

**Background Paper for Budget Focus Meetings:
HIV Infection and AIDS**

1. HIV Infection Rates

Recently revised, but conservative, estimates by the World Health Organization (WHO) indicate dramatic increases worldwide in human immune deficiency virus (HIV) infections and acquired immune deficiency syndrome (AIDS) cases. By the year 2000, 30 to 40 million men, women and children will likely be infected by HIV. Cumulative estimates of AIDS cases to date have increased to 1.5 million. The current number of AIDS cases reflects HIV infections acquired a decade ago. For a realistic picture of the pandemic today, one must look to the number of people infected with HIV. WHO currently estimates that between 9 and 11 million people have been infected with HIV to date, and that another 5,000 people are infected with the virus every day.

HIV/AIDS in Africa: The current level of HIV infection is highest in sub-Saharan Africa. An estimated 6 million people are infected; about one in every 40 adults. Most of the women infected are of childbearing age, and HIV transmission from the infected mother to fetus or infant is a widespread and increasing problem. More than 500,000 HIV-infected infants have already been born in Africa and millions more will be born by the end of the decade, contributing significantly to the already high child mortality rates in this region.

HIV/AIDS in Latin America and the Caribbean: The Pan American Health Organization (PAHO) estimates that between 750,000 and 1 million people in Latin America and the Caribbean are infected with HIV. While extensive spread of HIV probably began in this region among homosexual and bisexual men, the rate of heterosexual transmission has increased significantly in the last five years. A recent study conducted in a major Haitian city among a random sample of 3,688 adults showed that 1 out of every 20 adults may be HIV-infected. In Honduras, a 1990 study of several hundred prostitutes reported HIV prevalence of 35%, an infection rate as high as that among prostitutes in most of Africa.

HIV/AIDS in Asia and the Near East: In general the prevalence of HIV infection has been low in most parts of these regions, but the infection is spreading rapidly in some groups of people practicing high-risk behaviors. In Thailand, HIV prevalence among intravenous drug users in Bangkok increased from less than 1% in 1988 to about 50% in 1990; increases of 30-40% in HIV prevalence have been documented among female prostitutes in one Thai province; and 14% seroprevalence has been reported among young adult males in Northeast Thailand. In India, surveys indicate HIV infection rates as high as 70% in some groups of female prostitutes. In Bombay, the HIV infection rate among 1,900 prostitutes has increased from 1.6% to 23% in less than two years. It is feared that without appropriate interventions, the

Indian epidemic may follow the pattern evidenced in many African countries.

2. The Impact of the Pandemic

There is no question that the HIV/AIDS pandemic is accelerating and no part of the world can risk complacency. Already the leading cause of death in some urban centers of Africa, HIV/AIDS is now spreading to rural areas and may become the leading cause of death overall among young and middle-aged adults by the end of the decade. Seroprevalence rates among certain groups in Thailand and India portend a rapid spread of the infection if interventions are not implemented; and Latin America and the Caribbean are experiencing an alarming increase of heterosexual transmission of HIV infection.

By the year 2000, over 80% of all HIV infections are expected to result from heterosexual transmission. When the presence of HIV infection is coupled with a high rate of other sexually transmitted diseases (STDs), especially those associated with lesions, and social norms that accept multiple sexual partners, HIV infection rates will rise rapidly.

African data indicate that high rates of syphilis among women visiting antenatal clinics foreshadow not only a rapid increase in HIV infection rates, but also a dramatic rise in fetal death and infant mortality, as well as increased death rates among women of childbearing age. By 1995, WHO/GPA projects HIV-related increases in child mortality of up to 50% in Africa's most-affected cities.

HIV/AIDS threatens to halt or reverse the social and economic gains made in many developing countries. As more men, women and children become ill, health-care costs and demands upon the health-care infrastructure will escalate well beyond the resources available. Victims of AIDS will not be the only drain on the health-care system. Other infectious diseases will spread as dormant infections become active in persons with weakened immune systems and in turn those individuals infect others. For example, because of HIV infection, decades of declining tuberculosis-related deaths are now anticipated to rise sharply in Africa, Latin America and southeast Asia.

The development impact will also be felt within the cadre of trained and untrained human capital. When large numbers of people in their most productive years are stricken, the work force will be reduced, resulting in a decline in productivity, particularly in agriculturally-based labor-dependent economies. Investments in education and training will be squandered as the young and educated of many countries become infected. Ultimately

per-capita income will decline in the most severely infected countries.

Traditional social support networks will be stretched beyond capacity as more and more families are disrupted by AIDS deaths. Children will be orphaned and aged dependent adults will be left without support.

3. Legislative Directives

Congressional concern over the global HIV/AIDS epidemic is expressed in the following legislation proposed by the House Committee on Appropriations for FY 92 :

1. an earmark of \$65 million for International AIDS prevention and control as part of the overall earmark of \$345 million for health, child survival and AIDS;
2. a sub-earmark of the above \$65 million directing \$30 million to the continued support of the World Health Organization's Global Program on AIDS (WHO/GPA); and \$1 million for UNICEF's AIDS prevention advocacy program; and
3. a DFA target of \$50 million (or 5% of DFA) to support HIV/AIDS prevention and control programs in Africa (while DFA and central funds may be combined to achieve this target the House Committee indicated that it was its intention that the funds be derived from the DFA to the maximum extent possible).

AIDS EARMARKS/REGIONAL OBLIGATIONS (\$000)

	1990	1991	1992	1993
EARMARK	42.0	52.0	115.0*	
DFA	4.3	24.0	20.0	11.5
DA	26.0	29.2	32.1	42.3
WHO/GPA	21.0	23.0	25.0	30.0
DA + DFA TOTAL	51.3	76.2	77.1	83.8

* Includes \$50 million from DFA (target amount in HAC language)

4. The Agency's AIDS Prevention and Control Portfolio

In addition to being the largest financial supporter of the WHO/GPA since 1986, the Agency for International Development has developed its own bilateral assistance programs for AIDS

prevention and control and has launched over 650 activities in 74 developing countries.

A.I.D. Policy Guidance On AIDS provides the framework for our bilaterally and centrally funded prevention and control activities. The guiding principles are:

- o increase the awareness of policy-makers of the impact of HIV/AIDS on their societies
- o focus on prevention of the infection
- o create sustainable programs
- o emphasize continual program monitoring and evaluation

The strategic approach of the Agency's AIDS prevention activities focuses on:

- o reducing the sexual transmission of HIV
- o concentration of resources in key countries
- o development of public-private sector partnerships
- o community-based approaches/interventions
- o continued expansion of knowledge about sexual behavior and application of that knowledge toward the design of more effective interventions

Regional and Central Bureau Portfolios: Regional Bureaus maintain bilaterally and regionally funded AIDS prevention and control activities as well as centrally funded projects in their country portfolios.

**REGIONAL DISTRIBUTION OF AIDS FUNDING ALL SOURCES
FY 1990 - 1993
(\$000)**

	1990	1991	1992	1993
LAC	8.1	13.5	14.7	18.6
ASIA	1.2	3.3	5.9	6.3
NE	1.9	1.3	1.3	1.9
EUR	0.0	0.0	0.0	0.0
AFR	13.6	32.9	28.1	23.8
GLOBAL	6.0	2.2	2.1	3.2
GPA	20.5	23.0	25.0	30.0
TOTAL	51.3	76.2	77.1	83.8

Note: Regional totals are inclusive of central bureau contributions to mission implemented interventions.

Africa: The Africa Bureau implements the majority of its interventions through the HIV/AIDS Prevention in Africa Project (HAPA). HAPA's last year is FY 1993, however, and the Bureau has not indicated (at least in its ABS submissions) plans for a follow-on activity.

HIV/AIDS FUNDING FY 1990 - 1993
(**\$000**)

AFRICA	FY 1991	FY 1992	FY 1993
Burkina Faso	350	210	232
Cameroon	0	250	250
CAR	630	600	600
Cote D'Ivoire	672	816	1,224
Ghana	1,413	750	750
Kenya	0	200	200
Malawi	177	3,244	2,080
Mali	0	100	100
Nigeria	0	0	337
Rwanda	0	300	200
South Africa	740	1,540	560
Tanzania	0	700	700
Uganda	9,600	1,000	0
Zaire	300	4,800	2,600
Zambia	0	4,500	0
REDSO/W	0	110	110
Africa Regional	10,173	950	1,530
Africa Subtotal	24,056	20,070	11,473
R&D/Africa	8,883	8,056	12,343
Africa TOTAL	32,938	28,126	23,816

LAC: The major bilateral program in the LAC Bureau is in Haiti, with smaller activities in the Dominican Republic, Bolivia, Guatemala, Honduras and Jamaica. The Bureau also has a major Caribbean Regional activity.

LAC	FY 1991	FY 1992	FY 1993
Bolivia	604	1,000	1,000
Dominican Republic	850	759	796
Guatemala	118	74	73
Haiti	1,841	2,977	4,000
Honduras	133	170	182
Jamaica	745	965	965
Caribbean Region	1,691	1,876	1,247
LAC Regional	638	693	725
LAC Subtotal	6,620	8,514	8,988
R&D/LAC	6,909	6,265	9,625
LAC TOTAL	13,529	14,779	18,613

Asia/Near East/Europe: The Asia bilateral program is focused on India and Thailand. The Near East Bureau has a single activity in Morocco and the Europe Bureau has no bilateral AIDS activities.

ASIA	FY 1991	FY 1992	FY 1993
India	0	2,000	1,000
Thailand	0	595	510
South Pacific Reg.	547	700	600
Asia Regional	0	100	334
Asia Subtotal	547	3,395	2,444
R&D/Asia	2,745	2,507	3,881
ASIA TOTAL	3,292	5,902	6,325

NEAR EAST	FY 1991	FY 1992	FY 1993
Morocco	145	251	339
Near East Subtotal	145	251	339
R&D/Near East	1,202	1,073	1,653
Near East TOTAL	1,347	1,324	1,992

R&D: For the past four years, the R&D Bureau has provided broad-ranging technical assistance in AIDS prevention, principally through the Office of Health's Aids Technical Support Project. Over the past year, R&D has re-designed the project and recently signed a \$168 million cooperative agreement with Family Health International to implement an ambitious HIV/AIDS prevention and control program. The cooperative agreement will establish full-scale programs in most of the Agency's priority countries, combining central and bilateral funds to mount comprehensive national prevention and control campaigns.

R&D Regional	19,739	17,901	27,502
R&D WORLDWIDE	2,193	1,989	3,055
R&D TOTAL	21,932	19,890	30,557

WHO/GPA	23,000	25,000	30,000
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GRAND TOTAL	76,299	77,120	83,801
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The Agency Priority Countries for AIDS Prevention: In order to concentrate its AIDS funding sufficiently to have measurable impact, the Agency has decided to focus its AIDS prevention activities in fifteen priority countries and seeks to spend 75% of its AIDS funding in these countries. Each country will implement a full-scale program including the design and implementation of a National AIDS Control and Prevention Strategy

The selection of proposed priority countries has been based on the following criteria:

- o mission commitment/ availability of bilateral funds
- o potential for HIV transmission;
- o population size and distribution
- o country commitment/ capacity to respond
- o availability of other donor funds

The table below compares mission ABS funding levels for AIDS activities in the proposed priority countries with AIDS funding in non-priority countries and with central funding of AIDS activities in the region.

**PROJECTED FUNDING OF AIDS PREVENTION ACTIVITIES BY
AGENCY PRIORITY COUNTRY/NON-PRIORITY COUNTRY
(\$000)**

AFRICA	FY92	FY93
Priority Countries:		
Cote D'Ivoire	.8	1.2
Ethiopia	0.0	0.0
Malawi	3.2	2.1
Nigeria	0.0	.3
Senegal	0.0	0.0
Tanzania	.7	.7
Uganda	1.0	0.0
Zambia	4.5	0.0
Zimbabwe	0.0	0.0
Subtotal	10.2	8.6
R&D Regional	8.1	12.4
Non-Priority Country	9.8	7.1
TOTAL	28.1	23.8

ASIA	FY92	FY93
Priority Countries:		
India	2.0	1.0
Indonesia	0.0	0.0
Thailand	.6	.5
Subtotal	2.6	1.5
R&D Regional	2.5	3.8
Non-Priority Country	.8	.9
TOTAL	5.9	6.2

Near East	FY92	FY93
Priority Countries:		
Egypt	0.0	0.0
R&D Regional	1.0	1.6
Non-Priority Country	.2	.3
TOTAL	1.2	1.9

LAC	FY92	FY93
Priority Countries:		
Brazil	0.0	0.0
Haiti	3.0	4.0
Jamaica	1.0	.9
Mexico	0.0	0.0
Subtotal	4.0	4.9
Non-Priority Country	4.6	4.1
R&D Regional	6.2	9.6
TOTAL	14.8	18.6

6. Issues:

1) There is a disjunction between the list of proposed priority countries and their projected levels of obligations for AIDS prevention activities; in some cases there is also a mismatch between proposed priority countries and higher levels of AIDS funding for non-priority countries.

Proposed priority countries of Jamaica, Cote d'Ivoire, Ethiopia, Senegal, Tanzania, and Zimbabwe will all require increased mission funding over the life-of-project to sustain priority country program activities. In Zimbabwe OYB ceilings may need to be raised; in other missions internal budget priorities may require adjustment.

ADCs that are proposed priority countries such as Thailand, Nigeria, Mexico and Brazil will need to identify funding mechanisms for priority country AIDS prevention activities.

R&D funds can be used for gap-filling but are not intended,

nor are they sufficient, to cover the cost of mounting comprehensive programs in priority countries.

2) In FY92 projected AIDS obligations will fall short of Congressional targets by between \$30 and \$40 million.

The FY92 Congressional earmark for AIDS is anticipated to be \$65 million; HAC language also includes a DFA target of \$50 million; the combined earmarks total \$115 million. It is likely that some of the DFA earmark will be met with DA contributions to Africa Bureau activities, but it is anticipated that the Agency will be required to spend up to \$100 million on AIDS prevention activities in FY92. In contrast with the \$100 million figure, FY 1992 projected obligations for AIDS activities is \$77 million inclusive of activities now suspended in Zaire (\$4.8 million) and Haiti (\$3 million). If Zaire is excluded, the projected funding level for Africa Bureau AIDS programs in FY92 is \$15 million, substantially below the \$50 million target.

**AIDS FUNDING BY ACCOUNT
EARMARK VS. ACTUAL/PROJECTED
(\$000)**

	1990		1991	
	Approp./ Earmark	Actual	Approp./ Earmark	Actual
DA	21.0	26.0	29.0	29.2
DFA	0.0	4.3	0.0	24.0
ESF	0.0	.025	0.0	0.0
GPA	21.0	21.0	23.0	23.0
TOTAL	42.0	51.3	52.0	76.2

	1992		1993	
	Approp./ Earmark	Projected	Approp./ Earmark	Projected
DA	34.0	32.0	-----	42.3
DFA	50.0*	20.0	-----	11.5
ESF	0.0	0.0	-----	0.0
GPA	31.0**	25.0	-----	30.0
TOTAL	115.0	77.0	-----	83.8

* target

** includes \$1 million earmark for UNICEF

3) Staffing

Staffing for AIDS prevention programs is included within the HPN backstop (BS-50). Currently, there are only 4 direct-hire staff in Washington focused exclusively on AIDS and none in the field. Further in the 15 countries identified for priority AIDS programs over the next 3 years, 8 have no HPN officers and only 4 have more than 1 officer.

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From

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523

ASSISTANT
ADMINISTRATOR

NOV 14 1991

MEMORANDUM

TO: A-AA/OPS, Howard Fry
FROM: AA/R&D, Richard E. Bissell *REB*
SUBJECT: Budget Focus Reviews

Attached is the background paper on HIV Infection and AIDS which was omitted from my prior submission. This now completes the package of papers which we had promised to provide as a basis for a review of A.I.D.'s FY 92 and FY 93 budget priorities.

Attachment

cc: AA/OPS, Len Rogers