as well as that of their unborn infants and orphaned children. Only healthy well-cared for babies and children can ensure the survival of any nation. With limited adult nurturance, diminishing scarce resources and unrelenting illness and disease, unhealthy babies and children can guarantee disintegration of families and society.

There will be a positive impact on all aspects of the employment sectors with the implementation of effective HIV/AIDS prevention activities. Currently, these sectors, agricultural, mining, governmental, parastatals, commercial and industrial, are being severely weakened by the AIDS epidemic. Lost productivity is resulting from a less productive workforce and rising employee turnover rates. Replacing workers is a costly and lengthy process and in some sectors, like management, banking and agriculture, virtually impossible. Saving employees from the death and disability of this disease is a prerequisite to revitalizing the economy of Zambia.

HIV/AIDS prevention activities emanating from AIDS Control Project sub-project components are intended to modify the sexual attitudes and behaviors of Zambian people. Policy makers and influential leaders, including traditional healers, will become more enlightened about the epidemiology of the infection. This knowledge will be essential in helping them be more responsible

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to the health and social needs of the people. They will be encouraged to support risk-reducing behaviors of the population.

Modifications in the sexual behavior among men and women enhanced by changes in societal values will significantly reduce the transmission of HIV throughout the society. This will have a profound impact on the economic, social and health status of Zambia.

SPREAD EFFECT OF THE PROJECT

Participants and nonparticipants alike will benefit from the Project's activities. Participating in these activities will provide advance warning to families, communities and workplaces that will be affected with this health problem.

Once diagnosed as HIV-positive the infection can be contained. Partners who are not infected will be spared the agony and suffering of the illness. The infected client and his family, through supportive counseling will be able to plan for the future, making all necessary arrangements prior to death. Families will be better prepared to care for the client as his or her health deteriorates. Children will lose one, instead of both parents.

Employers will have devised plans for integrating the infected employee within the workforce and absorbing the inevitable loss. Better projections can be made which will reduce loss productivity and create more effective employee training programs. The reduction in force in all employment sectors will be curtailed once the spread of HIV infection is controlled. Zambia's economy would then be stabilized and this improvement will benefit the entire nation.

Public media educational programs will serve as a focal point in changing community thinking about the types of social behavior appropriate to combating preventable diseases.

Health care facilities and staff will become less overburdened with the care of AIDS patients which will benefit those persons who suffer from other illnesses like, malaria and malnutrition.

The interdependence of a healthy population and a stable national economy will be strengthened by effective HIV/AIDS prevention activities. This is desperately needed to ensure Zambia's prosperity.

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Economic Analysis

This economic analysis is presented using a non-traditional approach.¹ Rather than estimate several epidemiological scenarios resulting from the Project and then present the Project as having a high, medium, and low benefit-cost ratio, this analysis identifies the minimum decrease in the national HIV transmission rate necessary to for the Project's benefit-cost ratio to just exceed one. Given the humanitarian aspects of the Project and the Congressional mandate for HIV/AIDS prevention efforts in Africa, the economic test for this Project is to be extremely confident that at a minimum the benefits from the Project will be greater than the costs. The Mission fully expects a high benefit-cost ratio but, considering the nature of the Project and the difficulty in assigning impact values to the education activities, sees no need to develop and fine-tune elaborate epidemiological and economic projections.

The costs and benefits of the Project are presented in a simple model (see pages 4 through 14) that projects AIDS deaths with (page 4) and without (page 5) the Project. The source for the baseline level of HIV infections by year up to 1992 is Epi Model,² a simple computer program for short-term projections of AIDS cases. With the assumption that Zambia currently (1992) has 300,000 citizens infected with the virus, Epi Model interpolated the timing and rate of past infections. Approximately 300,000 current infections is reasonable as current estimates range between 200,000 and 400,000.

The annual growth rate in the cases of HIV infections was estimated at 4.5 percent for 1993 with an annual decrease of 0.1 percent thereafter to reflect the generally held belief that the epidemic will plateau out in the long-term. Four and a half percent growth is conservatively estimated when compared to the seven to nine percent growth rate suggested in the Epi Model calculations. The analysis used the Epi Model conversion table to calculate the number of HIV cases converting to AIDS by year. Once converted to AIDS, the analysis assumed the patient would die within one year.³

The average age at the time of death was estimated at 35 years (see page 13). This is considerably higher than actual because it conservatively does not factor in the AIDS infants

¹ This Annex presents all the calculations and numerical support which are not presented in the main body of the Project Paper.

² Epi Model was developed by staff and consultants at the World Health Organization's Global Program on AIDS.

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that pass away before the age of five. The estimated life span for those not infected and reaching 35 is estimated at 65. Since the average age at death from AIDS is probably lower than 35, 30 lost productive years are understated.

The analysis forecasts per capita GDP in 1997 to be \$400 and the cost of direct treatment per AIDS patient to be \$50. Real GDP is expected to grow at two percent per year and the discount rate is estimated at four percent. The model then assumes that a life protected from an HIV infection will generate surplus earnings of at least 20 percent per year for 30 years. Surplus earnings are defined as the amount not spent on maintenance of self and family.

These economic, demographic, and epidemiological assumptions are conservative and supportable. For instance, the direct cost per AIDS patient is probably higher; one recent study put it at \$400. The surplus earnings is probably much greater than 20 percent; one A.I.D. economist suggested 50 percent as more reasonable.

Using these extremely conservative assumptions, the minimum decrease in the national HIV transmission rate needed to justify the Project was calculated to be 3.33 percent (see page 4). That is, if the Project reduces the growth rate in the transmission of HIV by approximately 3.3 percent, the Project's benefit-cost ratio will be greater than one. For example, in a single year such as 1995, the Project would be expected at a minimum to reduce the annual growth in HIV transmission from 4.5 percent to 4.35 percent.

A 3.3 percent reduction in the growth rate is the equivalent of approximately 45,000 fewer HIV cases over a 22 year period, or on the average, 2,000 cases per year. The Project's condom social marketing component alone is expected to generate an annual demand for at least 7.5 million condoms. Since the number of HIV cases averted per million condoms sold is estimated to be 400, condom sales alone will generate a positive benefit cost ratio.

The Project's health education activities are expected to reach approximately 25,000 individuals per year during the life of the Project. Half of these are expected to have self selected themselves to be at risk for HIV infection. Behavior modification is necessary in: only one quarter of those receiving the Project-funded message in the early years of the Project; and, because the prevention message is expected to be passed on to larger numbers of recipients in the out years, in smaller and smaller percentage of the population at risk in the ensuing years.

Economic Analysis

While admittedly a simple model, the analysis demonstrates that it is reasonable to assume that the Project will bring about a decrease in HIV transmission rate capable of making the Project investment worthwhile. As a final assurance of economic justification, the Project has a tightly controlled monitoring and evaluation aspect to it which will evaluate the impact of the education activities in target groups using HIV tests to ensure accuracy. If reductions in the transmission rate are not evident, the Project's education activities will be redesigned or terminated, assuring that Project funds are not spent on efforts with no economic justification. Based on the nature of the Project, the high degree of confidence that the Project will have a positive internal rate of return, and the evaluation safeguard built into the design, the Project is considered to be economically sound.

Analysis of Reasonableness of Project Costs
Reduction in rate of transmission for Project to have a benefit-cost ratio > 1

	(a) NEW HIV W/O PROJ	(b) AIDS NEW	(c) DEATH NEW b after 1 yr	(d) COST PER AIDS DEATH	(e) COST W/O PROJ c x d
1992	60,068	12,726	11,160		
1993	62,771	16,157	12,726		
1994	65,533	19,775	16,157		
1995	68,351	23,472	19,775		
1996	71,222	27,170	23,472		
1997	74,142	30,855	27,170	1,816	49,343,305
1998	77,107	34,520	30,855	1,851	57,124,747
1999	80,115	38,184	34,520	1,887	65,154,990
2000	83,159	41,799	38,184	1,924	73,473,232
2001	86,236	45,336	41,799	1,962	81,996,701
2002	89,340	48,761	45,336	2,000	90,668,341
2003	92,467	52,066	48,761	2,039	99,420,175
2004	95,611	55,220	52,066	2,079	108,229,550
2005	98,766	58,212	55,220	2,119	117,025,781
2006	101,927	61,047	58,212	2,161	125,774,805
2007	105,087	63,746	61,047	2,203	134,478,064
2008	108,239	66,338	63,746	2,246	143,168,079
2009	111,378	68,859	66,338	2,290	151,902,940
2010	114,497	71,349	68,859	2,335	160,760,819
2011	117,588	73,859	71,349	2,380	169,833,884
2012	120,645	76,384	73,859	2,427	179,250,235
2013	123,661	78,921	76,384	2,474	189,010,505

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HIV	HIV TO AIDS CONVERSION WITHOUT PROJECT											TOTAL CONVERSIONS BY YEAR
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	
1980	0	39	1,891	5,270	10,312	16,627	23,719	31,095	38,318	45,040	51,006	0
1981												0
1982	0	0										0
1983	0	1	9									10
1984	0	2	47	26								76
1985	0	2	113	132	52							299
1986	0	3	113	316	258	83						773
1987	0	3	132	316	619	416	119					1,604
1988	0	3	132	369	619	998	593	155				2,869
1989	0	3	132	369	722	998	1,423	777	192			4,616
1990	0	3	132	369	722	1,164	1,423	1,866	958	225		6,862
1991	0	2	132	369	722	1,164	1,660	1,866	2,299	1,126	255	9,595
1992	0	2	76	369	722	1,164	1,660	2,177	2,299	2,702	1,275	12,726
1993	0	2	76	211	722	1,164	1,660	2,177	2,682	2,702	3,060	16,157
1994	0	2	76	211	412	1,164	1,660	2,177	2,682	3,153	3,060	19,775
1995	0	2	76	211	412	665	1,660	2,177	2,682	3,153	3,570	23,472
1996	0	2	76	211	412	665	949	2,177	2,682	3,153	3,570	27,170
1997	0	2	76	211	412	665	949	1,244	2,682	3,153	3,570	30,855
1998		2	76	211	412	665	949	1,244	1,533	3,153	3,570	34,520
1999			76	211	412	665	949	1,244	1,533	1,802	3,570	38,184
2000				211	412	665	949	1,244	1,533	1,802	2,040	41,799
2001					412	665	949	1,244	1,533	1,802	2,040	45,336
2002						665	949	1,244	1,533	1,802	2,040	48,761
2003							949	1,244	1,533	1,802	2,040	52,066
2004								1,244	1,533	1,802	2,040	55,220
2005									1,533	1,802	2,040	58,212
2006										1,802	2,040	61,047
2007											2,040	63,746
2008												66,338
2009												68,859
2010												71,349
2011												73,859
2012												76,384
2013												78,921

Epi Model used to calculate new HIV infections by year from 1980 to 1982. Annual increases in new HIV infections from 1993 to 2013 are made as Project assumptions.

Epi Model conversion table (page 12 of this Annex) used to determine conversions by year.

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HIV TO AIDS CONVERSION WITHOUT PROJECT

HIV	Annual increase												TOTAL CONVERSIONS BY YEAR
	1991	1992	4.50% 1993	4.40% 1994	4.30% 1995	4.20% 1996	4.10% 1997	4.00% 1998	3.90% 1999	3.80% 2000	3.70% 2001	3.60% 2002	
1980	56,045	60,068	62,771	65,533	68,351	71,222	74,142	77,107	80,115	83,159	86,236	89,340	0
1981													0
1982													0
1983													10
1984													76
1985													299
1986													773
1987													1,604
1988													2,869
1989													4,616
1990													6,862
1991													9,595
1992	280												12,726
1993	1,401	300											16,157
1994	3,363	1,502	314										19,775
1995	3,363	3,604	1,569	328									23,472
1996	3,923	3,604	3,766	1,638	342								27,170
1997	3,923	4,205	3,766	3,932	1,709	356							30,855
1998	3,923	4,205	4,394	3,932	4,101	1,781	371						34,520
1999	3,923	4,205	4,394	4,587	4,101	4,273	1,854	386					38,184
2000	3,923	4,205	4,394	4,587	4,735	4,273	4,449	1,928	386				41,799
2001	2,242	4,205	4,394	4,587	4,785	4,986	4,449	4,626	2,003	401			45,336
2002	2,242	2,403	4,394	4,587	4,785	4,986	5,190	4,626	4,807	416			48,761
2003	2,242	2,403	2,511	4,587	4,785	4,986	5,190	5,398	4,807	2,079	431		52,066
2004	2,242	2,403	2,511	2,621	4,785	4,986	5,190	5,398	5,608	4,990	2,156	447	55,220
2005	2,242	2,403	2,511	2,621	2,734	4,986	5,190	5,398	5,608	5,821	5,174	2,234	58,212
2006	2,242	2,403	2,511	2,621	2,734	2,849	5,190	5,398	5,608	5,821	6,037	5,360	61,047
2007	2,242	2,403	2,511	2,621	2,734	2,849	2,966	5,398	5,608	5,821	6,037	6,254	63,746
2008	2,242	2,403	2,511	2,621	2,734	2,849	2,966	3,084	5,608	5,821	6,037	6,254	66,338
2009		2,403	2,511	2,621	2,734	2,849	2,966	3,084	5,608	5,821	6,037	6,254	68,859
2010			2,511	2,621	2,734	2,849	2,966	3,084	3,205	5,821	6,037	6,254	71,349
2011				2,621	2,734	2,849	2,966	3,084	3,205	6,037	6,037	6,254	73,859
2012					2,734	2,849	2,966	3,084	3,205	3,326	3,449	6,254	76,384
2013						2,849	2,966	3,084	3,205	3,326	3,449	3,574	78,921

Epi Model used to calculate new HIV infections by year from 1980 to 1982. Annual increases in new HIV infections from 1993 to 2013 are made as Project assumptions.

Epi Model conversion table (page 12 of this Annex) used to determine conversions by year.

HIV	HIV TO AIDS CONVERSION WITHOUT PROJECT											TOTAL CONVERSIONS BY YEAR
	3.50% 2003	3.40% 2004	3.30% 2005	3.20% 2006	3.10% 2007	3.00% 2008	2.90% 2009	2.80% 2010	2.70% 2011	2.60% 2012	2.50% 2013	
1980												0
1981												0
1982												0
1983												10
1984												76
1985												299
1986												773
1987												1,604
1988												2,869
1989												4,616
1990												6,862
1991												9,595
1992												12,726
1993												16,157
1994												19,775
1995												23,472
1996												27,170
1997												30,855
1998												34,520
1999												38,184
2000												41,799
2001												45,336
2002												48,761
2003												52,066
2004	462											55,220
2005	2,312	478										58,212
2006	5,548	2,390	494									61,047
2007	5,548	5,737	2,469	510								63,746
2008	6,473	5,737	5,926	2,548	525							66,338
2009	6,473	6,693	5,926	6,116	2,627	541						68,859
2010	6,473	6,693	6,914	6,116	6,305	2,706	557					71,349
2011	6,473	6,693	6,914	7,135	6,305	6,494	2,784	572				73,859
2012	6,473	6,693	6,914	7,135	7,356	6,494	6,683	2,862	588			76,384
2013	3,699	6,693	6,914	7,135	7,356	7,577	6,683	6,870	2,940	603		78,921

Epi Model used to calculate new HIV infections by year from 1980 to 1982. Annual increases in new HIV infections from 1993 to 2013 are made as Project assumptions.

Epi Model conversion table (page 12 of this Annex) used to determine conversions by year.

TOTAL

HIV TO AIDS CONVERSION WITH PROJECT

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	CONVERSIONS BY YEAR
HIV	0	39	1,891	5,270	10,312	16,627	23,719	31,095	38,318	45,040	51,006	
1980												0
1981												0
1982	0											0
1983	0	1	9									10
1984	0	2	47	26								76
1985	0	2	113	132	52							299
1986	0	3	113	316	258	83						773
1987	0	3	132	316	619	416	119					1,604
1988	0	3	132	369	619	998	593	155				2,869
1989	0	3	132	369	722	998	1,423	777	192			4,616
1990	0	3	132	369	722	1,164	1,423	1,866	958	225		6,862
1991	0	2	132	369	722	1,164	1,660	1,866	2,299	1,126	255	9,595
1992	0	2	76	369	722	1,164	1,660	2,177	2,299	2,702	1,275	12,726
1993	0	2	76	211	722	1,164	1,660	2,177	2,682	2,702	3,060	16,157
1994	0	2	76	211	412	1,164	1,660	2,177	2,682	3,153	3,060	19,775
1995	0	2	76	211	412	665	1,660	2,177	2,682	3,153	3,570	23,469
1996	0	2	76	211	412	665	949	2,177	2,682	3,153	3,570	27,158
1997	0	2	76	211	412	665	949	1,244	2,682	3,153	3,570	30,829
1998		2	76	211	412	665	949	1,244	1,533	3,153	3,570	34,472
1999			76	211	412	665	949	1,244	1,533	1,802	3,570	38,106
2000				211	412	665	949	1,244	1,533	1,802	2,040	41,682
2001					412	665	949	1,244	1,533	1,802	2,040	45,171
2002						665	949	1,244	1,533	1,802	2,040	48,538
2003							949	1,244	1,533	1,802	2,040	51,777
2004								1,244	1,533	1,802	2,040	54,857
2005									1,533	1,802	2,040	57,765
2006										1,802	2,040	60,509
2007											2,040	63,107
2008												65,587
2009												67,987
2010												70,346
2011												72,716
2012												75,095
2013												77,479

Epi Model used to calculate new HIV infections by year from 1980 to 1982. Annual increases in new HIV infections from 1993 to 2013 are made as Project assumptions.

Epi Model conversion table (page 12 of this Annex) used to determine conversions by year.

HIV TO AIDS CONVERSION WITH PROJECT													
HIV TO AIDS:	Annual increase												BY YEAR
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	
HIV	56,045	60,068	62,681	65,345	68,057	70,813	73,610	76,444	79,311	82,206	85,124	88,061	0
1980													0
1981													0
1982													0
1983													10
1984													76
1985													299
1986													773
1987													1,604
1988													2,869
1989													4,616
1990													6,862
1991													9,595
1992	280												12,726
1993	1,401	300											16,157
1994	3,363	1,502	313										19,775
1995	3,363	3,604	1,567	327									23,469
1996	3,923	3,604	3,761	1,634	340								27,158
1997	3,923	4,205	3,761	3,921	1,701	354							30,829
1998	3,923	4,205	4,388	3,921	4,083	1,770	368						34,472
1999	3,923	4,205	4,388	4,574	4,083	4,249	1,840	382					38,106
2000	3,923	4,205	4,388	4,574	4,764	4,249	4,417	1,911	397				41,682
2001	2,242	4,205	4,388	4,574	4,764	4,957	4,417	4,587	1,983	411			45,171
2002	2,242	2,403	4,388	4,574	4,764	4,957	5,153	4,587	4,759	2,055	426		48,538
2003	2,242	2,403	2,507	4,574	4,764	4,957	5,153	5,351	4,759	4,932	2,128	440	51,777
2004	2,242	2,403	2,507	2,614	4,764	4,957	5,153	5,351	5,552	4,932	5,107	2,202	54,857
2005	2,242	2,403	2,507	2,614	2,722	4,957	5,153	5,351	5,552	5,754	5,107	5,284	57,765
2006	2,242	2,403	2,507	2,614	2,722	2,833	5,153	5,351	5,552	5,754	5,959	5,284	60,509
2007	2,242	2,403	2,507	2,614	2,722	2,833	2,944	5,351	5,552	5,754	5,959	6,164	63,107
2008	2,242	2,403	2,507	2,614	2,722	2,833	2,944	3,058	5,552	5,754	5,959	6,164	65,587
2009		2,403	2,507	2,614	2,722	2,833	2,944	3,058	3,172	5,754	5,959	6,164	67,987
2010			2,507	2,614	2,722	2,833	2,944	3,058	3,172	3,288	5,959	6,164	70,346
2011				2,614	2,722	2,833	2,944	3,058	3,172	3,288	3,405	6,164	72,716
2012					2,722	2,833	2,944	3,058	3,172	3,288	3,405	3,522	75,095
2013						2,833	2,944	3,058	3,172	3,288	3,405	3,522	77,479

Epi Model used to calculate new HIV infections by year from 1980 to 1982. Annual increases in new HIV infections from 1993 to 2013 are made as Project assumptions.

Epi Model conversion table (page 12 of this Annex) used to determine conversions by year.

TOTAL

HIV TO AIDS CONVERSION WITH PROJECT												CONVERSIONS BY YEAR
HIV TO AIDS	3.35%	3.25%	3.15%	3.05%	2.95%	2.85%	2.75%	2.65%	2.55%	2.45%	2.35%	
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	
HIV	91,011	93,969	96,929	99,885	102,832	105,762	108,671	111,550	114,395	117,198	119,952	
1980												0
1981												0
1982												0
1983												10
1984												76
1985												299
1986												773
1987												1,604
1988												2,869
1989												4,616
1990												6,862
1991												9,595
1992												12,726
1993												16,157
1994												19,775
1995												23,469
1996												27,158
1997												30,829
1998												34,472
1999												38,106
2000												41,682
2001												45,171
2002												48,538
2003												51,777
2004	455											54,857
2005	2,275	470										57,765
2006	5,461	2,349	485									60,509
2007	5,461	5,638	2,423	499								63,107
2008	6,371	5,638	5,816	2,497	514							65,587
2009	6,371	6,578	5,816	5,993	2,571	529						67,987
2010	6,371	6,578	6,785	5,993	6,170	2,644	543					70,346
2011	6,371	6,578	6,785	6,992	6,170	6,346	2,717	558				72,716
2012	6,371	6,578	6,785	6,992	7,198	6,346	6,520	2,789	572			75,095
2013	3,640	6,578	6,785	6,992	7,198	7,403	6,520	6,693	2,860	586		77,479

Epi Model used to calculate new HIV infections by year from 1980 to 1982. Annual increases in new HIV infections from 1993 to 2013 are made as Project assumptions.

Epi Model conversion table (page 12 of this Annex) used to determine conversions by year.

HIV to AIDS Conversion Table

Year	CUM %	%
1	0.0	
2	0.5	0.5
3	3.0	2.5
4	9.0	6.0
5	15.0	6.0
6	22.0	7.0
7	29.0	7.0
8	36.0	7.0
9	43.0	7.0
10	50.0	7.0
11	54.0	4.0
12	58.0	4.0
13	62.0	4.0
14	66.0	4.0
15	70.0	4.0
16	74.0	4.0
17	78.0	4.0
18	82.0	4.0

Average age at time of death	35
Average life span w/o infection	65
Real GDP growth rate	2.00%
Surplus Per capita GDP	20.00%
Direct treatment costs	50

Year of Death	Per Capita GDP	Surplus Per Capita GDP	Net Present Value of Surplus	
			4.00%	
1997	400	80	1,816	PV of Surplus Per Capita
1998	408	82	1,851	GDP over 30 years form
1999	416	83	1,887	year of death plus \$50 for
2000	424	85	1,924	cost of care, ie
2001	433	87	1,962	$1816=80/(1.04)^1 + \dots + 119/(1.04)^{30+50}$
2002	442	88	2,000	
2003	450	90	2,039	
2004	459	92	2,079	
2005	469	94	2,119	
2006	478	96	2,161	
2007	488	98	2,203	
2008	497	99	2,246	
2009	507	101	2,290	
2010	517	103	2,335	
2011	528	106	2,380	
2012	538	108	2,427	
2013	549	110	2,474	
2014	560	112		
2015	571	114		
2016	583	117		
2017	594	119		
2018	606	121		
2019	618	124		
2020	631	126		
2021	643	129		
2022	656	131		
2023	669	134		
2024	683	137		
2025	696	139		
2026	710	142		
2027	725	145		
2028	739	148		
2029	754	151		
2030	769	154		
2031	784	157		
2032	800	160		
2033	816	163		
2034	832	166		
2035	849	170		
2036	866	173		
2037	883	177		
2038	901	180		
2039	919	184		
2040	937	187		
2041	956	191		
2042	975	195		
2043	995	199		

Projected Project Expenditures by year

1993	3,963,200
1994	4,744,100
1995	4,557,100
1996	3,731,200
1997	2,704,400

Net Present Value of Project 17,660,467
expenditures @ 4 % discount rate

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Background¹

Acquired Immune Deficiency Syndrome (AIDS) is an epidemic of global concern which is caused by infection with the Human Immunodeficiency Virus (HIV). There appear to be two types (or serotypes) of HIV infection, HIV-1 and HIV-2, but there is no known clinical difference between these two viral diseases.

Understanding AIDS involves understanding the development of the disease from infection to death. There are three phases in the development of the disease. The first phase is characterized by negative blood tests during the first six to eight weeks following infection. A second blood test is required to establish the actual serostatus of an individual. The second phase begins when a positive blood test for the presence of the virus is obtained. In this phase the person is physically well, although more susceptible to other infections such as tuberculosis, but is definitely infectious. The third phase is when a person first evidences the symptoms of AIDS. The illness phase usually lasts less than two years, although there are some indications that, because of the lack of medical facilities, many Africans die within four months.

Since the disease goes through three phases, only the last of which is called "AIDS," throughout this paper the term "HIV/AIDS" will be used to refer to the entire course of the infection. The distinction between the three phases, particularly the difference between a person who is "HIV-seropositive" and a person who has AIDS, is critical to understanding the epidemiological information presented below.

Currently there is little that can be done to help a person once they have been infected. Some treatments exist which prolong life after the development of AIDS, but these are extremely expensive and very toxic. Thus preventing initial infection becomes of prime importance.

Early in 1991, the World Health Organization's Global Program on AIDS (WHO/GPA) estimated that about nine million adults and close

¹ Most of this Technical Analysis Support Section was originally prepared for REDSO/WCA for the AIDS portion of the Ivory Coast Health and Family Planning Project. Because technical information is generic or specific to Sub-Sahara Africa, it has been incorporated into the design of the Zambian HIV/AIDS Prevention Project.

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to a million children under age five throughout the world had been infected with HIV. Available data indicate that about 50% of the infected adults will develop AIDS and die within 10 - 12 years after acquiring the HIV infection. Virtually all HIV-infected persons will eventually develop the clinical disease, i.e., AIDS, and ultimately die. There is no cure for HIV, and effective vaccines are thought to be years away.

Primary Epidemiology of HIV/AIDS in Africa

In Africa, vaginal sex is the most common method of transmission. It ranks second behind anal sex as the most dangerous behavior. Though a woman has four layers of tissue on the vaginal wall and the tissue is much tougher and more capable of handling trauma than the rectum, there are certain times and conditions when a woman is vulnerable to HIV infection during vaginal sex.

- A woman is vulnerable when she has intercourse during her menstrual cycle, which can be 5 - 10 days a month in a premenopausal woman. Vaginal and cervical secretions facilitate semen traveling through the cervix into the uterus and fallopian tubes to fertilize the egg. Similarly, during menstruation, the vaginal/cervical fluids assist in the transportation of semen into the internal reproductive organs. If the lining of the uterus is being shed, the blood vessels are opened widely and if the man is HIV-infected semen has direct access to the woman's bloodstream.
- If a woman's cervix is eroded and bleeds easily, and if there is trauma to the cervix during intercourse and infected semen is deposited, the break in the cervical mucosa can be sufficient to provide access to the bloodstream.
- A cyst, genital ulcer or other imperfection on the vaginal wall that can rupture from the friction of intercourse may afford access to the bloodstream. Untreated genital ulcer disease is a particularly strong co-factor in heterosexual transmission in Africa and the Caribbean.
- If sexual intercourse is excessively rough and results in tissue trauma to the vaginal wall, it is possible to damage four layers of tissue and gain access to the bloodstream.

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HIV/AIDS Situation in sub-Saharan Africa with Respect to the Overall Health Status: The HIV/AIDS problem emerged in sub-saharan nations while governments and Ministries of Health were struggling with the problems of high child mortality, high prevalence of common infectious diseases (e.g. malaria, diarrheal disease, acute respiratory disease, measles), high maternal mortality, high population growth rates, and severe shortages of available resources. In order to increase governments' commitment to HIV/AIDS prevention and control, it is important to consider the HIV/AIDS problem in the context of a country's total health status.

Taking into account the extent of misdiagnoses, under-reporting and reporting delays, and those AIDS victims who never go to a health facility, WHO/GPA estimated that about 800,000 adult AIDS cases (a small portion of the six million Africans estimated to be HIV-infected) had actually occurred in sub-Saharan Africa by early 1991. Thus, sub-sahara Africa, with less than ten percent of the world's population, accounts for about two-thirds of the total estimated AIDS cases worldwide. Only about 86,000 AIDS cases actually had been reported in sub-Saharan Africa by April 1991.

When assessing the impact of AIDS, age-specific mortality rates are important for two reasons. First, crude death rates for sub-Saharan Africa are affected by the large number of deaths among children. It has been estimated that deaths of children under five account for more than 45% of total deaths in the Africa region. Second, in sub-Saharan African countries AIDS is transmitted more readily in certain age groups, particularly in children under five and sexually active adults.

The overall demographic impact of AIDS upon the health situation in sub-Saharan Africa has been the subject of study by WHO.² A demographic projection model was used to estimate and project AIDS cases and deaths up to the mid-1990s. Using input parameters which reflected average rates for sub-Saharan Africa, WHO estimated that, between 1985 and 1990, AIDS deaths in the hypothetical "average" country increased the crude death rate by 0.3 per 1,000 population over what would have been expected in the absence of AIDS, and a further increase of 1.1 per 1,000 population (or 8.7%) is expected by the mid-1990s.

Unlike developed countries, heterosexual transmission of HIV continues to be the predominant mode of spread in sub-Saharan

² WHO, Demographic Impact of AIDS among children, 1991.

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Africa, accounting for 80 - 85% of all HIV transmission. Because of this, many African women of childbearing age are infected. As with other sexually transmitted diseases (STDs), there is a slight excess of women infected with HIV for a variety of sociological and biological reasons. The overall male to female ratio in Africa is approximately 1:1.2. Approximately one-third of the children born to women who carry the HIV virus will themselves be infected and will ultimately develop AIDS.

Perinatal HIV transmission from the mother to fetus or infant is a widespread and increasing problem in sub-Saharan Africa. According to WHO/GPA,³ by early 1991 about 900,000 HIV-infected infants had been born in Africa, and by the end of the 1990s a projected total of 10 million or more such births may be expected. In addition, 90 percent of the estimated 400,000 worldwide pediatric AIDS cases occurred in sub-Saharan Africa.

At the start of the pandemic in Africa, there was almost no noticeable effect of HIV/AIDS on infant or child mortality. Yet, by the mid-1990s, according to the WHO model, infant mortality is expected to be 4% higher than it would have been in the absence of AIDS, and the probability of dying before age five is expected to increase by 7.6% as a consequence. WHO projects that the expected infant and child deaths in Africa due to AIDS may increase child mortality by as much as 50 percent. By the mid-1990s the WHO-projected increase in AIDS mortality in children will begin to negate the reductions achieved by child survival programs over the past two decades.

To compare AIDS with other leading causes of death in those under five, WHO estimated disease-specific mortality in children using information from WHO programs and other databases. These estimates were based on general assumptions and probabilities, and were intended to show expected general trends. Projections of under five death rates due to measles, malaria, diarrhea, and AIDS were calculated. These indicated that diarrhea will remain the predominant cause of death among children; malaria will continue to be important; and child deaths due to measles will decrease as a result of increasing use of measles vaccine. However, these estimates also show that before the mid-1990s, AIDS will cause more deaths in sub-Saharan African children than either malaria or measles.

Demographic Impact on Sexually Active Adults: In addition to impacting on children under five, HIV/AIDS affects sexually

³ WHO, Demographic Impact of AIDS among children, 1991.

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active adults in their most economically productive years. This encompasses the trained labor force, the well-educated, the military, and members of the social, economic and political elite.

According to the WHO demographic model, between 1985 and 1990 AIDS increased the annual death rate for those Africans aged 15 - 49 by an average of 10%; by the mid-1990s, it is believed that AIDS will cause the rate to rise by more than 40%. For those aged 14 - 40, AIDS is expected to reverse the declining trend in adult mortality rates. It should be noted that these are national projections; in many urban areas a doubling or tripling of the total death rate in this age group is expected.

Experience in other African countries demonstrates that the better educated, better trained and wealthier segments of society also tend to be severely affected by HIV/AIDS. This is not the case with other endemic diseases such as schistosomiasis, guinea worm, onchocerciasis, tuberculosis, and malaria.

In the developing countries of sub-Saharan Africa, all epidemiological data collected during the 1980s point to continuing large increases in HIV seroprevalence levels. For example, between one-quarter and one-third of all adults aged 15 - 49 living in large urban centers in east and central Africa had been infected with HIV by early 1991. On the basis of a large community-based survey, it was estimated that there were over 750,000 HIV-infected adults in Uganda alone by late 1988. Thus, during the 1990s and into the next decade, large increases in AIDS cases and deaths can be expected. The results of demographic modeling of the HIV/AIDS pandemic in sub-Saharan Africa reflect the projected increases in AIDS deaths. Although these projections have to be interpreted cautiously, there can be no doubt that during the next several decades, AIDS will be the leading cause of death among young and middle-aged adults and will also be one of the leading causes of infant and child mortality in this region. However, according to various demographic models, AIDS is not expected to have a major impact on the population growth rate in sub-Saharan Africa during the 1990s or the next decade.

Effective Interventions Available to Combat the Spread of HIV/AIDS

A number of interventions can halt or decrease the spread of HIV. Various data from developing as well as developed countries have shown that IEC programs that promote behavioral changes and increased condom use are important tools in the control of HIV

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spread. In vitro and solid epidemiological studies among prostitutes and discordant couples have shown that condoms are efficient barriers to HIV if used properly. On the medical side, blood screening, including reduction of inappropriate blood transfusion and the control of other STDs, can also help prevent the spread of HIV infection. The latter intervention has recently emerged as a critical element in the fight against HIV/AIDS since recent studies have demonstrated that high rates for other sexually transmitted diseases (STDs), especially those which cause ulcerative lesions such as chancroid and syphilis, are now believed to have facilitated the rapid spread of HIV in sexually active persons in the region. HIV transmission efficiency per single exposure increases from about 0.1 - 1.0% to 40% with an STD. Programs that reduce the frequency and duration of STDs may reduce the incidence of HIV/AIDS by 50%. For women, STD control is one of the few relevant strategies since they can avail themselves of this means of protection if diagnosis and treatment of STDs can be combined with other consultations requiring an internal examination. Condom usage, abstinence and faithfulness of both partners in a relationship are usually not under the woman's control.

With the recent development of an HIV/AIDS mathematical model by the Interagency Working Group on AIDS Models and Methods (chaired by the U.S. Department of State), researcher⁴ have examined the potential effects of the HIV epidemic on a population, given a particular set of inputs to demographic processes, behavior and disease parameters.

The inputs were chosen to represent processes and behavior similar to those in the sub-Saharan Africa region. The following is a description of four possible interventions which could be implemented in the 1990 - 1995 period to stop or decrease the spread of HIV. They are:

- the promotion of condom use that results in the participation of a certain percentage (5 to 25%) of urban women by 1995;
- an STD control program that reduces the duration of STDs by 5 to 25% in the urban population by 1995;

⁴ Way P and Stanecki K, The Demographic Impact of an AIDS Epidemic on an African Country: Application of the IWGAIDS Model. Center for International Research, U.S. Bureau of the Census.

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- an IEC program that reduced casual sex in the urban population (to 25%); and
- a 100% blood-screening program in operation by 1995.

Condom Use: A model of a five year program of condom promotion, beginning in 1990 and fully operational by 1995, was developed, using the assumption that 0.4% of urban women and men are using condoms in 1990. With no condom intervention, the model projects the prevalence rate of HIV infection by the year 2015 to be about 17% in the urban areas. With an intervention program resulting in the use of condoms by 5% of urban couples, the model projects an overall prevalence rate of less than 13% in the urban areas. According to the model, an intervention that results in condom use by 25% of urban couples will result in a declining epidemic with an urban prevalence rate of 0.6% by the year 2015.

Reducing Casual Sex (the number of sexual contacts outside monogamous sex): Under the assumptions of the model, a reduction of casual sex by 15% would be required in order to see a decline in the epidemic.

STD Control: A 5% reduction in the duration of STDs in urban areas would result in a 2 percentage point drop in urban seroprevalence levels by 2015 - from 17% to 15%. Lengthier reductions in STD duration would result in progressively larger decreases in seroprevalence levels in 2015.

Blood Screening: The model predicts little impact on the epidemic due to blood screening. With a 100% blood-screening program in place by 1995, the urban prevalence rate for the year 2015 would be reduced by less than 1 percentage point. Concentrating all available health funds on the establishment of a 100% screening program might not be as cost-effective as other types of interventions.

However, at this time, blood-screening is the only technology available which is effective within a short time period in stopping HIV/AIDS transmission through blood. Politically, this can be used by MOHs to demonstrate their commitment to HIV prevention and particularly their concerns about HIV infection amount children. In many African countries, children are at great risk of acquiring HIV infection because they receive large numbers of transfusions (some of which may be HIV-contaminated) for treatment of malaria and other causes of anemia. Thus, through an initial, successful blood-screening program, MOHs could acquire greater public credibility rather than through

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campaigns urging sexually active adults to change their sexual behavior.

In any case, blood screening programs should complement other interventions and not be considered in lieu of IEC and STD control activities. Alternative interventions to screening blood for HIV also should be explored. These should include the strengthening of blood donor screening in order to discourage those practicing high risk behavior from donating blood.

The HIV/AIDS model also shows that greater impact might be achieved with large-scale programs which include all four of the above-listed interventions.

Although these projections should be interpreted cautiously, recent data from Zaire provide evidence that condom use can be effectively promoted. The Zaire condom social marketing project has dramatically increased sales of condoms from 37,000 in 1987 to 1,000,000 in 1988, 4,000,000 in 1989, 9,000,000 in 1990, and an estimated 15,000,000 in 1991. Ninety percent (90%) of the condoms sold are reported to be for HIV prevention and control. In addition, all the studies have documented that reported behavioral change in Zaire, especially in males, is due to the threat of AIDS. The three most frequently cited changes in behavior in Zaire were: decrease in number of partners, less frequent or no sexual relations with prostitutes, and increased faithfulness to one wife, or two wives.

This project will focus on condom promotion and reduction of sexual partners through condom social marketing, community-based condom distribution and IEC activities.

Components of an HIV/AIDS Prevention Project

Health Information Systems

Health information is required for multiple purposes by an HIV/AIDS prevention and control program to:

- establish baselines against which program outcomes and impacts can be assessed;
- define target groups for various activities and target levels for various goals;
- quantify the level of program inputs achieved at each level and in each sector of the program;

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- monitor the processes involved in program implementation;
- measure outcomes of program activities; and
- measure impact of program activities.

Many of the above involve the establishment of measurable indicators. The most reliable indicator for the effectiveness of an HIV/AIDS prevention program would be change in the seroincidence (i.e., the number of new HIV infections acquired in a defined population for a specified unit of time) of HIV infection among selected populations. Seroincidence should decline as the effectiveness of the prevention messages results in fewer new infections. Tracking seroincidence, however, is presently a difficult task because of the problems associated with HIV testing. Collecting sera from a representative sample of the population for laboratory testing is not easy, especially when informed consent is required. In spite of the challenge, this Project will make extensive efforts to collect sera from representative samples on an on-going basis. The Project will not rely, however, exclusively on population-based incidence rates to indicate effectiveness. The HIV Testing and Survey Team will supplement testing with other measures of changes in HIV seroincidence, including incidence rates from anonymous, sentinel sero-surveys using convenient, nonrepresentative, sampling methods as well as the use of reductions in STD incidence, particularly gonorrhoea, to assess sexual behavior changes.

Without an effective vaccine or preventive/curative therapy, education is the primary intervention. Therefore, evaluation of a program's effectiveness must focus also on this intervention supplementing currently available tools such as research-focused knowledge, attitudes, beliefs, and practices (KABP) studies.

In the past several years, considerable work in the development of appropriate indicators has been undertaken by WHO/GPA, USAID, CDC, and others. Examples of such indicators are:

- percentage of population reporting sex with more than one partner in the previous 6 months;
- number of condoms distributed and sold during the previous 6 months;
- percentage of the population using condoms in the last sexual encounter;

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- percentage of health care providers giving appropriate treatment for sexually transmitted diseases, per unit of population;
- percentage of males aged 15 - 29 reporting an STD within the past 6 months;
- age-specific HIV+/- syphilis seroprevalence among pregnant women aged 15 - 29;
- number of peripheral level nurses trained in HIV counseling and prevention;
- number of district physicians trained in AIDS diagnosis and reporting;
- number of hospital laboratories with personnel trained in proper use of appropriate HIV diagnostics;
- number of AIDS cases newly diagnosed by health facilities and satisfying case criteria specified by the NAC;
- number of tuberculosis cases newly diagnosed by health facilities and meeting criteria specified by the national TB control program; and
- proportion of female population aged 15 - 29 who has had sex in exchange for goods/money during the previous 12 months.

The first six indicators listed above are those recently proposed by AID/W for HIV/AIDS programs. Again, the HIV Testing and Survey Team will be free to supplement its comprehensive HIV testing with these indicators.

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Administrative Analysis Support

1. The Copperbelt Health Education Project

Background

The Copperbelt Health Education Project (CHEP) was founded in 1988 by the Rotary Club in Ndola, the provincial capital of Copperbelt Province. CHEP works in AIDS education and support services for the people of the urban Copperbelt.

Information, Education and Communication

CHEP has target audience-specific objectives and strategies, and employs a variety of communications channels and networks in their outreach efforts. Their primary target, in addition to the general public, includes school children, out-of-school youth, members of the security forces and STD clinic attenders. Secondary target groups include health workers, traditional healers, religious leaders, educators, journalists, employers and managers.

CHEP publishes a variety of educational materials, in both English and Bemba, produces television spots, and conducts educational sessions and seminars throughout the Copperbelt for their target groups. An example of CHEP's active outreach approach is the recruitment of street youth from the urban townships for AIDS peer education training and subsequent formation of a cooperative for income generation.

Improving Support Services

Activities in improving support for HIV/AIDS prevention and management services include:

1. Improving institutional and home based care of people with HIV-related illness;
2. Training counselors and assuring their support and continued skill development; and,
3. Condom promotion
4. Strengthening the National STD and TB control programs

Monitoring and Evaluation

CHEP has employed the following approaches in small-scale research efforts and monitoring activities: analyses of seroprevalence studies of the NAPCP; KAP surveys; focus group

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discussions; monitoring of condom sales; monitoring STD incidence at sentinel sites; analysis of data on teenage pregnancy among school girls.

Organization

CHEP is a registered NGO in Zambia. It is headed by a director seconded from the Catholic Diocese of Ndola. A project coordinator, seconded from VSO carries out the daily management of project activities and supervises staff in the operational units (see Organizational Chart). The Board of Management of CHEP is comprised of individuals representing a broad spectrum of the community: government health services, religious leadership, the business sector, management (accountancy) and education.

Project coordination staff and project supervisors have professional backgrounds in health education, paramedical services, social work and education. In addition to the full-time professional staff, a team of 12 resource and outreach workers comprised of physicians, nurses and teachers, are available on an as-needed basis to provide special inputs. They are paid a flat fee for assignments such as lectures in the workplace, technical analyses in research and evaluation activities. A pool of volunteers from the Catholic congregation is available to train AIDS Prevention Officers in industrial settings.

The Field Work and Evaluation Team consists of four persons trained in survey methods, enumeration, data compilation and processing.

Relevant strengths of the organization

CHEP is well established, recognized and appreciated in the community it serves, and in Zambia at large. They have an extensive outreach network, and work with all sectors of society. CHEP coordinates and works closely with the Ministry of Health. Government officials, such as the Provincial Health Education Unit, solicit their help in carrying out education activities.

During 1991 CHEP'S primary funding sources were NORAD and WHO. Other donor assistance was provided by UNICEF, Christian AID, SIDA, and Catholic Fund for Overseas Development (CAFOD). CHEP maintains separate accounts for specific projects and has a good record of financial management. Audits are conducted quarterly and reports are available through 1991. CHEP's budget for 1992 is \$301,500.

Despite very limited resources, CHEP has made significant inroads in HIV/AIDS education in the Copperbelt. Staff operate from

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very inadequate office space and have functioned under considerable financial and transport constraints. Expansion of their activities through collaboration with this project will require greater office space, improved transport, and training and technical assistance in accordance with the agreed upon scope of work.

CHEP shares an interest and experience in a number of priority areas for the HIV/AIDS Prevention Project -- youth, traditional healers, and workplace based HIV prevention activities.

2. The Institute for African Studies (IAS)

Organization

The IAS is part of the University of Zambia, with an academic staff of 12 and 20 support staff. It is headed by a director, who serves as Chairman of the Board of Research Programs. Its four research programs include: economic and labor research, urban development research, health promotion research, and social and cultural research. Each research program is headed by a coordinator and staffed by one or more research fellows (see Organizational Chart). Research projects emanating from the Institute require the approval of the University Senate through its Research and Grants Committee. An Information Unit is responsible for library services, publications and data processing.

The IAS has a sizeable annual budget of which about 75 percent comes from sources other than the government. Accounts are centralized under the Office of the Bursar of the University of Zambia, although the Institute will maintain a separate bank account for this project.

Relevant research and collaboration

IAS has an excellent reputation for carrying out high quality work, both within Zambia and internationally. The IAS has a long history of successful collaborative efforts with other institutions and agencies on a broad range of projects. In the recent past the IAS has cooperated with UNICEF, SIDA, NORAD, the UNDP and the Friedrich Ebert Foundation. Some of these programs are ongoing.

The IAS has specific experience and on-site capability in areas which are directly relevant to the needs of this Project: health policy research; research on labor issues and unions; significant policy and economic related work; women's issues; anthropological research; traditional healing systems; behavioral research; and monitoring and evaluation.

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Presently the IAS is conducting a three-year interdisciplinary research project on HIV prevention, involving biomedical and behavioral scientists, in collaboration with the Department of International Health Care Research (IHCAR), Karolinska Institute, Stockholm. IAS is also engaged in a condom acceptability study. A number of ongoing projects concern the needs of women and girls. A study focusing on adolescent problems and peer counseling is also underway.

IAS studies are commissioned from a variety of sources: the government, international and bilateral agencies, foundations, parastatals and the private sector. Studies of the effect of IAS studies on policy and decision making have demonstrated a high level of impact on government and other sectors.

Constraints

As a result of previous government policies, the IAS has had difficulty training and maintaining qualified staff, due to poor conditions of employment in the government service. The intended staffing structure of four research assistants per research program has not been maintained for this reason. Of the twelve academic posts which are presently filled, five are out of Zambia on long term study leave or other leave of absence. Nevertheless the present core of exceptionally capable staff maintain a high level of professional research activity.

The staffing constraint is dealt with in a number of ways which greatly augment the capacity of the Institute: IAS draws on other professionals as needed from the entire University of Zambia system; collaborative arrangements with professionals or consultants outside of the University are arranged; research affiliations for collaborating organizations are established; and collaborating institutions send research staff to the Institute. Thus, the IAS offers a range of possibilities for complementing existing IAS capacity with specialists required for specific tasks.

Training opportunities for IAS researchers have been limited. Thus, the capability enhancement which accompanies collaborative research efforts such as this one is an important benefit for the host institution in this partnership.

Existing equipment and transport facilities at the IAS are marginally adequate for routine activities. Equipment and logistics support will be required according to the scope and nature of new projects undertaken.

The IAS is considered a very good support base for the AIDS control and prevention project given their research capability

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and profile in Zambia, their structure, which uniquely addresses the needs of the project, and their staff resource base which provides access to the wider university system and professional structures beyond.

3. The MOH STD Control Program

Background and organization

The MOH established the STD Control Programme in 1980 with two clinics in Lusaka and Kitwe. In 1989 the network expanded to include district and provincial hospital-based clinics. The program now covers all of the 9 provincial hospitals, 22 of the 36 district hospitals and 9 health centers serving large populations. The program is also found in university and military clinics.

The objectives of the program are:

- To assess the nature and extent of STDs in Zambia;
- To improve management of STDs through specialized clinics
- To train personnel through inservice training
- To increase public awareness about STDs
- To coordinate research, treatment and preventive activities to reduce the incidence of STDs

The STD Control Programme falls under the Primary Health Care Programme of the Ministry of Health, headed by the Deputy Director of Medical Services, Primary Health Care, and directed by the national STD Manager who also is the Head of Dermato-Venereology at the University Teaching Hospital.

STD control clinics are staffed by teams of specially trained clinical officers (physician assistants), one or more nurses, a laboratory technician and a counselor. An STD surveillance information system is established, in which incidence for six STD diagnoses by gender are tallied monthly and aggregated at the central level.

A supervisory system for all STD clinics is in place using structured evaluation instruments.

Research and cooperation

Expansion of the STD Control Programme has been made possible through training and substantial inputs into equipment, drugs, and diagnostics. The main sources of this support have been WHO, UNICEF, the EEC and A.I.D. through the Henry Jackson Foundation (USUHS). The STD Control Programme, in addition to providing services and training, conducts research and works on policy

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issues related to management of HIV/AIDS through the NAPCP Clinical Support Unit, under the direction of the STD Control Programme Manager. Guidelines for STD diagnosis and management were published in 1991, and a tropical atlas on HIV infection has been prepared by the Head of the Department of Dermato-Venereology. Some of their recent or ongoing research activities include: a demonstration project to assess the impact of prompt STD management, contact tracing and condom promotion on HIV infection rates; a perinatal study to follow-up HIV positive mothers and their children to determine infection and survival rates; a trial of IMH prophylaxis for healthy HIV positive subjects; and a discordant couple study, examining the effect on HIV infection rates of counseling and provision of condoms over time in a test and control group. There is also an evaluation of the syndromic approach to HIV/AIDS diagnosis. A total of 70 papers have been published based on the work of the STD Control Programme.

Constraints

There are serious staffing constraints at the UTH STD Clinic, as in other clinics. Of eight established posts for physicians, only four are presently occupied. In the categories of clinical officers, nurses and lab technicians, the vacancy rate is 25-30 percent. Senior medical staff serving in the unit do not have post graduate training in STDs or public health. The current manager is functioning in an acting capacity.

Since UTH came under the direction of the UTH Board of Management in 1986, recruitment of staff has become increasingly difficult due to inadequate funds. Restructuring of UTH and the Ministry of Health at large may have an impact on how the STD program will operate. Presently it is a separate department, but there have been suggestions to subsume it under the Department of Medicine.

Augmenting staffing within the government structure poses difficulties, and the most feasible approach initially will be to assure that all vacant established posts are promptly filled. The enhancement of training and resources in the STD program which this project will confer will act as an incentive to attract interested health professionals to the STD field.

Working space is inadequate for the current needs of the STD clinic, as throughout UTH. Expansion and improvement of the program will require enlarging or augmenting the current space available.

There is long-term shortage of drugs resulting in increasing self-care, use of traditional remedies for STDs, and indiscriminate use of "black market" antibiotics. The drug

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deficiency needs to be urgently addressed to prevent the rising "loss" of patients who, untreated, stand at higher risk of contracting and transmitting HIV. Diagnostics and consumable goods are also in short supply.

Training support, particularly in counseling and communication skills, needs to be expanded, as the STD clinic system expands. Refresher courses are needed to update skills on a regular basis.

Accounting

The annual budget for the STD Control Programme in 1990 was approximately \$700,000. This figure represents the upgrading inputs mentioned above, and therefore previous and subsequent annual budgets are lower.

The STD Control Programme maintains separate accounts for special projects. Transactions are handled under the Financial Controller of UTH. Audits are conducted by the same auditors as those handling UTH accounts.

Summary

The STD Control Programme provides an excellent platform on which to build up STD prevention and control measures. In addition to the improvement of clinical care and counseling, linkages and referral networks with other components of the project will evolve -- in counseling, testing, policy and evaluation.

4. Tropical Disease Research Centre (TDRC)

Background

The Tropical Diseases Research Centre (TDRC) was founded in 1975 as one of the first of the WHO regional research institutions. In 1981 the Center became a national institution, and was established as a parastatal body in 1982. TDRC has had an emphasis on institutional development and epidemiological research since it became a national research base.

Organization

TDRC is governed by a Board of Directors composed of heads of major scientific and medical institutions in Zambia, and the WHO Area Representative. Its Director and Deputy Director oversee program areas, core units and training.

The staff of TDRC include six medical doctors, three of whom are presently on overseas training. There are 19 nurses permanently attached to TDRC from Ndola Central Hospital as well as two RNs

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and three enrolled nurses. The core units and programs are staffed by a range of biomedical professionals in the fields of epidemiology, pharmacology, biostatistics, and parasitology as well as senior technical staff in laboratory sciences, statistics and library sciences (see organizational chart). An active staff development program has provided high levels of specialized graduate training for senior staff.

The TDRRC has linkages with numerous international research and academic institutions including Centers for Disease Control, Atlanta, International Development Research Center, Canada, London School of Hygiene and Tropical Medicine, Harvard University, International Centre for Diarrhoeal Disease Research, Bangladesh, and many others. TDRRC collaborates with the University of Zambia and all other relevant national and regional institutions.

Relevant research

Research in HIV/AIDS, particularly the epidemiology, clinical presentation and microbiology of AIDS, figure prominently in the research agenda of TDRRC. TDRRC has conducted seroprevalence studies, carried out drug clinical trials for AIDS/ARC patients, evaluated HIV screening kits and HIV routine diagnosis, studied the natural history of HIV infection in pregnancy and infancy; assessed the impact of health education on sexual behavior and HIV transmission; and studied the interaction of HIV infection with malaria and other endemic parasites. Findings have been presented at major international conferences and are published in professional journals.

The Laboratories Department of TDRRC is comprised of 5 units: Immunology, Parasitology, Biochemistry, Hematology and Vector Biology. Each unit employs a minimum of 3-4 staff. A total of 30 lab technologists/technicians serve under the Chief Laboratory Technologist. The Hematology laboratory serves the northern region of Zambia.

Potential Participation in Project

The Immunology Unit of the Laboratories Department has the capability to undertake the HIV testing in the Copperbelt. TDRRC is able to establish the quality assurance/quality control measures required by the testing component. Operations research studies associated with the testing and counseling interventions can be undertaken by staff of the Epidemiology Department.

As a parastatal institution, the TDRRC can recruit staff and provide attractive conditions of service, assuring professional quality and a positive working morale.

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Accounting procedures comply with operative international accounting standards. Financial statements are available through 1991. Separate bank accounts are maintained for special projects.

5. YWCA

Background

The YWCA of Zambia is a legally incorporated NGO established in 1957. It is "dedicated to the empowerment of women in order to achieve a better community" (Mission Statement). The empowerment of women is achieved through provision of relevant information, knowledge and skills. Its activities in support of women take several forms:

- skills development
- income generating projects
- primary health care activities including AIDS awareness
- introducing appropriate technology devices
- nursery schools for the children of working women
- hostels for young women and female transients
- consciousness raising and empowerment

The YWCA is governed by a national council which is served by a Board of Directors. The Board, in consultation with standing committees, guide the work of the branches. There are presently ten active branches, five of which have full-time staff, and the remainder are staffed by volunteers. Programs are implemented by the branches.

The YWCA is financed from a number of sources: member support, World YWCA; volunteer fundraising activities; income generating schemes; and donor agencies/organizations. Donor support has recently been received from the Protestant Association for Cooperation in Development (EZE - Germany), the Interchurch Organization for Development Cooperation (ICCO - Netherlands), CIDA, NORAD, the Catholic Fund for Overseas Development (CAFOD - Ireland), the Catholic Agency for World Development (TROCARE), and SIDA. Separate accounts are maintained for donor funded projects and auditor's reports are available. The YWCA annual budget for 1992 is K30,000,000 (\$240,000) of which about 50 percent is generated locally.

Relevant experience and interests

The first goal of the PHC program strategy of the YWCA includes the promotion of AIDS awareness (YWCA 5 Year Plan 1990-1994), targeting youth, health workers and traditional birth attendants. The YWCA has conducted workshops on AIDS

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awareness for their membership, focus group discussions on AIDS for young women, AIDS awareness campaigns for school children and communities, and development of the "YWCA AIDS Free Life-Style Pledge". The YWCA is presently working on a program focused on prevention of teenage pregnancy, AIDS and STDs. The program aims at empowering girls with information as well as training them in peer counseling. The YWCA collaborates with PPAZ, the Anti-AIDS Project, UTH Home Care Services and the Ministry of Health in their AIDS-related activities.

The YWCA has expressed an interest in working with out-of-school youth, through their existing program of Y Teens, which targets youth aged 10-19 years.

Constraints

The YWCA is a staff-volunteer based organization. The strongest of the YWCA branches are those with full-time staff. To insure continuity of efforts and maximizing resources, there is a need to have adequate full-time staff. Only two branches have a vehicle, and lack of transport curtails outreach. Fund raising and collection of membership fees is becoming increasingly difficult given the present economic environment and the growing competition in community fund raising among voluntary organizations.

Local Resources

The YWCA at national level has a well established infrastructure and capacity to take on projects such as HIV Prevention targeting Out-of-School Youth. Their core of dedicated volunteers and staff, as well as their wide membership network also constitute a significant resource which will greatly facilitate the implementation of this component. The YWCA has a strong presence in Lusaka and in the Copperbelt, where there are two branches (Kitwe and Chingola). A third, inactive Copperbelt branch in Ndola could be reactivated through this project. With one other strong urban branch in Livingstone, there is clearly a good infrastructure for accessing out-of-school youth in priority areas.

6. The MOH Health Education Unit

IEC activities under the AIDS control program are coordinated through the HEU in the MOH. The HEU is currently composed of a Head, Dr. Ben Chirwa and four full-time professional members, two of whom are on leave of absence for training overseas. The Unit has other responsibilities, primarily health care education.

A member of HEU staff, Dr. Nicholas Phiri, is seconded to the AIDS control program office as an IEC Coordinator. WHO/GPA provides technical assistance to the AIDS control program

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through the IEC coordinator, Mrs. Florida Kweekeh, who works in collaboration with Dr. Phiri.

The HEU's responsibilities include overall review and approval of HIV/AIDS activities and materials developed by government agencies, NGOs, and other cooperating agencies. Specifically the IEC Unit of the HEU has been responsible for activities to disseminate general information through the mass media, activities targetted towards school youth, regular liaison with NGOs, and an assessment of community-based educational and developmental programs.

7. Other Counselling Institutions

The Churches Medical Association of Zambia (CMAZ) specializes in counselling in rural areas. Around 80 health personnel from smaller hospitals and from RHCs have been trained, mostly at NAPCP training courses. Nurses and Clinical Officers in rural hospitals or rural health centres figure among the trainees, although usually their professional duties do not allow them sufficient time to function as counsellors. Other health care staff such as Health Assistants are trained to do counselling. The counselling at RHCs stresses a caring and supportive role.

CMAZ feels the need, after about six years' experience with counselling, to introduce a better demarcation of counselling services and techniques between health care levels. The district/general hospital may need a different counselling content than the RHC, which will be closer to the community and need to be more caring and supportive. Some form of "general counselling" (distinct from IEC activities) below the RHC, i.e. in the community itself, has been suggested. Chikankata Hospital, for example, does "preventive counselling" in the community as one element of its tightly integrated approach to home-based care. Presumably other models could be designed with the objective of counselling the "worried well".

In the Chikankata Home Care and Prevention Programme, counselling is viewed as a means of conveying information continually reinforced, in order to bring about sexual behaviour change. It is an inter-active process which seeks to instill a sense of responsibility in the individual, family and community for preventing HIV transmission. This "transfer of responsibility" for care and prevention to families and communities, supported by visits from the home care and prevention team, is a unique feature of Chikankata's integrated approach.

The AIDS Counselling Unit at Chikankata trains staff social workers, doctors, clinical officers and nurses as counsellors both in courses and on-the-job training. They provide post-test and some pre-test counselling in the hospital, and

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longterm counselling of individuals, families and community as part of the home care visits. The Unit also serves as a training and observation site for prospective counsellors from many institutions both within and outside Zambia.

In the urban areas, especially Lusaka, there exists a wider range of counselling services. Despite the continual training of counsellors, it still seems that there are not enough of them.

UTH can serve as an example of urban hospital - and urban clinic-based counselling. The counselling services are arranged through the home-based care programme by counsellors seconded to the programme by MOH.

At UTH itself, most counsellors are HIV-positives already ill with symptomatic disease. Medical staff in the different wards refer the patients for pre-test counselling. The home-based care counsellor takes contact with the patient for pre-test counselling, notifies the patient of his/her HIV status after the test, does post-test counselling and, after discharge, does follow-up counselling of both patient and family once a week through the home-based care programme. In UTH there are around 8 - 10 referrals per day, and in 1991 some 1,351 patients were reportedly counselled by the home-based care programme.

In Ndola Central Hospital and Kitwe General Hospital there are also counsellors (30 counsellors at Kitwe) who are called on by the different departments and wards to do pre-test and post-test counselling. These institutions are large, often overcrowded and understaffed. It is difficult to determine the criteria used to decide who should be counselled in hospital, given that the reporting practices on HIV/AIDS from these and other hospitals is uniformly poor.

Little information appears to be readily available on the monitoring and evaluation of counselling in the hospital setting. Certain departments or groups do run well-controlled counselling services, using locally adapted methodologies. For example, the neonatal wing (D Block) at UTH has trained all its staff in compassionate approaches to the family using what is termed "experiential reflective learning", by which is meant learning from personal work experience. It is a closely-knit group in which nurses, maids and ward clerks have been trained and refresher-trained to counsel families of HIV-positive infants. Outreach services, however, are piecemeal because of time constraints and other demands on professional time.

NGO Counselling

As well as counselling HIV-positives, the walk-in and hot-line services offered by Kara Counselling help to fill a gap for

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the "worried well" in urban Lusaka. They exploit a number of innovative features such as training HIV-positive people to act as peer educators.

During the past year, monthly numbers of counselling requests have ranged from a low of 49 (July 1992) to a high of 130 (November 1991). The most frequent requests are from clients in the age-range 20-30, and men slightly outnumber women.