

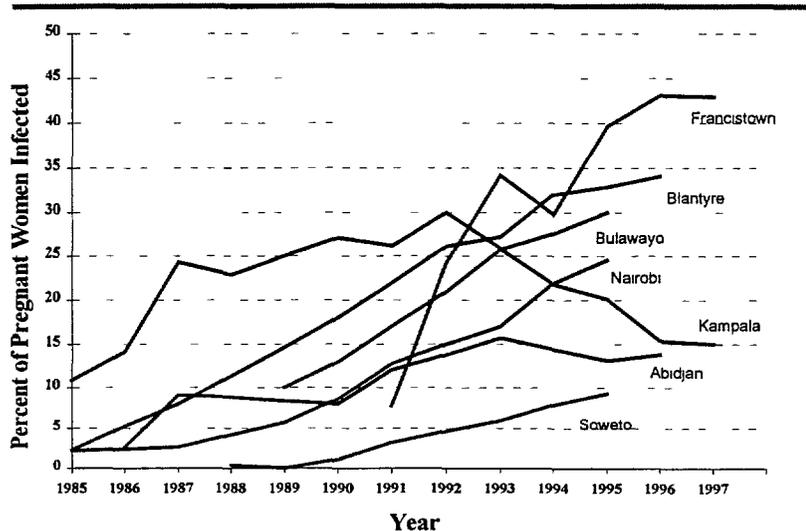
HIV/AIDS Prevention and Mitigation in Africa Africa R4 2000 Wrap-Up June 17, 1998

Overview

During the past twenty years, since the HIV/AIDS epidemic was first recognized, there has been significant effort and progress in containing the spread of the disease. However, the spread of the infection continues, fuelled by economic and political challenges that strain health budgets and household coping mechanisms. Since the early 80's an estimated 30 million people worldwide have been infected with the virus, of which nearly seventy percent live in Sub-Saharan Africa.

In Sub-Saharan Africa, 7.4% of all individuals 15 to 49 years of age are infected with HIV. There are significant regional variations in levels of HIV infection among countries, between urban and rural areas and between populations. The estimated seroprevalence ranges between 2 to 12 percent in urban areas and can be as high as 40 percent among groups engaged in sexual risk taking. Heterosexual transmission accounts for most infections, with 50% of these in women and with over 400,000 infants infected in 1997 alone. The best available source of information about rates of HIV is sentinel surveillance systems tracking HIV rates of pregnant women at antenatal care centers. Figure 1 shows different levels of HIV seroprevalence amongst pregnant women in selected urban areas. The rate of increase of prevalence varies also.

Figure 1 HIV Seroprevalence Rate for Pregnant Women in Selected Urban Areas of Africa, 1985 - 1997



Source: U.S. Bureau of the Census, International Programs Center and ICMH

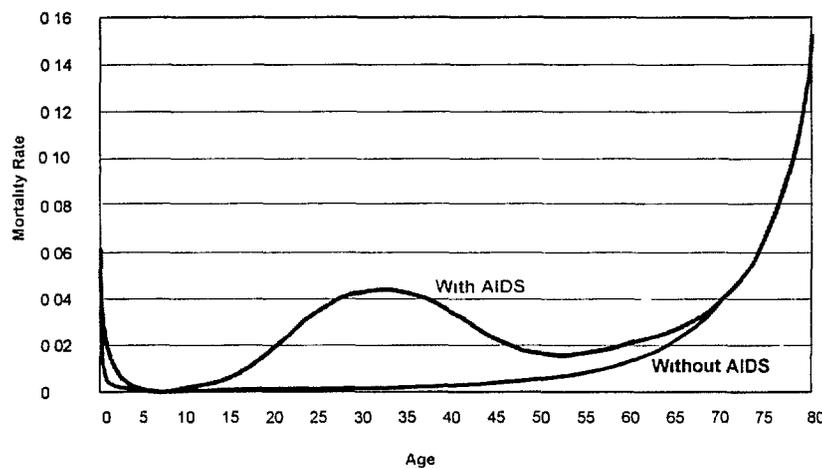
At national levels, there is a high variation. In South Africa, nearly 20% of pregnant women are infected, in Zambia the HIV prevalence is 15 percent among pregnant women (aged 15 - 16 years), whereas in Senegal the estimate is as low as 2% among pregnant women.

Societal Impact of HIV/AIDS

1) Human Toll Morbidity & Mortality

Apart from the high rates of morbidity in the Africa, mortality rates are rising drastically reducing life expectancy by as much as thirty years. Figure 2 shows the "death gap," the difference between death rates with and without AIDS by age group. The greatest losses to HIV/AIDS are between the ages of

Figure 2 Impact of HIV on Age-Specific Mortality Rates at Approximately 20% Adult Prevalence



Source: U.S. Bureau of the Census, International Programs Center, 1998

20 and 45 during which an individual is economically most productive and supportive to the family. Also, HIV/AIDS has a profound effect on mortality of infants and children below the age of five due to intrauterine infection and perinatal transmission. In countries like Zambia and Zimbabwe infant mortality rates have doubled and child mortality rates may triple by the year 2010. Yet because of population momentum at the national level, population growth will continue to rise even in the worst hit countries.

2) Economic Impact

Thus far, the economic impact of HIV has been observed at the family and community level. Not surprisingly, the poorest are most severely affected. A household with a member infected with AIDS will bear expenditure increases due to medical care, special diet, etc. and loss of income due to lower agricultural production, absenteeism caused by illness, or death of friends and relatives. In industry and commerce, as well as other sectors the epidemic is expected to have a further impact due to workforce inefficiency, loss of trained staff and the costs of searching for and training of replacements. All these causes, plus diversion of government expenditures to fight the epidemic are predicted to add up to have macro-economic effects. Attempts to model economic impact estimate economic growth to be 25 percent lower than it would have been otherwise.

3) Social Disruption

Not only do persons with HIV suffer as they get sick with AIDS and prematurely die, their family members, friends and colleagues bear immense burdens of care and social stigma that exacerbate the direct impact of HIV. Hard won gains in girls' education are threatened when families withdraw their daughters from school in order to work or care for the sick. The pernicious effects of AIDS stigma jeopardize social relationships, employment and even access to health care - not only for people living with HIV/AIDS (PLWHA) but also for people thought or assumed to have the infection.

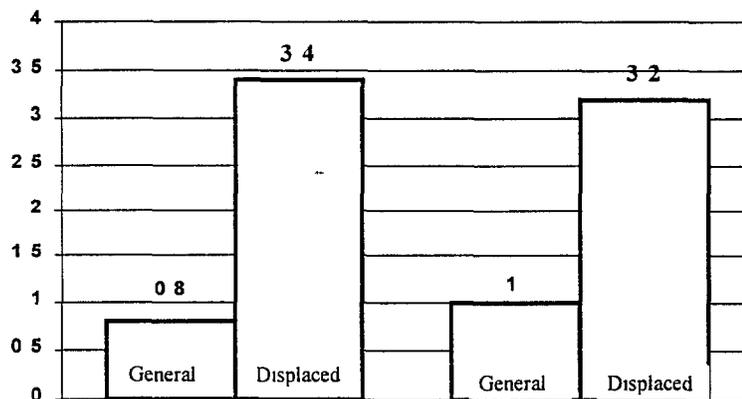
HIV/AIDS also stresses already vulnerable systems in health care, and community life. Some communities in high prevalence areas have already exceeded their abilities to absorb destabilized families, orphans and dependents. However, we have not yet seen the peak number of orphans who will require additional support. In Sub-Saharan countries, orphanhood is expected to rise to 13.5 percent of children under age 15 by the year 2010. The sharp increase in orphanhood will reduce enrollment in schools and increase child labor.

4) Political Destabilization

Just as civil conflict increases the opportunities for HIV to enter new environments, AIDS itself also threatens political stability revealing the fault lines of communities and nations. The military is one of the most affected sectors in East and Southern Africa. In the aftermath of conflict, HIV can be spread as decommissioned personnel return home. Tanzania's 1992 invasion into Uganda and the 1994 genocide in Rwanda, for example, are partially blamed for the surge in AIDS in those regions. Similarly, the difference in the HIV prevalence among the general and displaced population has been noted. For example, in Mozambique there is a threefold difference in HIV prevalence between the general and displaced populations (Figure 3, below).

Figure 3 Conflict, War, and HIV/AIDS

HIV Seroprevalence Rates among General and Displaced Populations in Mozambique 1987/1992



Consequences of political and civil unrest and subsequent population displacement have led to an increased spread of HIV transmission International Conference on AIDS 1996

Source: U.S. Bureau of the Census, International Programs Center, 1998

Overview of USAID's Efforts in Africa

Since the international epidemic was recognized, USAID has been a global leader in bilateral and multilateral support for HIV/AIDS prevention. USAID was one of the key advocates for developing a UN system-wide response to the epidemic, and since 1996 has also been the lead sponsor of UNAIDS. USAID, other donors, UNAIDS, and national governments work together at the country level, so while it is difficult to fully isolate the contribution of a single donor's efforts in Africa, several nationwide and targeted programs have had a significant impact in achieving results.

USAID has focused on preventing the heterosexual transmission of HIV in over twenty countries. Significant progress has been made via programs that

- increase knowledge about HIV among the population,
- change risky sexual behavior, through education, motivation and innovation, promote condom use,
- increase the availability of condoms and access to quality STI and other reproductive health services,
- conduct research to improve the cost-effectiveness of programs.

Recently USAID has responded to the escalating call to help countries develop effective and affordable approaches to HIV care and support.

Mission programs have had very different experience with the epidemic, coordination among Ministries of Health, NGOs, other donors, and the scale and scope of their programs. Missions have responded with single interventions such as adding condom social marketing to an existing child survival or reproductive health portfolio, to comprehensive programs including behavior change communication, condom social marketing, the control of sexually transmitted infections (STI), policy dialogue and research. Mission programs are at different levels of achieving their objective of HIV/AIDS prevention and mitigation. A variety of indicators to measure the performance of HIV/AIDS related programs are used and only a few missions are able to determine seroprevalence rates. Figure 4 summarizes the indicators used by USAID programs in Africa to measure the results (with the number of missions using the indicator).

While a small number of quantitative indicators can never capture the success and synergies that are being

Figure 4 Program Indicators
(Number of Missions Using)

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- **HIV Seroprevalence (4)**
Few countries are able to determine seroprevalence trends
Seroprevalence changes in Uganda are being further analyzed for programmatic implications
 - **Behavioral Indicators**
Condom use (6)
 - **Indicators of Knowledge and Attitudes**
Knowledge of two means to prevent HIV transmission (4)
Knowledge of condoms as means of prevention (2)
 - **Service Supply Indicators**
Condom supply social marketing (11)
Access to HIV testing and counseling (4)
Quality of HIV/STD services (1)
Number of new HIV positive individuals counseled (1)

observed every day, especially in the comprehensive multi-faceted programs implemented in countries such as Zambia and Uganda, these measures assist in monitoring programs and optimizing the potential for success

Key Issues

Mitigation is Essential to HIV Prevention

- Since the outset of the epidemic, USAID and other donors have focused their resources on HIV prevention, as the most cost-effective strategy to control the epidemic. But as the numbers of people living with HIV/AIDS (PLWHA) have increased (to an estimated 20.8 million Africans by the end of 1997), this position is no longer wise
- Mitigation efforts are desperately needed, including care and support for individuals and communities, and structural interventions to reduce the economic, political and other societal-level barriers that create HIV risk and impede prevention programs
- As a customer focused Agency, USAID must respond to the expressed needs of communities and governments that are struggling with overburdened health systems and escalating demands for HIV-related medical care
- In addition, PLWHA are the most important clients for prevention interventions and the most effective agents of behavior change communications. HIV/AIDS programs are strengthened by the participation of PLWHA, and lose credibility when the needs of this important audience for care and support are ignored

HIV/AIDS still is being compartmentalized

- Despite rhetoric of "multi-sectorality" in state of the art policies and many African national HIV/AIDS strategies, the reality is that HIV is still too often approached at the government level as the responsibility of Ministries of Health alone. A recent World Bank situation analysis in Malawi, where nearly a third of adults in urban areas are believed to be HIV seropositive, likened the threat of AIDS to a military threat - and called for a full-scale mobilization, as though the country was facing a war. Any other threat that threatened to take out a tenth to a third of the adult population would surely evoke the kind of concerted, cross-sectoral mobilization we have seen in response to major military and natural disasters. Yet the equally lethal threat of HIV/AIDS languishes in the under-funded and under-staffed ministries of health, where it is often ignored by public and private sector leaders alike

Stigma and Silence lead to Inaction

- HIV/AIDS makes people uncomfortable - both because of its health consequences, and also because early in the epidemic, it became associated with behaviors and populations that violate social norms

- Silence about HIV/AIDS and the stigma and discrimination societies have heaped upon it, is not neutral, it actually makes the stigma worse. Things that people don't talk about are perceived as "bad."
- These associations and feelings have caused and been used to rationalize serious discrimination and harm to people who do or are suspected of having HIV at their jobs, in their homes, in their relationships and communities. The stigma of HIV/AIDS thus greatly increases the practical as well as the emotional burdens on PLWHA and their families.
- Fear of those consequences, and fear of being identified or associated with HIV/AIDS, leads people to fear learning their own serostatus, and to conceal their fear and their serostatus from others. This has complex and devastating effects on prevention programs. Fear of being thought to have HIV/AIDS, or to be practicing risky behavior, is a common reason men give for not using condoms. Fear of being associated with HIV/AIDS makes leaders ignore it in their policy documents and speeches.

Lack of Leadership and Political Will

- Mobilizing support of political and other key leaders has been a continuing challenge since the outset of the epidemic, due to a complex of factors including HIV/AIDS stigma and the competition for their attention and scarce resources from other serious health and development challenges. This problem is not unique to African countries, nor to the developing world.
- Lack of visible public engagement about HIV/AIDS by respected community and national leaders reinforces HIV/AIDS stigma, and creates the false impression that the problem is not sufficiently grave to warrant policy-makers' attention. In such an environment it is impossible to mobilize the kinds of broad social and economic support required to provide services for prevention and care.
- On the other hand, involvement by key policy-makers and public opinion leaders creates a supportive environment for HIV/AIDS programs, makes it easier to provide accurate HIV and STI information and services, stimulates creative thinking across sectors about how their activities could become "part of the solution," and conveys the message to ordinary people that responsible citizens are or should be involved with HIV/AIDS prevention, care and support.

Current Monitoring and Evaluation (M&E) Methods are Insufficient for Decision-making

- Although results-based programming has improved rational strategy and program design, the R4 process has reaffirmed the awareness that
 - available monitoring and evaluation methods are incomplete
 - some desired data are expensive to collect, and are not appropriate for annual reporting (e.g. some outcomes change more slowly than others)
 - quality control on data collection, reporting, and analysis and dissemination has been relatively neglected

- In order to know "what works" under what circumstances, HIV/AIDS and STI programs have two jobs to do – establishing the effectiveness of particular interventions (e.g. do some forms of voluntary counseling and testing reduce subsequent high risk sexual behavior?), improving the delivery of established interventions (e.g. what is the best way to treat and prevent asymptomatic STIs in women?) Thus the M&E agenda is broader than in some more established development fields
- To improve the fit between data gathering strategies and the needs of decision-makers, players at all levels require increased awareness and training in the interpretation of M&E

Recommendations

To approach the above mentioned issues the recommendations of USAID are as follows

Take a leadership role in addressing AIDS-related stigma

- Create a forum for discussion of HIV/AIDS stigma by and for Africans. Assist African partners to develop anti-stigma strategies which build upon lessons learned from the previous public health campaigns that have reduced stigma (e.g. mental illness, adoption, TB)

Help re-mobilize leadership and political will in HIV/AIDS

- Step up efforts within all development sectors to engage a wider array of African leaders in solutions to their countries' HIV/AIDS problems
- Strengthen linkages with the US domestic HIV/AIDS community to develop better models of political leadership and policy makers
- Engage other "critical agents of change" (community, business and foreign policy partners) in this effort

Increase the strategic focus on adolescents

- Increase programming on HIV/AIDS and reproductive health designed for and with adolescents
- Leverage adults' concerns about their youth to motivate behavior change and support

Develop and use more effective evaluation methods and strategies

- Continue collaboration of USAID Africa and Global Bureaus with UNAIDS, US Bureau of the Census, CDC and other key partners to define and disseminate second generation sentinel surveillance methods
- Finalize field test and refine common indicators for HIV/STI programs including measures for care and support and other new intervention strategies
- Promote standardization for improved comparability across programs and across sources