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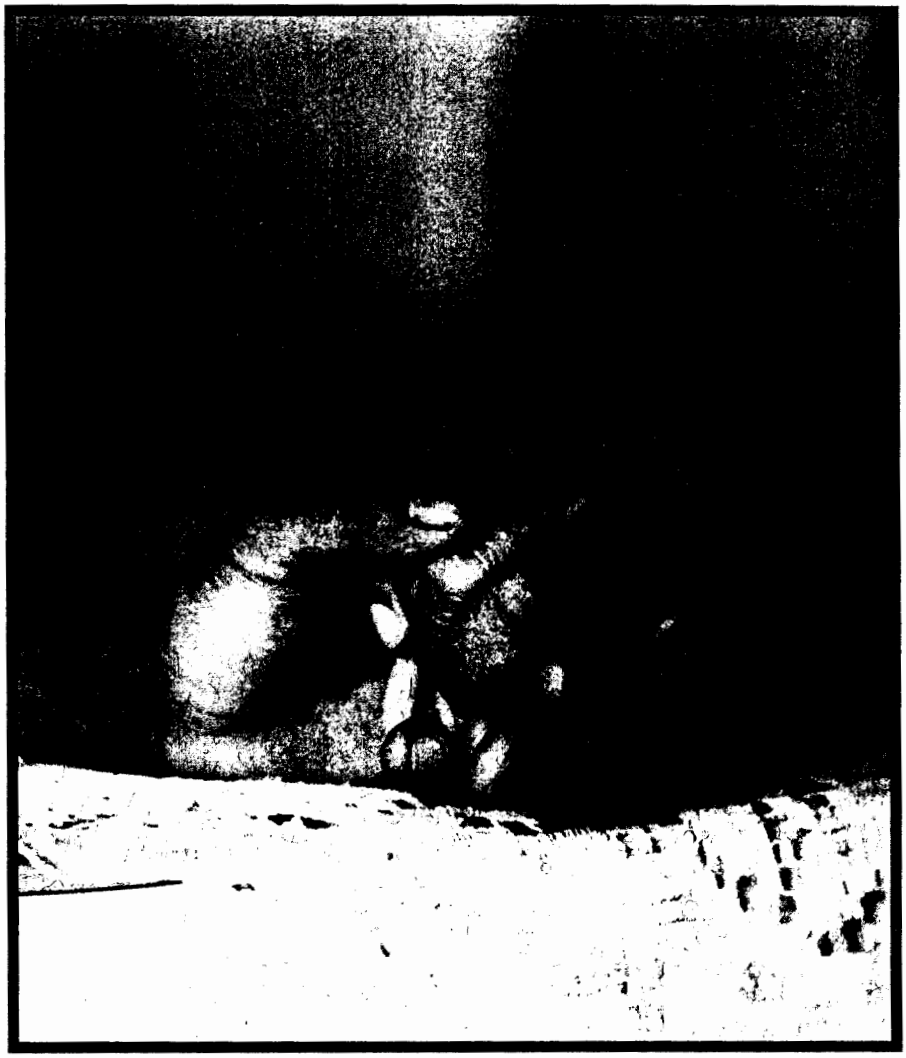

USAID RESPONDS TO HIV/AIDS

A REPORT ON THE FISCAL YEAR 1994 HIV/AIDS PREVENTION PROGRAMS OF

THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID

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Cover photo: An AIDS counselor clasps the hand of a person living with HIV.

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HIV/AIDS AND SUSTAINABLE DEVELOPMENT

A deadly virus that has struck an estimated 19.5 million people since the late 1970s, HIV is recognized as one of the most urgent health problems of our time. As countries in every region of the world begin to experience the devastating social and economic effects of HIV/AIDS, the epidemic has also emerged as a serious threat to sustainable development. HIV/AIDS is already reversing hard-won gains in child survival, health, education and economic development.

After two decades of progress in improving children's health, infant and child mortality rates are rising in many countries as a result of HIV/AIDS. By the year 2000, infant mortality is projected to increase by 35 percent in the Honduran city of San Pedro Sula. Child mortality in Thailand will more than triple and in Kenya and Zimbabwe will more than double during the next 15 years unless there is a sharp decline in the rate of HIV infection. (See graph on page 5.)

Life expectancy at birth, an important measure of health and development, is declining for the first time in decades in many countries with advanced HIV/AIDS epidemics. In Uganda it has already dropped to 37 years—the lowest in the world—because of HIV/AIDS. By the year 2010, life expectancy will decline by more than 25 years in a number of Asian and African countries. In Zimbabwe, for example, AIDS could reduce life expectancy from 70 to 40 years during the next 15 years. (See graph on page 5.)

HIV/AIDS has a greater social and economic impact than other communicable diseases because it strikes adults during the years when they are most economically productive—between the ages of 15 and 45. The loss to illness and death of so many working-age adults and the resulting burden on those who are left behind to care for orphans and the elderly has a profound effect on families, communities, businesses and nations.

At this stage of the epidemic, families are bearing the brunt of the social and economic consequences of HIV/AIDS. AIDS illnesses and deaths also place new burdens on communities as the extended family system tries to cope with increasing numbers of dependents and decreasing numbers of providers. The commercial sector is losing skilled workers to AIDS, while national economies struggle to meet the cost of AIDS care and other health and social service demands created by the epidemic.

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FAMILIES AND HIV/AIDS

For families, AIDS means increased expenditures and reduced investment. Family income is threatened and savings are lost as money is diverted to pay for increasing medical costs, special foods and other expenses. In severely affected countries in Asia and East Africa, 30 to 50 percent of household income is devoted to care and support for family members with AIDS-related illnesses. When family members die, funeral expenses can cost the equivalent of a year's income.

Increasing medical and funeral costs are only part of the financial burden of AIDS on a family. Studies in Kenya and Malawi report that two-thirds of an individual's lifetime production is lost due to early death from AIDS. Other members of the family may have to give up their jobs to care for those who have AIDS or replace them in the fields. Rural families may shift production to less labor-intensive crops, which can result in poorer nutrition or an additional loss of income from cash crops. Children are often removed from school because their labor is needed at home or because their families can no longer afford school fees.

BUSINESSES AND HIV/AIDS

In the commercial sector, health care and death benefit costs, absenteeism and the cost of training new workers to replace those who have died of AIDS are expected to cause the greatest financial losses. A study in Kenya estimated that HIV/AIDS could increase labor costs for some businesses by 23 percent by the year 2005.

Some businesses are beginning to report steep increases in absenteeism and turnover among their workers as a result of HIV/AIDS. The Uganda Railway Corporation has an annual turnover rate of 15 percent; about 10 percent of its 5,600 employees have died from AIDS in recent years. A study in Thailand estimates that through the year 2000, it will cost $8 million to replace long-distance drivers lost to HIV/AIDS. In Guatemala the average person with HIV/AIDS will lose 18 productive years of life, totalling $28,000 in economic value. (See graph on page 6.)

NATIONS AND HIV/AIDS

AIDS-related illness and increasing poverty caused by HIV/AIDS also put economic pressure on governments. In many countries the demand for health care and social welfare support is increasing as a result of HIV/AIDS at the same time that public resources are shrinking.

Although most hospitals in the developing world can offer only minimal levels of care to people with HIV/AIDS, the cost of maintaining AIDS patients in hospitals remains high. In some sub-Saharan African countries, HIV/AIDS treatment consumes from one-quarter to more than half of the government's total spending on health. These costs could rise to 80 percent in parts of Africa and Asia by the year 2010.

In Kenya, for example, the government would have to spend up to $170 million annually by the year 2000 to maintain the current level of hospital care for AIDS patients. During the early 1990s the Kenyan government spent about $120 million per year on all health care.

Health care costs are the most easily quantifiable economic burden imposed by the epidemic. Less is known about the indirect costs of AIDS—which can include decreases in productivity and tax revenues, tourism losses and reduced investment—and their impact on national economies.

A ten-year-old girl, orphaned more than likely by AIDS, holds her doll and stuffed bear at Masulita Children's Home in Masulita, Uganda. The home was funded partly by USAID.
KAREN KASMAUSKI

Few studies have examined the overall impact of the epidemic in developing countries. World Bank economists project that over the next 15 years, the size of the Tanzanian economy could be 14 to 24 percent smaller than it would have been in the absence of AIDS. Another study shows that AIDS could reduce Kenya's gross domestic product by 14 percent within 10 years, with per capita income declining by 9 percent.

The HIV/AIDS epidemic also represents a potential security threat in many countries because of high rates of HIV among military personnel. In Zimbabwe, for example, half of the country's 50,000 soldiers are thought to have HIV or AIDS.

THE GLOBAL EPIDEMIC

The dire predictions of the 1980s are becoming the reality of the 1990s as HIV moves from its latent stage to active disease in an increasing number of people around the world. But the statistics in today's headlines are only a portent of the suffering and death still ahead. The majority of people who have been infected with HIV—an estimated 10 million men, 7 million women and 1.5 million children—have yet to develop AIDS.

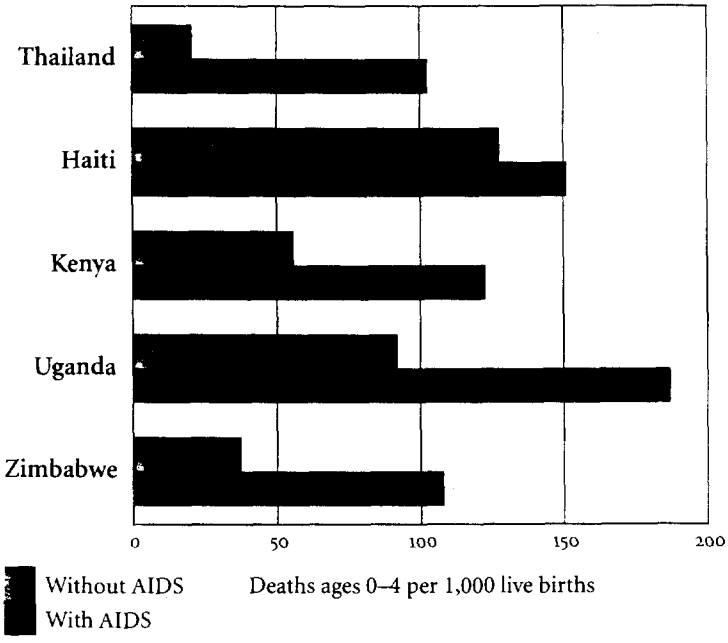
Halfway into the second decade of the epidemic, 4.5 million people have developed AIDS and more than 3 million of them have died. During the next five years, up to 20 million more will become infected with HIV and about 8 million people will die of an AIDS-related illness.

The spread of HIV is exacerbated in many countries by the high prevalence of other sexually transmitted diseases (STDs). The presence of an STD dramatically increases the efficiency of HIV transmission. In addition, the same behaviors that put people at risk of acquiring other STDs can also lead to HIV infection. Every year at least 250 million cases of curable STDs are contracted through unprotected sexual intercourse.

Ranchod Patel, his wife and six children have four acres of land in the tribal area of Chotta Nagpur, India. As many as 10 million people in India could be infected with HIV by the year 2000, which could make it the country with the largest number of HIV infections.

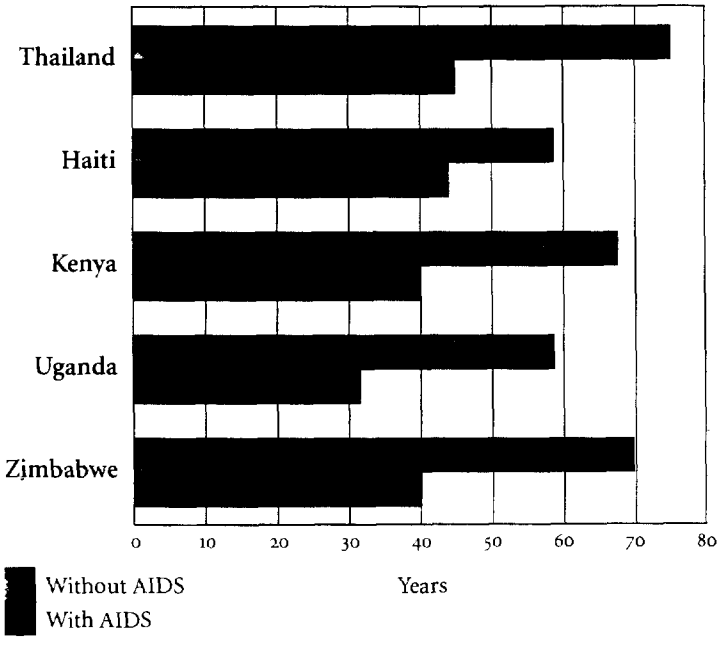
RAGHU RAI / MAGNUM

CHILD MORTALITY RATE WITH AND WITHOUT AIDS, FOR SELECTED COUNTRIES BY THE YEAR 2010



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

LIFE EXPECTANCY AT BIRTH WITH AND WITHOUT AIDS, FOR SELECTED COUNTRIES BY THE YEAR 2010



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

The vast majority of HIV infections and AIDS cases occur in the developing regions of Africa, Asia, and Latin America and the Caribbean. An epidemic of global proportions, HIV/AIDS is in reality a collection of distinct regional epidemics, each with different distribution dynamics, affected populations, modes of transmission and virus strains.

SUB-SAHARAN AFRICA

With less than 10 percent of the world's population, sub-Saharan Africa has 70 percent of the world's people with HIV and more than two-thirds of its AIDS cases. Since the emergence of the epidemic in the region more than 15 years ago, an estimated 10 million adults and 1 million children have been infected with the virus and as many as 3 million people have died as a result of AIDS-related illness.

Throughout sub-Saharan Africa, the majority of HIV infections are acquired through heterosexual intercourse, and more women than men have become infected. More than 5 million African women of childbearing age are believed to be infected with HIV.

ASIA

While the majority of African countries have begun to recognize HIV/AIDS and its devastating impact, the virus is spreading unnoticed throughout most of Asia—the most populous region of the world. The World Health Organization (WHO) estimates that by the late 1990s, the annual number of new infections in the region will surpass that of Africa, reaching a cumulative total of 55 million HIV cases by the year 2020.

The total number of Asians infected with HIV rose from 500,000 to 3.5 million from 1991 to 1994. The majority of HIV-positive people in Asia are still in the long latency period between infection and the first signs of disease. From July 1993 to July 1994, however, the number of AIDS cases in the region increased eight-fold, from 30,000 to about 250,000. WHO projects that 1.4 million people in Asia may develop AIDS by the end of the century, with millions more to follow as the epidemic matures.

HIV was first identified in Asia among injection drug users and men who have sex with men.

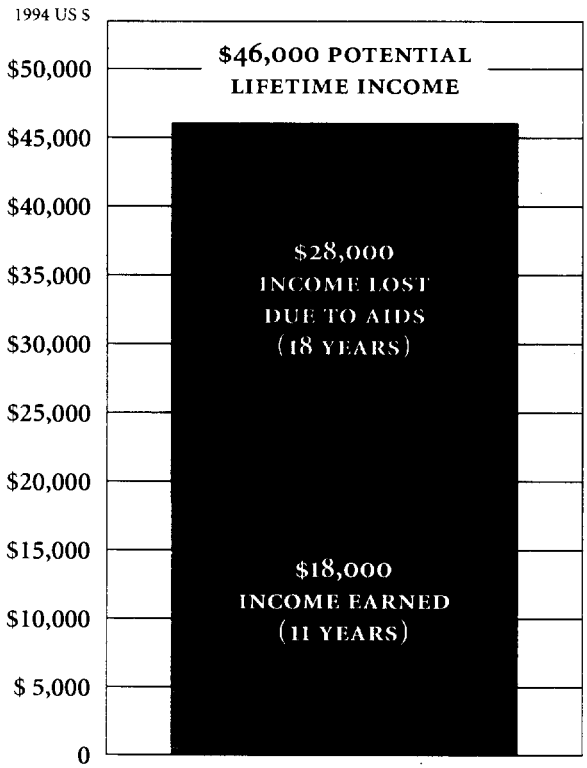
Injection drug use and blood transfusions still play an important role in the spread of HIV in the region, but heterosexual transmission is the leading cause of infection.

LATIN AMERICA AND THE CARIBBEAN

Latin America and the Caribbean have fewer HIV infections than Asia or Africa. But with 8.4 percent of the world's population, these regions are home to 11.5 percent of all people with HIV. Homosexual and bisexual transmission continue to be important in the region, but heterosexual contact is becoming the primary mode of transmission. Needle sharing is also a common channel for HIV transmission in many cities.

Between 1988 and 1992, HIV infection rates in Latin America and the Caribbean almost tripled. By late 1994, the region had more than 2 million HIV infections and about 405,000 AIDS cases.

PROJECTED INCOME LOST FOR INDIVIDUALS WITH AIDS: GUATEMALA



Source: AIDSCAP 1995.

GLOBAL TRENDS

WOMEN AND HIV/AIDS

One of the most striking trends in the epidemic during the past decade has been its rapid rise among women. Worldwide, women are becoming infected at faster rates than men. Young women are particularly vulnerable: the United Nations Development Programme estimates that 70 percent of the women with HIV are between the ages of 15 and 24.

Biologically, women are more susceptible to HIV infection because sexual transmission of the virus is more efficient from men to women than from women to men. Higher levels of undiagnosed STDs among women also increase their susceptibility to HIV/AIDS.

But social and economic forces play an even greater role in increasing women's risk of acquiring HIV infection. The imbalance of power between men and women in most cultural settings limits women's ability to protect themselves. Many women are forced by their social and economic position to accept risky sexual partnerships.

Women account for about 40 percent of all HIV infections, but by the end of the decade, there will be as many women infected as men. The number of HIV infections among women is expected to double from 7 million in 1994 to 14 million by the year 2000.

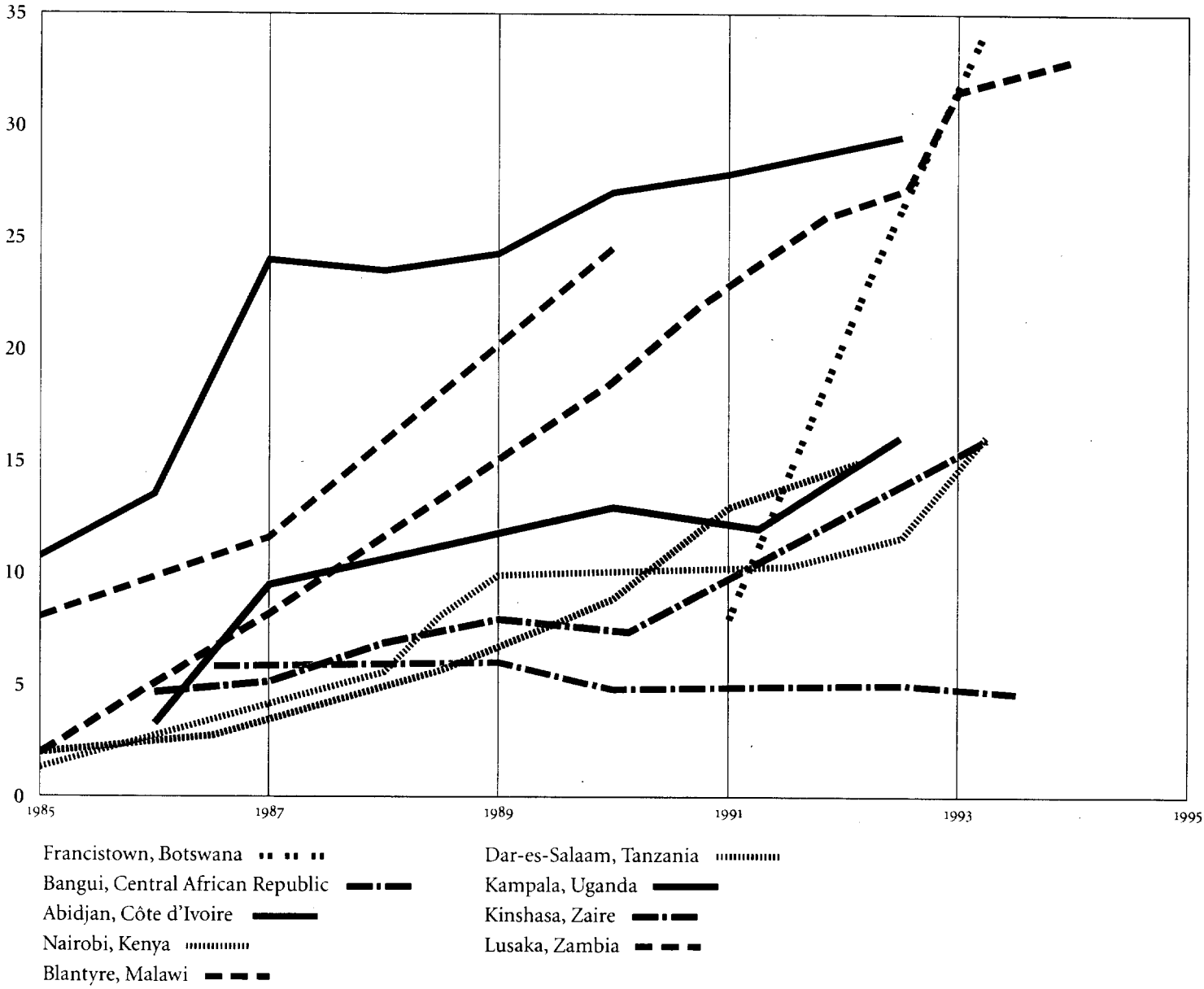
CHILDREN AND HIV/AIDS

Rising HIV rates in women are accompanied by a corresponding increase in the number of children infected at birth. On average, one-third of infants born to HIV-positive mothers are infected. By age two, half of the children infected with HIV will have died. By age five, 80 percent will have died.

The majority of children born to HIV-positive mothers ultimately become orphans. WHO estimates that 5 to 10 million children will be orphaned as a result of the AIDS-related death of one or both parents by the end of the 1990s. In central and eastern Africa, at least 2 million children have already lost a parent to AIDS. (See graph on page 8.)

HIV SEROPREVALENCE[1] FOR PREGNANT WOMEN IN SELECTED URBAN AREAS OF AFRICA: 1985–1994

Percent of HIV Seroprevalence Includes Infection From HIV-1 and/or HIV-2.



1. Seroprevalence is the percent of an identified population that is infected with HIV.

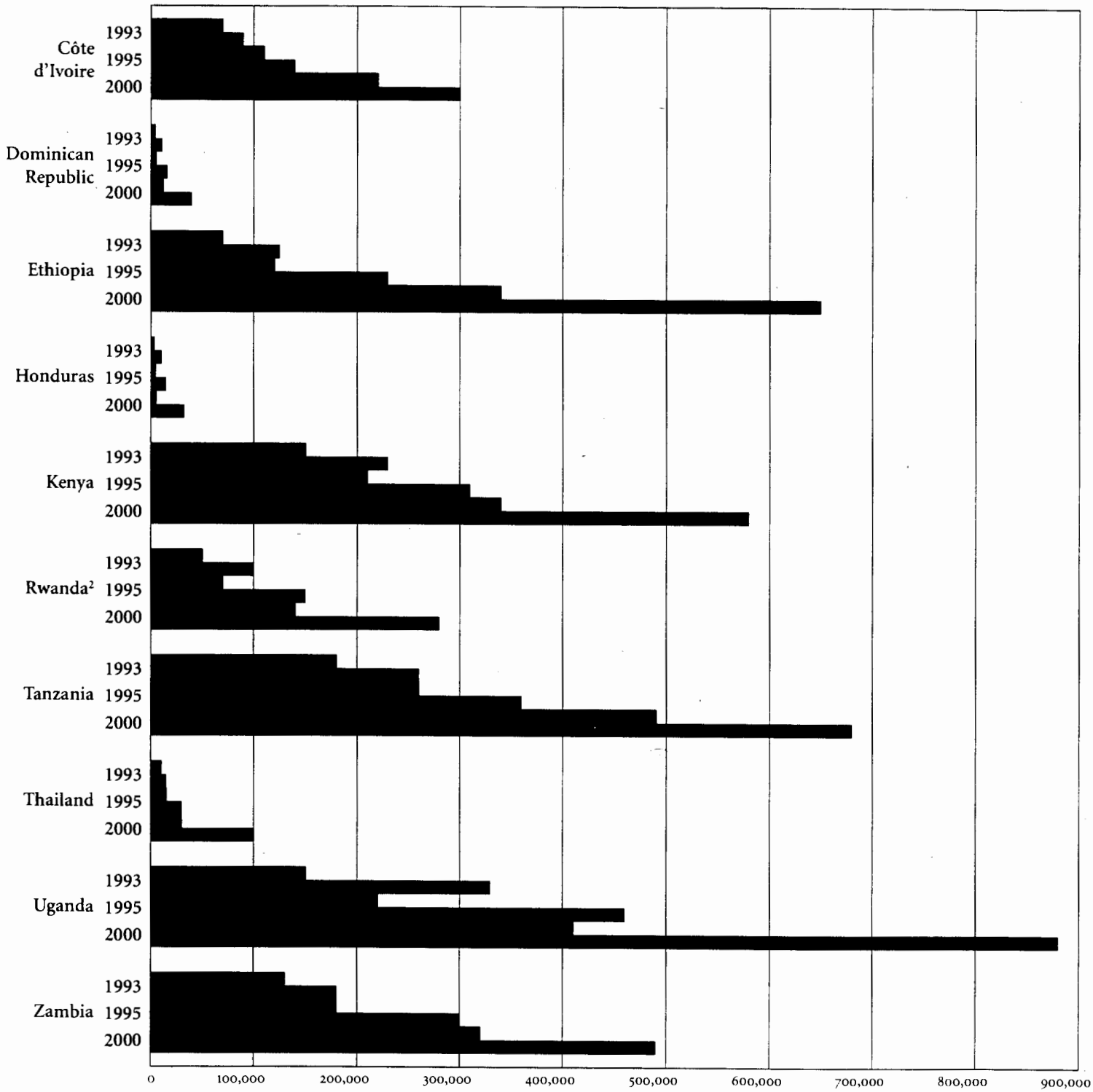
Source: International Programs Center, U.S. Bureau of the Census.

AIDS AND TB DEATHS

Another important trend is the dramatic increase in AIDS cases and deaths during the past two years. The estimated number of AIDS cases rose by 60 percent from July 1993 to July 1994. Even larger increases in AIDS caseloads and deaths can be expected in the future because most of the people with HIV have yet to develop AIDS.

HIV/AIDS is also contributing to a parallel epidemic of tuberculosis that threatens to kill 30 million people by the end of the decade. Up to 50 percent of adults in many developing countries carry latent TB virus from childhood infections. HIV breaks down the immune system, allowing the dormant TB virus to become active.

PROJECTIONS OF MOTHERLESS AIDS ORPHANS LESS THAN 15 YEARS OLD IN SELECTED COUNTRIES



Low Estimate
High Estimate

1. This table contains range estimates of the cumulative number of children whose mothers have died of HIV/AIDS before the child reaches the age of 15, and the estimated proportion of those children who remain age 14 or less in the population 0–14 years in the years 1995 and 2000.

2. The estimates for Rwanda do not take into account the population effects of the civil strife that occurred in 1994.

Source: Dr. David Michaels, The City University of New York Medical School and The Orphan Project.

In Kyakasolo, Uganda, a grandfather, whose three sons have died from AIDS, struggles to care for his eight grandchildren.
JOEL STETTENHEIM / SABA

In some African and Asian countries, TB rates have doubled during the last three years. WHO estimates that the number of TB cases will rise to 10.2 million worldwide by the year 2000—a 36 percent increase over the 7.5 million cases in 1990. Half of the increase in TB infections will be due to HIV/AIDS.

The difficulty of controlling this burgeoning tuberculosis epidemic is compounded by the emergence of TB bacilli that are resistant to the common anti-tuberculosis drugs as a result of the fact that many TB patients do not complete a full course of treatment. Because drug-resistant tuberculosis is even more difficult to treat, the number of annual TB deaths is expected to increase from 3 million to 4 million by 2005.

A NEW EPICENTER: ASIA

Another marked trend during the 1990s has been the increase in HIV/AIDS outside of Africa—particularly in Asia, which will soon have more new HIV infections than any other region of the world. The role of mobile populations in the rapid spread of the virus in Asia has focused attention on the importance of cross-border transmission in many parts of the world and on the need for regional approaches to HIV/AIDS prevention.

THE USAID RESPONSE

Since 1986, the U.S. Agency for International Development (USAID) has been the global leader in the response to the HIV/AIDS epidemic. Through its support for multilateral efforts and its regional and bilateral programs in more than 40 countries, the Agency has focused on reducing further spread of HIV and mitigating the epidemic's impact on sustainable development.

USAID has committed more than $700 million to HIV/AIDS programs during the past eight years. This commitment has enabled the Agency to establish effective partnerships with international organizations, donors, national governments and nongovernmental organizations (NGOs), develop innovative approaches to HIV/AIDS prevention, and build community capacity to slow the spread of the epidemic. Partnership and prevention are the guiding principles of USAID's response to the challenge of HIV/AIDS.

GLOBAL PARTNERS IN PREVENTION

Through USAID, the U.S. government has been the largest contributor to the World Health Organization's Global Programme on AIDS (WHO/GPA), providing over $175 million since 1986. In fiscal year 1994, USAID funding for WHO/GPA totalled $28.5 million. The Agency also provided $1 million to the United Nations Development Programme and $500,000 to the the United Nations Children's Fund to support their HIV/AIDS prevention efforts.

But financial support is only part of USAID's contribution to the Global Programme on AIDS and other U.N. efforts. The Agency works closely with WHO/GPA and other international partners to coordinate donor efforts against HIV/AIDS and provide technical guidance for prevention programs. Most recently, USAID and WHO/GPA collaborated to develop better ways of measuring progress in HIV/AIDS prevention and to field test simpler, less expensive methods for diagnosing and treating STDs.

As a member of the WHO/GPA Task Force on HIV/AIDS Coordination (representing Australia, Canada, Japan and the United States) and the WHO/GPA Management Committee, USAID has helped lead efforts to consolidate United Nations HIV/AIDS programs. Scheduled to begin in 1996, the new Joint United Nations Programme on HIV/AIDS (UNAIDS) will coordinate the HIV/AIDS efforts of five U.N. agencies and the World Bank.

USAID also coordinates U.S. HIV/AIDS prevention assistance in developing countries with the activities of other nations. For example, through the Common Agenda for Cooperation in Global Perspective, an ambitious program established by the President of the United States and the Prime Minister of Japan in July 1993, the two countries will tackle a number of pressing global issues, including population and HIV/AIDS. In fiscal year 1994, Egypt, Ghana, India, Indonesia, Kenya and the Philippines were identified as priority countries for cooperative efforts, and coordination of assistance to NGOs began in some of these countries.

Although the U.S.-Japan Common Agenda is the Agency's first official "trilateral" effort in HIV/AIDS, most USAID prevention programs involve coordination with national and international donors. Bilateral programs between the United States and host-country governments are designed to complement the efforts of other organizations working in those countries.

In addition, innovations advanced by USAID's bilateral and regional programs, including peer education, condom social marketing and cross-border interventions, have become models for HIV/AIDS prevention activities throughout the world. By providing technical leadership and collaborating with other

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governments and donors, USAID multiplies the reach and impact of U.S. investments in HIV/AIDS prevention.

USAID HIV/AIDS POLICY

Given the threat the epidemic poses to sustainable development, USAID has made reducing transmission of HIV and other sexually transmitted diseases one of its strategic objectives. To achieve this objective, the Agency:

- Implements HIV/AIDS prevention programs using proven strategies to prevent transmission.
- Encourages policy reform to address social, cultural, regulatory and economic barriers to controlling HIV/AIDS and other STDs.
- Develops and tests new strategies and methods for preventing transmission and mitigating the impact of the HIV/AIDS epidemic.

USAID's strategy is outlined in its policy guidance on HIV/AIDS, which affirms the Agency's continued commitment to helping developing countries address the challenges posed by the epidemic. This guidance is designed to be flexible, enabling USAID to respond quickly to new trends in the epidemic and to incorporate advances in HIV/AIDS prevention measures as they are developed.

First drafted in 1987, the policy guidance was refined recently to reflect the lessons learned from eight years of experience with the HIV/AIDS epidemic in more than 40 countries. It continues USAID's emphasis on reducing sexual transmission of HIV, which is responsible for more than 80 percent of HIV infections worldwide, and targets populations at particular risk of acquiring or transmitting the virus, including women, young adults, migrant and displaced people, and people with STDs.

Given the lack of an effective HIV/AIDS vaccine or treatment, USAID's strategy focuses on prevention. In recent years, however, the Agency has supported efforts to identify models of care and support for people living with HIV/AIDS and their families, as well as research and training to improve TB diagnosis and treatment.

A young man at Wat Phrabatnamphu, an AIDS hospice and former monastery in Lopburi, Thailand, sits on his bed with a stuffed monkey that he received as a birthday present from the founder of the hospice, a Buddhist monk.

ED PETERS/IMPACT VISUALS

USAID'S CROSS-BORDER STRATEGY: REACHING MOBILE POPULATIONS IN ASIA

Haad Lek, a subdistrict along Thailand's border with Cambodia, is a crossroads for tourists and traders from both countries. Thais and Cambodians live in settlements on both sides of the open border, moving between the two countries by road and by sea.

With relative peace along the border as a result of efforts to end Cambodia's long civil war, trading has increased. The Cambodian timber industry regularly brings logging crews through the area. Merchant vessels dock at ports along the Gulf of Thailand, and an active fishing industry attracts thousands of boats that ply the waters of the gulf, stopping in Thailand, Cambodia, Vietnam, Malaysia and Singapore.

The ports are also recreational centers whose hotels, nightclubs and commercial sex establishments draw local and international tourists as well as fishermen and laborers. Guides are available at the border to bring men into Cambodia to low-cost sex establishments supplied by a complex, efficient network that allows for continual recruitment of young girls from Cambodia and Vietnam.

Throughout Asia, this potentially deadly combination of a highly mobile population and a thriving commercial sex industry fuels the rapid spread of HIV/AIDS. In Thailand the epidemic has already spread to the general population through sexual networks that involve men who frequent commercial sex establishments but also have sexual relations with wives and other partners.

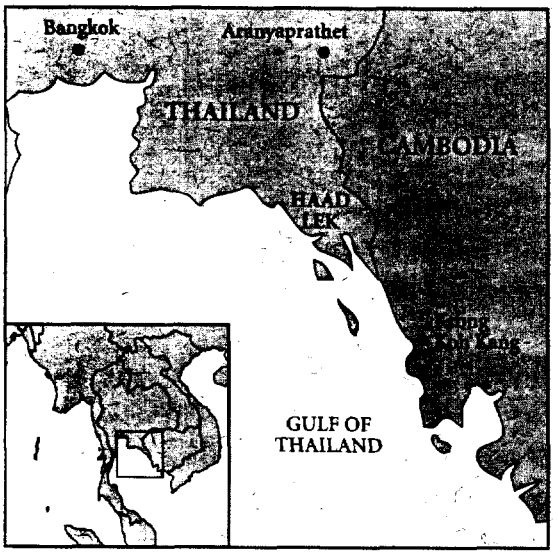
To address the threat posed by cross-border HIV transmission in Asia, USAID has developed a unique strategy aimed at slowing the spread of the epidemic among transport workers, business travelers, commercial sex workers, migrant laborers and other groups who may be at higher risk of acquiring the virus than more stable populations. Recognizing that HIV/AIDS does not respect national borders, the Agency is supplementing more conventional bilateral programs with targeted prevention efforts in cross-border areas.

USAID and its AIDS Control and Prevention (AIDSCAP) Project implement this strategy in border regions and other "areas of affinity" in Asia that share common cultural, political, economic, demographic or epidemiologic characteristics. To date, the Agency has identified five areas of affinity throughout the region for potential interventions.

During fiscal year 1994, AIDSCAP carried out rapid ethnographic assessments in four areas of affinity: the Thai-Laos border, the South Pacific Islands, the Thai-Cambodia border, and the trucking routes that connect Nepal and Bangladesh with the northern Indian states. Designed to acquire a broad understanding of cross-border sexual activity and the economic and social factors that drive it, these assessments use systematic qualitative methods to identify patterns of movement and sexual activity, target audiences and potential interventions.

The first assessment found a potentially explosive situation along the porous 1,400-kilometer Lao-Thai border. Ten of Laos' 18 provinces share a border with Thailand, and traders, businessmen, tourists, truckers, migrant workers and transient tribal minorities travel easily between the two countries. Although commercial sex is illegal in Laos, an increase in clandestine commercial sex has accompanied a recent boom in foreign trade and tourism. Commercial sex is also available in towns just across the border in Thailand, and casual sexual relationships with multiple partners are tolerated among many ethnic groups in Laos. USAID is working with the Lao National AIDS Control Program to plan comprehensive prevention efforts in market towns along the border.

An assessment of the transport and commercial sex industries in Papua New Guinea



(PNG), the commercial center of the South Pacific Island region, confirmed expectations that sailors and truckers were frequent customers of commercial sex workers and infrequent users of condoms. The USAID Mission in PNG closed in September 1994, but the assessment team's recommendations for reaching these target groups were used by the PNG Institute of Medical Research to design an STD/AIDS prevention project proposal that has been submitted to the Australian development agency.

A third assessment was conducted in Haad Lek and another district in eastern Thailand, Aranyaprathet of Sra Keo Province, which shares a 170-kilometer border with Cambodia. Preliminary results from the Haad Lek phase of the assessment suggest that the risk of HIV transmission is high and that the virus is beginning to spread among the general population. Another study began at the end of the fiscal year along the truck routes that link Nepal and Bangladesh with the Indian city of Calcutta, where HIV seroprevalence among truckers at a voluntary testing and counseling center had reached 7 percent by mid-1994.

Results of these assessments will be used to design multicultural, multilingual interventions at special sites, including border crossings, hotels and commercial sex establishments. Along the Thai-Cambodia border, for example, possible interventions include a trilingual Thai-Cambodian-Vietnamese radio program and training of commercial sex establishment proprietors to encourage consistent condom use among clients.

Such cross-border interventions hold great promise for slowing the rapid growth of HIV/AIDS in Asia. Recognizing its potential, other international organizations are looking to USAID's cross-border strategy as a model for HIV/AIDS prevention efforts in Asia and other regions of the world.

To achieve the greatest possible impact on the spread of HIV/AIDS, USAID concentrates its efforts in the countries it considers most critical for controlling the global epidemic. Interventions are based on the following lessons:

- Sustained behavior change is required to limit sexual transmission of HIV and other STDs.
- Correct, consistent condom use prevents the spread of STDs and HIV.
- Improving STD diagnosis, treatment and prevention is an efficient, effective way to reduce the spread of HIV/AIDS.
- New or improved prevention technologies, such as microbicides and female condoms, are needed to provide greater options for women to reduce their risk of HIV infection.
- The participation of communities, including people living with HIV and AIDS, in designing, implementing and evaluating HIV/AIDS prevention policies and programs is essential to building relevant, sustainable programs and maintaining behavior change.

HIV/AIDS PREVENTION AND CARE INITIATIVES

Currently the only way to prevent sexual transmission of HIV/AIDS is to adopt safer sexual practices, which include delayed initiation of sexual activity, sexual abstinence, mutual monogamy between uninfected partners and consistent, correct use of condoms. But convincing people to change their behavior—and to sustain behavior change over a lifetime—is extremely difficult.

USAID HIV/AIDS prevention projects use proven strategies to reduce sexual risk behavior. Project design begins with a strategic assessment to gain a thorough understanding of the target audience, the factors that influence sexual behavior and the available resources. This information is used to develop comprehensive programs that combine communication to encourage behavior change, access to condoms, and improved STD prevention, diagnosis and treatment. Interventions are developed in collaboration with members of the target audience to ensure that they are relevant and effective, and methods for monitoring progress and measuring impact are built into project design.

BEHAVIORAL RESEARCH

Understanding why people engage in behavior that places them at risk of HIV infection is the first step toward helping them change that behavior. Therefore, behavioral research is a part of the design of all USAID-supported HIV/AIDS prevention projects. In addition, the Agency sponsors program-related research to determine how to improve specific interventions, such as targeted ethnographic research for STD programs (see p. 17), and commissions larger studies to advance the scientific understanding of risk behaviors and how to modify them.

An example of such commissioned research is a study by USAID's AIDS Control and Prevention (AIDSCAP) Project and the Center for AIDS Prevention Studies of the University of California at San Francisco (CAPS), in collaboration with WHO/GPA, on the role of voluntary HIV counseling and testing in prevention. HIV counseling takes many forms and can play a variety of roles beyond the minimum requirement that people understand and consent to an HIV test. Training and employing counselors is expensive, so it is important to develop low-cost models that promote appropriate behavior change. This controlled study is designed to provide information that can help guide public health practice and policy.

Sites and principal investigators were selected and protocols were developed for the counseling and testing study during fiscal year 1994. USAID-funded research will begin in Kenya and Tanzania in 1995. WHO/GPA will support parallel studies in Indonesia and Trinidad.

Other USAID studies are designed to develop model HIV/AIDS interventions. In northern Thailand, for example, Johns Hopkins University and Chiang Mai University are investigating the sexual decision making and practices of young adults and testing controlled interventions to reduce their risk of HIV transmission. In South Africa, the University of Natal and the International Center for Research on Women (ICRW) are using the results of an earlier ICRW-funded study in KwaZulu/Natal to test the efficacy of behavior change interventions among women and men attending an STD clinic in a peri-urban area.

BEHAVIOR CHANGE COMMUNICATION

Behavioral research has taught us that knowledge of the basic facts about AIDS is not sufficient to change behavior. To adopt safer sexual practices, people need to understand and recognize their individual risk and vulnerability. They also

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need to learn the skills required to practice safer sex, such as negotiation and condom use.

Research has also shown that programs targeting individuals alone are unlikely to result in long-term behavior change. Individual behavior is influenced by a variety of social, cultural, political and economic factors that must be addressed if behavior change is to be sustained. People need realistic strategies and the support of their peers and communities to maintain safer sexual practices.

During the past eight years, USAID has served as a catalyst in moving HIV/AIDS prevention programs from providing basic information about transmission to designing communication strategies to influence individual behavior and social norms. The Agency supports carefully targeted interventions that use multiple communication channels, from face-to-face discussions to radio soap operas, to reinforce sexual risk-reduction messages.

These interventions take HIV/AIDS prevention messages to the places where people live, work and play. Provocative theater by the Centro de Orientación e Investigación Integral in the streets and bars of the Dominican Republic draws crowds with debates over condom use, giving actors an opportunity to step out of character to provide information about HIV/AIDS and distribute condoms. In Zambia, Morehouse University's School of Medicine has trained 963 people to carry out HIV/AIDS prevention programs in public and private sector workplaces. And in the Philippines, a mass media campaign implemented by Johns Hopkins University encourages young adults to talk to their partners and friends about safer sexual options.

USAID programs have pioneered the use of peer educators for HIV/AIDS prevention. In schools, neighborhoods and workplaces throughout the developing world, trained volunteers are providing HIV/AIDS information and encouraging their peers to adopt safer sexual practices. Chosen for their leadership ability and the trust they inspire in their peers, these educators are effective communicators.

A couple chats while relaxing along the waterfront in the Dominican Republic.

ALEX WEBB / MAGNUM

In addition, using influential peer leaders to promote safer sex is one of the most effective ways to change social norms that discourage preventive behavior.

Skill building is another important part of behavior change communication. USAID-funded activities give people opportunities to learn and practice negotiation, condom use and STD treatment-seeking skills. To ensure that people can act on behavior change messages, the Agency supports comprehensive HIV/AIDS prevention programs that link communication interventions with support services, such as condom distribution and STD diagnosis and treatment.

CONDOM SOCIAL MARKETING

Many USAID HIV/AIDS behavior change communication interventions are linked to condom social marketing (CSM) projects. In 1994, USAID-supported CSM projects sold more than 470 million condoms in 43 countries.

CSM projects use private sector infrastructure and commercial marketing techniques to make affordable, quality condoms available to people when and where they need them. Condoms are sold in street markets, gas stations, motels, bars and night clubs. In Brazil, they are even sold by a cosmetic company's door-to-door salesforce.

These projects promote correct and consistent use of condoms. Sales agents show their clients how to use the product properly, and product inserts reinforce the message. Innovative advertising campaigns address negative stereotypes about condoms and position them as an acceptable and effective product.

As a result of social marketing projects for HIV/AIDS prevention, condom sales have increased dramatically in many countries. In Ethiopia, for example, annual sales increased five-fold in four years, totaling almost 17.3 million in 1994. Despite difficult conditions and political unrest in Haiti, the USAID-supported social marketing project has boosted condom sales from 580,000 in 1991 to over 7.5 million in 1994. In Côte d'Ivoire, a social marketing project used mass media promotion and an extensive network of retail outlets to sell 6.4 million condoms during its first year.

IMPROVING STD SERVICES

Improving STD control is considered one of the most effective strategies for limiting the spread of HIV/AIDS. Yet throughout the developing world, most people with STDs do not receive appropriate diagnosis and treatment.

Specialized STD clinics in developing countries reach only a small proportion of the affected population. Public sector STD services are often offered in crowded clinics that do not have the necessary drugs, equipment or trained staff. Faced with long waits for laboratory results, ineffective treatment and negative attitudes of clinic staff toward STD patients, many people turn to traditional healers or try to treat themselves with medicine bought from pharmacists or street vendors. Self-treatment in turn encourages resistance to inexpensive antibiotics, which makes access to affordable treatment even more problematic.

STDs can cause life-threatening complications in women, yet women rarely receive appropriate treatment. Most women with STDs have no symptoms. Women who have recognizable symptoms are often deterred from seeking treatment because of the stigma associated with STDs, and many who do seek treatment cannot find clinics with the equipment, supplies or skilled staff needed to diagnose their STDs.

To address these problems, USAID supports policy dialogue with health officials and physicians to address barriers to effective STD care, training of STD care providers, and development of tools to improve STD services in primary health care clinics. Given the limited access to laboratory services in developing countries and the difficulty of diagnosing asymptomatic STDs in women, identification of rapid, simple, inexpensive diagnostic tests is one of USAID's top priorities for STD control.

DEVELOPING DIAGNOSTIC TOOLS

The STD Diagnostics Initiative (SDI), sponsored by USAID and other donors with a secretariat at WHO/GPA and implemented by the Program for Appropriate Technology in Health, aims to identify or develop affordable diagnostic tools appropriate for use in settings with limited resources and to introduce these tools into STD control programs. Priorities include a

simple test for gonorrhea in women and a rapid test for syphilis in both men and women.

During fiscal year 1994, SDI supported field evaluations of existing diagnostic tests and began soliciting research proposals. In September 1994 the initiative held a meeting with diagnostics industry representatives to discuss the objectives of the SDI, product development and marketing issues, and possibilities for future collaboration.

PUBLIC HEALTH APPROACH

In the absence of rapid, simple, inexpensive STD diagnostic tests, USAID promotes "syndromic" management of STDs in settings where laboratory services are not available or affordable. This approach uses flow charts developed in collaboration with WHO to enable providers to diagnose and treat STD syndromes based on a clinical examination and a patient's reported symptoms.

USAID works with the Ministry of Health and the medical community in a country to build consensus on measures to improve access to quality STD services and to develop national treatment guidelines. In a number of countries, the Agency has supported technical assistance to help STD control personnel assess the susceptibility of various infections to antibiotics and the diagnostic validity of the syndromic treatment charts under local conditions. The results of such studies are discussed with policy makers and health care providers and used to develop STD treatment protocols.

In Jamaica, an assessment of two treatment charts for managing abnormal vaginal discharge led to development of a protocol that will be used in all public health clinics. Adoption of syndrome management at Jamaica's central STD clinic has already cut patient waiting times in half. Fewer laboratory tests are required, freeing staff to screen pregnant women for syphilis at a large antenatal clinic.

Once national STD management guidelines have been adopted, USAID supports training to reorient health care providers to a more public health approach to STD management that includes syndromic diagnosis and treatment, counseling, partner referral and condom promotion. During the past three years USAID's AIDSCAP Project has worked with 36 public and private organizations in 15 countries to upgrade STD diagnosis, treatment and counseling.

A volunteer "peer educator" in an African Medical and Research Foundation (AMREF) project educates a trucker about the risks of AIDS at a stop along the highway in Mashinari, Kenya.

KAREN KASMAUSKI

UNDERSTANDING COMMUNITY PERCEPTIONS

The Agency also sponsors ethnographic research to help STD program managers improve their programs. The targeted intervention research (TIR) model, a research tool developed by AIDSCAP, allows STD program managers to explore people's perceptions of STDs, what causes them, and how they should be treated.

Designed to be conducted by STD managers without outside technical assistance, the TIR uses a variety of qualitative and quantitative methods to rapidly collect information needed to answer programmatic questions. With this information, a program manager can ensure that services are tailored to meet clients' needs.

TIR results are being used to strengthen STD services in Senegal and Malawi; similar studies will begin in 1995 in Ethiopia and the Philippines. In Malawi, researchers found that many of the illnesses mentioned by those interviewed closely matched Western biomedical definitions of STDs. For some STDs, however, the early and late stages of the infection were considered separate illnesses and were given different names and treatments. An understanding of such distinctions can help STD care providers communicate with their clients and provide more effective care.

PROMOTING POLICY DIALOGUE

Throughout the world, progress in slowing the HIV/AIDS epidemic is threatened by social, cultural, economic and regulatory barriers to prevention, ranging from widespread failure to recognize the severity of the problem to discrimination against individuals living with HIV/AIDS. USAID supports policy dialogue and reform at the international, country and local levels and in the public and private sectors to create an environment where HIV prevention programs can operate effectively and efficiently.

Powerful arguments are needed to persuade decision makers to allocate adequate funding for HIV/AIDS programs and adopt sometimes controversial policies to strengthen prevention efforts. During the past eight years, USAID has pioneered the use of socioeconomic analysis and computer modeling to raise awareness about HIV/AIDS among policy makers and build support for comprehensive prevention policies and programs.

In Honduras, for example, USAID's AIDSCAP Project worked with the Ministry of Health to project the social and economic impact of HIV/AIDS in the country during the next decade. A presentation of the results to 350 government officials, journalists, and community, business and religious leaders led to the creation of an AIDS advisory committee chaired by the First Lady of Honduras, widespread media attention and increased donor support for prevention. Similar policy work in the Dominican Republic contributed to passage of AIDS legislation outlawing discrimination against people with HIV/AIDS and requiring every government ministry to develop a plan to address the epidemic.

In addition to raising awareness and mobilizing resources, policy dialogue informs decision makers about effective HIV/AIDS interventions and helps them set priorities. USAID supports the use of simulation modeling to enable policy makers to assess the potential impact of different prevention interventions. The Agency also brings people from different countries and regions together to share lessons learned in HIV/AIDS prevention. For example, USAID's Asia and the Near East Bureau sponsored a series of study tours to give Indonesian government and NGO leaders an opportunity to learn firsthand about a mature and successful HIV/AIDS prevention program in Thailand. Policy tour participants played key roles in developing Indonesia's National AIDS Program.

USAID policy efforts also address specific regulatory barriers to AIDS prevention. In Brazil, the Agency worked with local advocates to lobby for repeal of a 15 percent import tax on condoms. The group's analysis showed that the tax made condoms too expensive for most people who needed them and helped convince policy makers that a supply of affordable condoms was crucial to slowing the spread of HIV/AIDS in Brazil. The tax was withdrawn in April 1994.

Government is not the only target of USAID policy efforts. The Agency also works with the private sector to encourage businesses to establish workplace HIV/AIDS prevention programs and adopt supportive personnel policies. In Africa, for example, a private sector AIDS policy presentation (PSAPP) developed by AIDSCAP will demonstrate the financial, legal and ethical reasons for private sector investment in workplace HIV/AIDS prevention programs. It will also provide managers and workers' groups with guidelines to help them implement appropriate HIV/AIDS policies and prevention programs.

INVOLVING WOMEN

As HIV prevalence continues to rise faster among women than men, it is increasingly clear

that traditional prevention messages and methods do not offer adequate protection for many women. Monogamy and partner reduction are not effective strategies for women whose partners are not monogamous. Many women are unable to negotiate condom use with a partner.

To make HIV/AIDS prevention interventions more relevant for women, USAID is involving women in designing, carrying out and evaluating programs and policies at every level. The Agency also supports efforts to gain a better understanding of the factors that affect women's risk of infection, develop more effective methods for reducing HIV among women, and integrate HIV/AIDS prevention into family planning and maternal child health programs (see box, p. 30).

WOMEN AND AIDS RESEARCH

The Women and AIDS Research Program of the International Center for Research on Women (ICRW) was one of USAID's first efforts to identify the behavioral, sociocultural and economic factors that influence women's vulnerability to HIV and opportunities for reducing women's risk of infection. Seventeen research projects sponsored by the program in Africa, Asia, the Pacific, Latin America and the Caribbean yielded important insights into the realities of women's lives and resulted in a set of policy and program recommendations.

The program found that providing women with opportunities for individual counseling and group interaction to share personal experiences could enable them to adopt new sexual behaviors and learn how to negotiate with partners. It also recommended promoting sexual and family responsibility in programs targeting men and improving women's economic status through enhanced access to credit, training, employment, and particularly primary and secondary education.

In fiscal year 1994 USAID supported expansion of eight of the ICRW projects to give research teams the opportunity to implement

A woman is cared for by her mother as her baby lies next to her at Kitovu Hospital in Masaka, Uganda, where about 80 percent of the people in the hospital have AIDS. Although the woman had not been tested for HIV, it was suspected that she had AIDS.

KAREN KASMAUSKI

RESEARCH MAY YIELD NEW HIV PREVENTION OPTIONS FOR WOMEN

With limited options available for preventing sexual transmission of HIV, women must rely on men's cooperation for protection against the virus. Evidence that HIV rates are rising faster among women than in any other group points to the urgent need for prevention methods women can control—and use, if necessary, without a partner's knowledge.

In 1993 the Population Council launched an initiative to develop a woman-controlled product that will protect users from infection by microorganisms that cause HIV and other sexually transmitted diseases (STDs). As a result of this ambitious effort, funded by USAID and other international donors, a safe, effective vaginal microbicide could be available before the end of the decade.

Ultimately, scientists hope to produce a barrier to HIV infection that a woman could use without impairing her ability to conceive. But until critical questions about reproductive biology can be answered, a noncontraceptive, woman-controlled method of HIV prevention is probably a distant goal.

In the meantime, remarkable progress has been made in basic research on the mechanisms of HIV transmission in women, identifying compounds that block HIV infection in the test tube, and designing safety and acceptability studies. In addition, the Council has begun a unique collaboration with women's health advocates to incorporate women's perspectives into every stage of product development, from formulation of products in the laboratory to design of study protocols and implementation of field research.

Because little is known about how HIV is transmitted to women, researchers began by developing a laboratory model to simulate natural infection in the reproductive tract. They also developed two assays to test how well various agents can block infection with HIV.

After screening various compounds with both assays, the researchers found that a family of chemicals called sulfated polymers, which are already used in many foods and cosmetics, was highly effective in blocking HIV infection in the test tube, even at extremely low concentrations.

One of the most exciting discoveries during 1994 was the finding that these compounds could also block infection by another serious and more prevalent sexually transmitted infection, Chlamydia trachomatis. Future research will determine whether sulfated polymers can inhibit infection by other sexually transmitted pathogens.

During the past year the Population Council has also made significant progress in testing various formulations of sulfated polymers to determine the correct concentration, consistency and method of controlling acidity. Experiments demonstrated that the most promising formulation did not irritate the vagina of animals and that it would remain stable under the kind of extreme heat found in tropical countries.

All of this research culminated in submission of an investigational new drug application to the U.S. Food and Drug Administration (FDA) in September 1994. Approval of the application cleared the way to begin the clinical trials required for FDA approval to market a drug or medical device.

The first safety study, which will test whether the most promising compound causes vaginal irritation, will begin in five study centers in 1995. Twenty-five women at each site will use the vaginal gel once a day for seven days without having sexual intercourse and will undergo a gynecological examination before and after using the product. If no adverse effects are detected, larger studies will eventually be conducted to assess the product's effectiveness.

During 1994 the Population Council also developed a protocol to assess the acceptability of various vaginal formulations using currently available, over-the-counter spermicides. A study that began in early 1995 involves 25 women volunteers in each of five sites in Africa, Asia and North America who agreed to use a gel, a film and a vaginal insert containing nonoxynol-9 for one month each. This study will provide valuable insights into women's preferences that will guide the formulation of new microbicidal products.

One of the greatest challenges for the microbicide development effort is the design of an efficacy trial that is scientifically rigorous and ethically sound. Attention to the ethics of clinical trial design is particularly important because women who are most vulnerable to HIV infection are also extremely vulnerable to exploitation and discrimination.

In 1994 the Council collaborated with the International Women's Health Coalition and the Pacific Institute for Women's Health to establish a consultative process to facilitate genuine and sustained dialogue between researchers and women's health advocates. During 1994 two meetings were held with advocates from every region of the world to solicit their opinions, ideas and recommendations.

A symposium to highlight the challenges of conducting responsible research among vulnerable groups of women at heightened risk of HIV infection is planned for 1996 as part of the Population Council's continuing dialogue with women's advocacy groups. Their contributions throughout the microbicide development process will help ensure that the products developed will be accepted and used by women throughout the world.

intervention strategies identified or pilot tested during the first phase of the program and to evaluate their impact at the community level. In the summer of 1994, projects began in Mexico, Thailand, Senegal, Sri Lanka, South Africa, Zimbabwe and Brazil.

WOMEN'S INITIATIVE

In 1994 USAID also launched a program to strengthen HIV/AIDS prevention efforts for women in developing countries through the AIDSCAP Project. Activities begun under the Women's Initiative in fiscal year 1994 include a project with the Women's Market Association of Senegal to link HIV/AIDS prevention with economic empowerment of women, planning for a regional workshop on women and AIDS in Asia, and training to help community volunteers working with young women in the Dominican Republic adopt a more gender-sensitive approach to HIV/AIDS prevention.

WOMAN-CONTROLLED PREVENTION

A research protocol drafted by the AIDSCAP Women's Initiative will be used in three countries to investigate women's perceptions of the female condom as a protective method against HIV and other STDs. In contrast to earlier studies that focused on the acceptability of the physical properties of the device, this research will examine the influence of various social, cultural and economic factors on acceptability, the degree to which women feel use of a woman-controlled method increases their power within a relationship, and the strategies they use to protect themselves from infection. Studies will begin in three countries in 1995.

Developing and field testing woman-controlled barrier methods for HIV/STD prevention is a high priority for USAID-supported HIV/AIDS research. The Agency and other international donors are sponsoring promising research by the Population Council to develop microbicides women could use as a vaginal gel, foam, suppository or film to protect themselves from HIV and other sexually transmitted infections. The availability of such a microbicide could help revolutionize HIV prevention efforts around the globe.

EVALUATION

Monitoring and evaluation are critical to ensuring that USAID resources are used effectively and that they achieve results. All Agency-funded projects include systems to monitor progress and evaluate impact, and measures of success are defined at the outset.

Measuring behavior change and its impact on disease transmission is a challenging task. This is particularly true for HIV/AIDS prevention because of the nature and sensitivity of sexual behavior, which makes it difficult to collect valid data on changes in behavior, and because of the long latency period of HIV. Since it takes an average of six to eight years for HIV infection to develop into AIDS in developing countries, decreases in HIV prevalence will not be measurable for at least five to fifteen years.

In the interim, USAID HIV/AIDS prevention projects use a variety of measures to assess their progress along a continuum. Short-term "process indicators," such as the number of condoms sold or number of people reached by an intervention, measure whether a project has met targets considered essential to achieving its objectives. Medium-term indicators of the outcome of a project include changes in knowledge of preventive practices among the target audience and in the proportion of the population reporting consistent condom use. Reductions in STD prevalence are an excellent proxy for assessing the long-term impact of HIV/AIDS prevention, and can be evaluated after three to five years.

In collaboration with WHO, the Agency has established a set of standardized prevention indicators that can be used by HIV/AIDS control programs around the world. These indicators measure target audiences' knowledge, condom availability, use of condoms and other reported changes in sexual behavior, and the quality of STD case management, as well as the prevalence of specific STDs and HIV.

USAID continues collaborative efforts to refine these evaluation indicators and develop more sensitive measures of the impact of HIV/AIDS prevention activities on sexual behavior and disease transmission. Most recently the Agency worked with the staff of the Demographic and Health Survey to select questions for an HIV/AIDS module for the next phase of national field surveys.

HIV/AIDS CARE AND PREVENTION

As the number of people who have developed AIDS begins to rise dramatically, policy makers and health care providers are struggling with two difficult questions: What is HIV/AIDS care, and how can it be provided to tens of millions of people in countries with limited resources?

Many people think of HIV/AIDS care as expensive antiviral therapy, which is available to only a small number of people in the developing world. Yet even in industrialized countries, some of the most effective interventions for prolonging and improving the quality of life of people with HIV are more "low tech."

In the United States, for example, AIDS program personnel say that the most important services they provide for people living with HIV/AIDS include counseling, social services and support, advocacy and assistance in adopting healthier lifestyles.

At the Whitman Walker Clinic in Washington, D.C., more than 2,000 volunteers assist in providing care and support to people living with HIV/AIDS. Psychosocial support through the clinic's "buddy" program, which pairs trained volunteers with HIV-positive people, helps people stay healthier by reducing stress. Volunteers in many programs help people with HIV resolve practical problems, such as how to secure or retain employment and housing or how to access available health and social services.

Nutrition guidelines, assistance in quitting smoking, and guidance on how to avoid infections that will assault an already weakened immune system also can help people with HIV live longer, healthier, more productive lives.

Following such guidance may seem impossible when a person is too sick to work and cannot afford the appropriate food or when safe water is not available. But even in the

poorest settings, with family or community support a person with HIV can maintain a minimum level of nutrition and hygiene.

Prompt and appropriate treatment of the common illnesses that affect people with HIV/AIDS, such as diarrhea and bacterial pneumonia, also may be feasible in such settings. Many of the essential drugs needed to treat these illnesses are available in district hospitals in the developing world. Information, education and communication about the proper uses of available drugs are needed to ensure that people seek and comply with treatment.

Improving diagnosis and treatment of tuberculosis is particularly important in developing countries. In the poorest of these countries, TB is estimated to be the cause of death for as many as half of those who die with HIV.

The World Health Organization believes that comprehensive HIV/AIDS care, including medical services, nursing care, counseling and social support, should be available across a continuum extending from home and community to hospital. Nurses in all district hospitals should be trained to counsel patients and their families about hygiene, nutrition, and emotional and physical rehabilitation, as well as HIV prevention.

This continuum must be linked by strong referral networks. Hospitals and clinic staff should be able to refer people to community-based organizations that provide social, economic and legal support for individuals and families affected by HIV/AIDS. The staff of these organizations, in turn, should be trained to refer patients to appropriate sources of clinical care.

A recent evaluation of the services provided by The AIDS Service Organization (TASO) in Uganda found that care—defined as medical treatment, counseling and nursing—had helped people plan for the future, practice safer sex and seek early treatment. TASO has made important strides in developing models of community-based care, but sustainability is a problem because all of the organization's funding comes from external donors.

Given the limited resources available, most donors concentrate on HIV/AIDS prevention rather than care. But many working in the field believe that the most effective prevention programs are, like TASO's, integrated with care and support services.

The experience of two programs at Harlem Hospital in New York City demonstrate some of the advantages of an integrated approach to care and prevention. One program, funded by the State of New York, was required to hire a separate HIV/AIDS counselor for pretest and post-test counseling. Clients were reluctant to go to this counselor because everyone knew that she only counseled people about HIV/AIDS. In the other program, all staff at a prenatal clinic were trained to provide HIV/AIDS counseling as well as a range of other services. Ninety percent of the women attending the prenatal clinic accepted voluntary HIV testing, compared to less than 50 percent of patients in the state-funded program.

Experiences like those of TASO and Harlem Hospital suggest that providing AIDS care can strengthen HIV prevention efforts. One of the most important challenges during the next decade is to identify cost-effective ways of integrating basic AIDS care and support with HIV prevention efforts.

SEAN SPRAGUE/PANOS PICTURES

HIV/AIDS CARE AND SUPPORT

Faced with limited funds and the lack of an effective, affordable treatment for HIV/AIDS, USAID has concentrated most of its resources on preventing further spread of the epidemic. But for grassroots organizations struggling to help families cope with AIDS-related illness and to encourage behavior change in communities where many people are already HIV-positive, there is no separation between prevention and care.

WHO CARE INITIATIVE

During the past five years, USAID has responded to the growing need for care and support of people living with HIV/AIDS and their families by sponsoring pilot efforts to identify effective community-based interventions. Recently the Agency has also supported the World Health Organization's Care Initiative, which works with national AIDS programs to integrate comprehensive care by families, communities, and health and welfare systems into countries' responses to HIV/AIDS.

In fiscal year 1994 USAID earmarked $700,000 of its contribution to WHO/GPA to the program's Care Initiative. USAID's contribution helped support WHO/GPA's first consultative meeting on AIDS care, as well as production of several manuals and adaptation and field testing of WHO's AIDS Home Care Handbook in Asia. Other projects funded in part by USAID include a study of the feasibility of integrating STD care with maternal child health and family planning services in Thailand and a participatory evaluation of the counseling, medical and social services provided by The AIDS Service Organization in Uganda.

CARE AND MANAGEMENT GRANTS

In fiscal year 1994 USAID also launched a small grant program for community-based care and awarded the first three grants. This program provides seed grants to help NGOs create and share effective, appropriate, affordable models of AIDS care and management. One-year grants of up to $20,000 are available to community-based groups in 11 countries in Africa and Latin America and the Caribbean to fund innovative pilot programs that:

- address care and management of people with HIV/AIDS;
- develop or strengthen support systems for AIDS orphans; or
- demonstrate effective linkages between AIDS care and HIV prevention.

TB RESEARCH

In the early 1990s, when tuberculosis control emerged as an increasingly important AIDS care issue, USAID sponsored some of the first studies to investigate the relationship between the HIV/AIDS and TB epidemics. One study by the U.S. Centers for Disease Control and Prevention (CDC) found that in ten sub-Saharan countries, TB rates were directly correlated with HIV seroprevalence and inversely correlated with the quality of TB programs. The Agency also supported CDC assessments to make recommendations for improving the TB programs in Tanzania and Botswana and a study by the U.S. National Institutes of Health (NIH) that compares the anticipated impact of the global TB epidemic with that of other emerging disease threats. Results of these studies will help policy makers set priorities for TB programs.

USAID also is funding research and training designed to improve TB diagnosis and treatment in the developing world. The Agency is working with CDC to develop the first international training course in applied research on HIV-related tuberculosis. Designed to strengthen the research and management skills of key investigators from developing countries, the course is scheduled to begin in 1995.

In fiscal year 1994, USAID awarded funding for three studies on TB control under a grant program that links developing country investigators with NIH-funded researchers in the United States. One study will identify TB prevention interventions for a hard-hit area of South Africa. Another study—the only one of its kind in the developing world—will investigate the risk of infection with drug-resistant TB among HIV-infected patients hospitalized for TB in Tanzania and make recommendations for preventing such "super-infection." In Honduras the Agency is

These young boys have been orphaned by AIDS and attend the Bukulula Village School in Bukulula, Uganda. Half the students at the school are AIDS orphans.
ALEXANDRA AVAKIAN / CONTACT

supporting an assessment of a new diagnostic test that could reduce the time needed to diagnose drug-resistant TB from 12 weeks to six hours.

ORPHAN SUPPORT

USAID-sponsored research and pilot programs in Uganda have led to a better understanding of how to address another emerging problem associated with the HIV/AIDS epidemic: care for children orphaned by the AIDS-related deaths of parents. Funded by USAID's Displaced Children and Orphans Fund, these programs emphasize strengthening the ability of families and communities to care for AIDS orphans, rather than isolating children from the community in more expensive institutions.

Since 1991, USAID has provided a total of $600,000 to support the efforts of Save the Children of the United Kingdom to move orphans from institutional to family settings, train child care providers and strengthen the Ugandan ministry responsible for child welfare policy. By March 1994 almost half the Ugandan children living in children's and babies' homes had been resettled with relatives.

Guided by the findings of Save the Children's report, "Managing Uganda's Orphans Crisis," USAID awarded a total of 20 grants to NGOs in 1992. Managed by World Learning, Inc., the grant program strengthened the management abilities of local NGOs and allowed them to test a variety of approaches to orphan support in different parts of the country. These approaches included vocational training and income-generating projects for parents living with HIV/AIDS, families caring for orphans and older orphans themselves; provision of school fees and supplies; and training and technical assistance to grassroots organizations.

ALLIANCE PROMOTES LOCAL GOVERNANCE OF HIV/AIDS PROGRAMS

Sixteen community-based nongovernmental organizations (NGOs) received grants from the Philippines HIV/AIDS NGO Support Program (PHANSuP) in 1994 to carry out education and counseling programs. Unlike most HIV/AIDS prevention programs in the Philippines, these programs are located outside Manila, in other areas. In many regions and provinces, these new NGO activities are the only HIV/AIDS prevention programs.

Most of the NGOs who received grants had extensive community development experience, but had never worked in HIV/AIDS prevention. To enhance NGO personnel's knowledge of HIV and its prevention, PHANSuP organized four regional training workshops in fiscal year 1994. During the year it also provided technical assistance to the grantees in proposal development, training, setting up accounting systems, and monitoring activities.

PHANSuP's grant program and capacity building efforts are part of an ambitious experiment to promote local governance of HIV/AIDS prevention and care activities by NGOs and other community-based organizations (CBOs). The Filipino NGO is one of six "linking organizations" supported by the International HIV/AIDS Alliance to strengthen and expand NGO responses to the causes and consequences of the epidemic in the developing world.

Funded by USAID, the European Community and other donors, the International HIV/AIDS Alliance was founded in December 1993. It collaborates with governments, foundations and the private sector to support NGOs working in HIV/AIDS prevention and care and to encourage exchange of information about successful activities that could be replicated and adapted in other settings.

Transferring governance from distant donors to affected communities is at the heart of the Alliance's approach because the most successful responses to HIV/AIDS are built upon local leadership, commitment and responsibility. In each country where it works, the Alliance forges a partnership with a linking organization like PHANSuP. The Alliance provides technical assistance, management support and funding to each linking organization. The organization, in turn, channels resources to local NGOs and works with them to strengthen their capacity to manage, implement and evaluate HIV/AIDS programs.

In addition to developing appropriate approaches to evaluate activities carried out by each funded NGO or CBO, the Alliance is engaged in a process of strategic review. Each link of the support and implementation chain, from headquarters to the CBOs, conducts periodic self-review, as well as undergoing review by its supporters and beneficiaries, so that plans and programs can be adjusted in response to unanticipated successes or obstacles.

During fiscal year 1994 the Alliance established linking organizations in six countries: Bangladesh, Burkina Faso, Ecuador, the Philippines, Senegal and Sri Lanka. Initial program development also began in Morocco, Pakistan and Tanzania in 1994; expansion to Côte d'Ivoire, Mozambique and Peru is planned in 1995.

Alliance countries are chosen based on their need for HIV/AIDS assistance, NGO sector capacity, leadership and commitment, the willingness of national officials to allow independent funding of NGOs for HIV/AIDS activities, and the availability of donor funds to support activities in a particular country.

Linking organizations are encouraged to channel support toward interventions, organizations and communities that are underserved by other funding mechanisms.

The activities or programs they fund may be intended to:

- prevent HIV infection;
- care for people with HIV or AIDS and their loved ones;
- prevent or respond to discrimination related to HIV/AIDS;
- advocate for more effective policies in other institutions;
- engage in broader "development" work addressing the causes or consequences of the epidemic; or
- support participatory research or institutional development by NGOs involved in these activities.

The experience of PHANSuP, the first linking organization created under the Alliance, has shown that such organizations can achieve many of the Alliance's goals: directing funds and training to small but dynamic community groups; mobilizing AIDS action in the broader health and development community; and acting as a catalyst for strategic thinking, planning and cooperation among NGOs.

PHANSuP is also an example of the Alliance's efficient use of funds. Only one-third of total Alliance expenditures for the program in the Philippines funded the central secretariat and international support costs, while two-thirds was transferred directly to PHANSuP. PHANSuP, in turn, spent over 70 percent of its budget on prevention and care services for local communities.

Overall, the Alliance model of encouraging local governance and leadership has resulted in support for small, truly community-based programs, integration of HIV/AIDS into other development efforts, greater inclusion of people living with HIV/AIDS, and a higher level of attention to STD diagnosis and treatment.

The program demonstrated that a network of NGOs linked to government child welfare authorities can be a powerful vehicle for improving child protection, promoting appropriate interventions and training small NGOs. Based on the lessons identified by a midterm evaluation, USAID has developed guidelines for a collaborative donor strategy to meet the critical needs of the growing number of children orphaned by the global HIV/AIDS epidemic.

BUILDING COMMUNITY CAPACITY

Like AIDS care and support, sustained behavior change depends on community involvement. People are more likely to maintain individual changes in sexual behavior in a social environment that encourages risk reduction, and new sexual norms cannot be imposed on communities from the outside. Therefore, community participation in design, implementation and evaluation is critical to developing HIV/AIDS programs that are relevant, effective and sustainable.

Over the past decade, NGOs have demonstrated that they are in the best position to mobilize communities for HIV/AIDS prevention and care. Their close relationships with target communities and their experience in community development enables NGOs to work with community members to develop responsive, cost-effective programs.

Many community-based NGOs, however, have little experience with HIV/AIDS. Others, organized in response to the epidemic, may lack technical or managerial experience. In addition to providing financial support, USAID builds on NGOs' strengths by improving their ability to design, implement and evaluate HIV/AIDS programs.

During the 1990s, USAID has expanded its support for nongovernmental groups, including

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churches, businesses, and community and professional associations, to promote community involvement in HIV/AIDS prevention. The Agency uses three mechanisms for building NGO capacity:

- direct support to local NGOs;
- cooperative support through U.S. and international private voluntary organizations (PVOs) and other NGOs; and
- funding and technical assistance to national, regional and global NGO networks.

During the past two years, USAID's direct support for indigenous NGOs has increased over six-fold, totaling $20 million, or about 30 percent of the nongovernmental sector HIV/AIDS budget, in fiscal year 1994. In South Africa, for example, the USAID Mission provides direct funding for the HIV/AIDS prevention activities of nine national, regional and local NGOs.

The Agency's cooperative support to local NGOs and affected communities through private voluntary organizations and international NGOs such as the International HIV/AIDS Alliance builds effective partnerships for HIV/AIDS prevention. In Uganda, for example, World Learning, Inc., manages a project to strengthen the capacity of 14 local organizations and coordinate activities in HIV/AIDS prevention education, HIV testing and counseling, STD control and community outreach. In Indonesia, through the Enabling Private Organizations to Combat HIV (EPOCH) Project, the PVOs Project Concern and Private Agencies Collaborating Together (PACT) provide technical assistance to 11 NGOs carrying out HIV/AIDS prevention activities in Jakarta, Surabaya and Bali.

The AIDS Control and Prevention Project's PVO/NGO grant program also pairs U.S. and international PVOs with local NGOs. Collaborative community-based projects are underway in eight countries. In addition, 75 percent of all AIDSCAP-supported activities are carried out by PVOs, NGOs and other community-based organizations in 35 countries. The project has forged partnerships with more than 100 community-based organizations, ranging from community development and health NGOs to women's associations, trade unions, and local church, youth and community groups.

USAID supports NGO networks through an agreement with the National Council for International Health (NCIH). NCIH distributes a bimonthly newsletter, coordinates workshops on HIV/AIDS prevention for NGOs, and strengthens national, regional and global NGO networks.

In fiscal year 1994, NCIH worked with NGOs to plan two important meetings: one with the International Council of AIDS Service Organizations in Washington, D.C., in December 1994 and another, for five Latin American NGO networks involved in HIV/AIDS prevention and care, in Bogotá, Colombia, in January 1995. Both meetings will improve communication and collaboration among NGOs and NGO networks and provide opportunities for the networks to develop strategic plans for the next two years.

Through all these mechanisms, USAID is strengthening communities' ability to confront HIV/AIDS. Partnerships between NGOs and communities will ensure a long-term, sustained response to the evolving epidemic.

FUTURE DIRECTIONS

Since USAID began its first HIV/AIDS prevention efforts eight years ago, the epidemic has changed dramatically. HIV has spread to every region of the world. Millions of people infected with HIV during the first decade of the epidemic are developing opportunistic infections and other AIDS-related illnesses, and many are dying. Women and children are among those most vulnerable to HIV infection. As HIV prevalence and AIDS mortality soar, millions of children will lose their parents.

HIV/AIDS is having a devastating impact on the health and well-being of families, communities and nations worldwide. The epidemic's effects on the structure of societies and the productivity of their members undermine efforts to promote sustainable development around the globe.

USAID's approach to slowing the spread of HIV/AIDS relies on strategies tested and refined over the past eight years. At the same time, the Agency is moving forward to address new challenges posed by the evolving epidemic.

MEETING THE CHALLENGE

One of the important lessons learned during the past decade is that an effective response to HIV/AIDS requires the full participation of people and communities affected by the virus. Although people living with HIV/AIDS are among the most successful advocates and communicators for prevention, too often their voices are not heard or heeded. Greater involvement of people living with HIV/AIDS is essential to creating the supportive political, legal and social environments needed to control the epidemic.

In December 1994 at the Paris AIDS Summit, representatives of 42 governments adopted a resolution pledging greater support for networks of people living with HIV/AIDS. Before and during the summit, members of these networks worked with government and multilateral organizations, including USAID, to develop a plan for translating the words of the resolution into concrete action. The Agency is committed to ensuring that people living with HIV/AIDS are accepted in full partnership with governments, international organizations and the private sector in developing, implementing and evaluating HIV/AIDS policies and programs.

People living with HIV/AIDS and community-based organizations have been at the forefront of efforts to draw attention to the connection between compassionate AIDS care and effective HIV prevention. In the absence of a vaccine or cure, USAID continues to emphasize HIV/AIDS prevention. But as the number of people suffering from AIDS-related illness begins to increase dramatically, the Agency is also exploring ways to reduce the social impact of AIDS and enhance prevention efforts by integrating prevention and care.

The Agency will also continue to pioneer regional approaches to an epidemic that does not recognize national boundaries. Cross-border interventions throughout the world will target mobile populations, including migrant workers, tourists, traders, transport workers and people displaced by war and social disruption.

Results from USAID-supported research on preventing HIV/AIDS in women, from microbicide development to behavioral research on communication between men and women, will play a key role in slowing the rapid spread of the epidemic in the future. The Agency will continue to support research designed to strengthen programs for women and will move quickly to incorporate promising prevention methods into field activities. USAID will also work to reduce women's vulnerability to HIV prevention by promoting multisectoral efforts to improve their economic and social status.

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INTEGRATING HIV/AIDS PREVENTION INTO HEALTH AND FAMILY PLANNING PROGRAMS

The predominance of heterosexual transmission of HIV worldwide and rapid increases in infection among women are redefining HIV/AIDS as a critical threat to the health of women and children. Recognition of the devastating impact of the epidemic on women and children has led to a search for strategies to reach women once considered at low risk of acquiring HIV and to help them protect their children from HIV/AIDS.

One of the most promising strategies for expanding HIV/AIDS prevention services for women is integration into family planning programs that serve millions of women worldwide. Often the only health services that women receive, these programs can increase women's access to information and counseling about HIV/AIDS and other sexually transmitted diseases (STDs). At the same time, integration can strengthen family planning programs by equipping them to address all of women's reproductive health needs.

USAID has been at the forefront of efforts to integrate prevention of HIV and other STDs into family planning services. The Program of Action adopted by more than 160 nations at the International Population Conference in September 1994 reflects the Agency's commitment to increasing access to comprehensive reproductive health services as part of a global effort to improve women's lives.

The Agency has formed a working group to determine the most appropriate, cost-effective ways to incorporate HIV/STD activities into family planning programs. These activities could include education, counseling, condom promotion and distribution, STD treatment or referral and, in some settings, voluntary HIV testing. The working group will identify and disseminate lessons learned from integrated programs and provide guidance on implementing comprehensive reproductive health programs.

Family planning programs in Jamaica, Honduras and Brazil have successfully incorporated HIV/STD prevention through a USAID-funded project implemented by the International Planned Parenthood Federation (IPPF) of the Western Hemisphere Region. These projects, which rely on a well-established network of IPPF affiliates, have trained clinic and outreach staff to include HIV/STD education and counseling and condom promotion in their daily activities.

The IPPF projects have proved to be a cost-effective way to reach women with HIV/STD prevention services. Although many providers initially feared that such integration would dilute their mission of family planning, they found that it actually enhanced the quality of services by helping them meet the reproductive health needs of their clients.

In Africa, USAID has adopted a strategy calling for the use of all health, population and nutrition programs, where appropriate, to prevent HIV transmission. New bilateral programs that integrate HIV/AIDS prevention with family planning and health have begun in Botswana, Ghana, Malawi, Kenya and Côte d'Ivoire. Lessons learned from these and other integrated projects will be discussed and recommendations for follow-up activities developed at a workshop for USAID personnel and their counterparts from 14 sub-Saharan countries in 1995.

The Agency is identifying other opportunities to reduce HIV/AIDS among women and children by including prevention interventions in its child survival projects. The USAID PVO Child Survival Support Project, implemented by Johns Hopkins University, convened a task force in August 1994 to

advise PVOs on integrating HIV/AIDS prevention and child survival interventions. The project also supported a workshop in Guatemala that enabled participating PVOs to develop action plans for including HIV/AIDS interventions in their child survival projects.

USAID's Expanded Promotion of Breastfeeding (EPB) Project, carried out by Wellstart International, is focusing on improving our understanding of a potential threat to child survival: HIV transmission through breastfeeding. Despite strong evidence for this transmission route, many questions remain about the rate, timing, mechanism and risk of such transmission.

Given these uncertainties and the known health benefits of breastfeeding, the World Health Organization recommends that mothers breastfeed regardless of their HIV status in settings where safe and effective alternatives are not available and where the most common causes of death in infants are infectious disease and malnutrition.

Wellstart's efforts to disseminate information about HIV and breastfeeding in fiscal year 1994 included publication of an annotated bibliography of all published papers on the subject and a fact sheet for program managers and policy makers. The EPB Project will continue to assist managers and policy makers in interpreting the existing literature on this complex issue and will identify critical questions for future breastfeeding and HIV research.

These and other efforts to incorporate HIV/AIDS prevention into health and family planning programs offer useful models for expanding such integration to other development sectors. Programs in education, agriculture and human resource devselopment can also make important contributions to preventing HIV/AIDS and reducing the social and economic impact of the epidemic.

Recognizing the growing threat HIV/AIDS poses to child survival, the Agency will support efforts to identify and test methods of preventing transmission from mother to child, such as Vitamin A supplements, vaginal irrigation and other promising interventions. In addition, USAID will expand efforts to reduce HIV/AIDS among women and children by integrating prevention interventions into its family planning and child survival programs.

Effective use of integrated interventions is critical for HIV/AIDS prevention because the virus affects people who are most active in the development process. Decades of progress in health and development are jeopardized by the social and economic impact of the epidemic. Without careful planning, development activities, in turn, can promote the spread of HIV/AIDS by encouraging migration and the separation of workers from their families.

Most integration efforts to date have been in health and family planning, but other development sectors have an important role to play in HIV/AIDS prevention. In the future, the Agency will pursue opportunities for reducing HIV transmission and mitigating the impact of the epidemic on sustainable development through its programs in education, agriculture, and human resource and microenterprise development.

USAID's approach to HIV/AIDS has evolved along with the epidemic. To meet the challenges ahead, the Agency will continue to adapt its strategies and programs in order to benefit from lessons from the field and new opportunities for building effective partnerships. Given the epidemic's profound implications for health, economic growth and social stability, USAID's investment in HIV/AIDS prevention will save millions of lives and promote sustainable development throughout the world.

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AFRICA

Most of the world's HIV infections and AIDS cases have occurred in sub-Saharan Africa during the past 15 years. With the most advanced epidemic in the world, the region beginning to experience declines in life expectancy, child survival and economic productivity as a result of HIV/AIDS.

Central and eastern Africa remain the hardest hit by th epidemic. These areas, which account for approximately one-sixth of the region's population, harbor between hal and two-thirds of its HIV infections. In many urban are an estimated 25 to 30 percent of those 15- to 49-years-ol are HIV-positive. For example, prior to the civil strife in early 1994 in Kigali, Rwanda, one in three adults was believed to be infected with the virus. It is estimated tha one in every eighteen adults in Kenya and about 8 perce of Uganda's population are living with HIV.

The epidemic is also well-established in West Africa. In this area, HIV is associated with commerce and trade routes and international travel to the economic centers of the region. In Abidjan, the capital of Côte d'Ivoire, AIDS is already the leading cause of death among adults With an HIV prevalence of 3.8 percent in adults, Nigeri is usually considered a low-prevalence country, but this classification is deceptive because of the country's large population. Over 2 million Nigerians are estimated to b infected with HIV.

In southern Africa HIV is believed to have traveled wi truckers and migrant workers and their sex partners alo the trade routes. Studies in the urban areas of Botswana suggest that 18 percent of those between the ages of 15 a 49 are infected. In Zimbabwe, 10 percent of the country population is estimated to be HIV-positive. Over 500 ne infections occur every day in South Africa.

REGIONAL INITIATIVES

The USAID Bureau for Africa's regional strategy of "HIV/AIDS Prevention and Mitigation" calls for the use of all available health, population and nutrition progran where appropriate, to prevent HIV transmission in sub-Saharan Africa. Under this strategy, the Bureau will develop activities in other sectors, including agriculture, democracy/governance and human resource developme to mitigate the adverse economic and social consequenc of the epidemic in the region.

The Africa Bureau has led the way in evaluating the feasibility and appropriateness of integrating HIV/AIDS programs into programs in family planning, maternal ar child health, and other development sectors. In fiscal yea

1994 the Bureau began planning a workshop on integration for African decision makers that will be held in May 1995. The purpose of the meeting is to identify lessons learned from USAID programs that have tested integration strategies and to plan follow-up activities that will promote integrated program and policy responses to sexually transmitted diseases (STDs) and HIV.

Through the U.S. Peace Corps, USAID has supported integration of HIV/AIDS prevention into projects in other development sectors in several African countries. In Côte d'Ivoire and the Central African Republic, for example, Peace Corps volunteers have incorporated HIV/AIDS prevention activities into their community health projects. The Peace Corps also has developed an innovative curriculum that volunteers and their counterparts in Cameroon use to teach students about HIV/AIDS prevention as part of their English-language classes.

To help decision makers choose appropriate strategies and interventions for HIV/AIDS prevention in Africa, the Bureau has developed a research and analysis agenda for HIV/AIDS, other STDs and tuberculosis. The following research priorities were identified by USAID personnel and their counterparts from 14 African countries at a workshop organized by the Bureau in December 1993:

- effective information, education and communication strategies to promote behavior change;
- implementation and evaluation of integrated services;
- analysis of the impact of HIV/AIDS on sectors other than health;
- effectiveness of counseling and testing and community involvement in counseling and testing;
- strengthening STD services; and
- monitoring and evaluating program impact.

The Africa Bureau carries out its analytic agenda for HIV/AIDS and other health and human resources issues through the four-year, $40-million Health and Human Resources Analysis for Africa (HHRAA) Project, which began in fiscal year 1992. The purpose of the project is to increase the use of research, analysis and information to improve health, nutrition, education and family planning strategies, policies and programs in Africa.

Research sponsored by HHRAA includes a World Bank study on the economic impact of fatal adult illness due to HIV/AIDS and other causes, studies on tuberculosis and HIV by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. National Institutes of Health, and pilot projects to test the efficacy of a social marketing approach to improving reproductive health programs for young adults in Botswana and South Africa. HHRAA is also supporting development of an STD Database for Africa by the U.S. Bureau of the Census, which maintains a global database on HIV/AIDS and tracks trends in the epidemic for USAID.

Prior to HHRAA was the Africa Bureau's HIV/AIDS Prevention (HAPA) Project, implemented from 1989 to

"Puppets Against AIDS" puppets Joe, Mary and Harry walk through the streets of Alexandra township in Johannesburg, South Africa, to publicize their show.
GISÈLE WULFSOHN / IMPACT VISUALS

1992. The HAPA Project demonstrated the success of large-scale funding of PVOs for work in HIV prevention, leaving a rich legacy and continuing effort by the Agency to work through nongovernmental organizations to achieve sustainability of health and development projects not only in Africa but around the world.

BURUNDI

SITUATION ANALYSIS

Burundi's HIV/AIDS epidemic is severe and spreading quickly, mostly through heterosexual contact, from groups practicing high-risk behaviors in urban settings to the general population. The HIV seroprevalence rate is approximately 15.2 percent in urban areas and 14.7 percent in semi-urban areas. Although no data are available at this time, it is estimated that the political crisis will result in increasing levels of infection in refugees and displaced persons. A large AIDS awareness campaign was conducted through the media in the last two to three years, but few prevention interventions have been implemented.

Reported AIDS cases:* 7,772
Date of last report: 3/94

Increase over 1993 report:** 7%

Total population: 5,500,000

Cumulative incidence:
1413 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
10.5%
Population at low risk: 2.9%

USAID STRATEGY

USAID began an HIV/AIDS prevention project in March 1990. Interventions target groups practicing high-risk behaviors, including factory workers, commercial sex workers and young adults, as well as refugees and displaced individuals. USAID also supported strengthening the capacity of the National AIDS Control Program (PNLS) to carry out prevention interventions and activities that focus on providing information, education and communication (IEC) and condom social marketing at a national level through Population Services International (PSI).

USAID-SUPPORTED COUNTRY PROGRAMS

Burundi Health System Support
This $50 million, 10-year project, established in September 1993, aims to increase the contraceptive prevalence rate from 3 percent to 11 percent by the year 2003. It will also support the development of a sentinel surveillance system to track the HIV epidemic in Burundi. Assistance will be provided to establish a system with up to 16 reporting sites and five reference laboratories; establish a program to train staff to run and ensure the quality control of the HIV/AIDS surveillance system; provide laboratory equipment (up to five ELISA readers and related equipment) and reagents for HIV/AIDS diagnosis, including ELISA and limited Western Blot test kits and other chemicals; provide computer hardware and software and training in their use for HIV/AIDS data entry and analysis; and develop, implement and evaluate cost-effective HIV testing algorithms for the surveillance system and AIDS diagnostic and counseling services.

Social Marketing of Condoms
Financial and technical assistance from USAID has led to the development of locally packaged commercial condoms, Prudence, and a campaign to promote the product by Population Services International (PSI). Promotional advertisements are placed regularly in the *Announcer* magazine, and television and radio spots in both French and Kirundi are run by Burundi National Radio and Television (RTNB). Other promotional activities include nationwide IEC activities and televised debates.

CAMEROON

SITUATION ANALYSIS

Cameroon, with a population of 13.5 million, is at an early stage of the HIV/AIDS epidemic. According to recent studies, HIV seroprevalence ranges from 5 to 5.5 percent in the general population to 45.3 percent in commercial sex workers (CSWs) in Douala and 25 percent in Yaounde. A national AIDS committee was formed in 1988, and soon after the National AIDS Control Program was created.

Reported AIDS cases:* 5,375
Date of last report: 11/94

Increase over 1993 report:**
75.2%

Total population: 13.5 million

Cumulative incidence:
398.1 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
25 to 45.3%
Population at low risk: 5 to 5.5%

USAID STRATEGY

Working in collaboration with the Government of Cameroon international organizations an nongovernmental organizatior (NGOs), such as the World Health Organization (WHO), Geselschaft Für Technische Zusammenarbeit (GTZ), Popul tion Services International (PSI CARE International and Save tl Children, the USAID/Cameroo program focuses on behavior change communication (BCC sexually transmitted disease (STD) case management and nationwide condom social marketing. The target groups for interventions are CSWs an their clients, STD patients, military and police personnel, youth in- and out-of-school, truck drivers and migrant workers.

USAID-SUPPORTED COUNTRY PROGRAMS

Commercial Sex Workers
USAID activities have trained over 140 sex workers as peer educators in six major urban areas. The educators have reach over 24,000 CSWs and clients with information on STDs an HIV/AIDS, correct condom us and health-seeking behavior a bars, hotels, "chicken" parlors and health clinics served by th project. Commercial sex work also serve as condom sales ager in nontraditional venues.

Military and Police
This intervention targets the 30,000 people in the military and the 15,000 police with pee education, improved STD services at military garrisons and enhanced condom distrib tion. The project covers seven the country's ten garrisons wit information and education pr moting safer sexual practices and improving access and avai ability of condoms.

University Students
Over 115 peer educators have been trained and are conductir education sessions for student on the four national campuses

In collaboration with PSI, the project is establishing and expanding condom distribution outlets on and around campuses. To improve health care services at university health centers, 15 health care staff in Douala and Yaoundé have been trained in HIV prevention and standard treatment guidelines for urethritis and other STDs. Since the beginning of the project in June 1993, over 13,000 students have been reached with HIV/AIDS education messages and condoms.

In-and Out-of-School Youth
With funding from the AIDSCAP competitive grants program, CARE is providing AIDS prevention education to youth in the Eastern Province. The three-year project will use behavior change strategies to encourage youth to adopt low-risk behavior. The project expects to reach 64,000 young adults.

Condom Social Marketing
Since being launched by PSI in October 1989, over 23 million condoms have been sold through this project. In 1994 7.2 million condoms (30 percent of total sales) were sold, and average monthly condom sales increased from 394,000 to 770,000. The project has used proven marketing techniques such as radio advertisements, theater performances, point of purchase materials, consumer and distributor incentives and special events to make Prudence Plus the most well-known and widely-used condom in Cameroon. PSI is expanding its product line in Cameroon to include Promesse, a condom brand promoted for family planning targeting women.

STD Prevention and Control
USAID is collaborating with the Ministry of Public Health to develop diagnostic and treatment guidelines. Health care workers in eight cities are being trained in STD diagnosis and control. A feasibility study of prepackaged treatment for urethritis was conducted at 21 military and university health clinics and two private pharmacies. The final evaluation of this study, to be completed in fiscal year 1995, included interviews with 15 medical and public health decision makers and qualitative and quantitative surveys among prescribers and users of the treatment.

Sentinel Surveillance
This project is tracking and monitoring levels of syphilis prevalence in pregnant women in Douala, Garoua, Yaoundé, Bertoua, Limbé and Bamenda. Implemented in collaboration with the National AIDS Control Unit, GTZ and WHO, this project will also assist in monitoring the impact of USAID activities in Cameroon.

CÔTE D'IVOIRE

SITUATION ANALYSIS

The first AIDS case in Côte d'Ivoire was diagnosed in 1985. By 1992 infection levels in clients of sexually transmitted disease (STD) clinics had risen to 20.1 percent. Awareness of HIV/AIDS is very high in Côte d'Ivoire, and AIDS is now largely recognized as a critical public health problem. In September 1994, the Prime Minister of the Government of Côte d'Ivoire announced during a donor meeting on HIV/AIDS that the government plans to allocate approximately $1.9 million to support HIV/AIDS prevention activities. Prevention efforts are being initiated by the health delivery system, the Ministry of Health and Social Welfare and by several nongovernmental organizations (NGOs). The majority of initiatives target groups practicing high-risk behaviors, women and youth in the large cities.

Reported AIDS cases:* 18,870
Date of last report: 2/94

Increase over 1993 report:** 42%

Total population: 14,295,501

Cumulative incidence:
1,319.9 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
Not Available
Population at low risk:
10.5 to 14.8%

USAID STRATEGY

The HIV/AIDS prevention component of the Health and Family Planning Project includes four interrelated elements: development of an indigenous NGO to support voluntary testing and counseling and community-based interventions; information, education and communication (IEC) support to provide information on available HIV prevention options, motivate behavior change, and promote appropriate testing and counseling; a condom supply management program to ensure an adequate and reliable supply of condoms; and policy development to promote decentralized intersectoral activities and involvement of the private sector in HIV/AIDS prevention and control. This project is being terminated following USAID's decision to close out the bilateral Côte d'Ivoire program.

USAID-SUPPORTED COUNTRY PROGRAMS

Condom Social Marketing
Population Services International (PSI) is implementing a condom social marketing program that promotes condom use among people practicing high-risk behaviors as well as among the general population. The social marketing program has maintained a high volume of condom sales, selling almost 6 million condoms in 1993, and per capita sales are among the highest in Africa.

Community-Based HIV/AIDS Prevention
In Abidjan, the capital city, a local NGO called ESPOIR-CI has conducted numerous community-based IEC activities and provided anonymous, voluntary HIV testing and counseling in the Center for HIV Information and Prevention (CIPS), the first such facility in West Africa. The center receives between 30 and 40 people a day. An association of seropositive people, Lumière-Action, has been created by women and men who discovered their HIV serologic status through CIPS.

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

HIV IN THE DEVELOPING WORLD

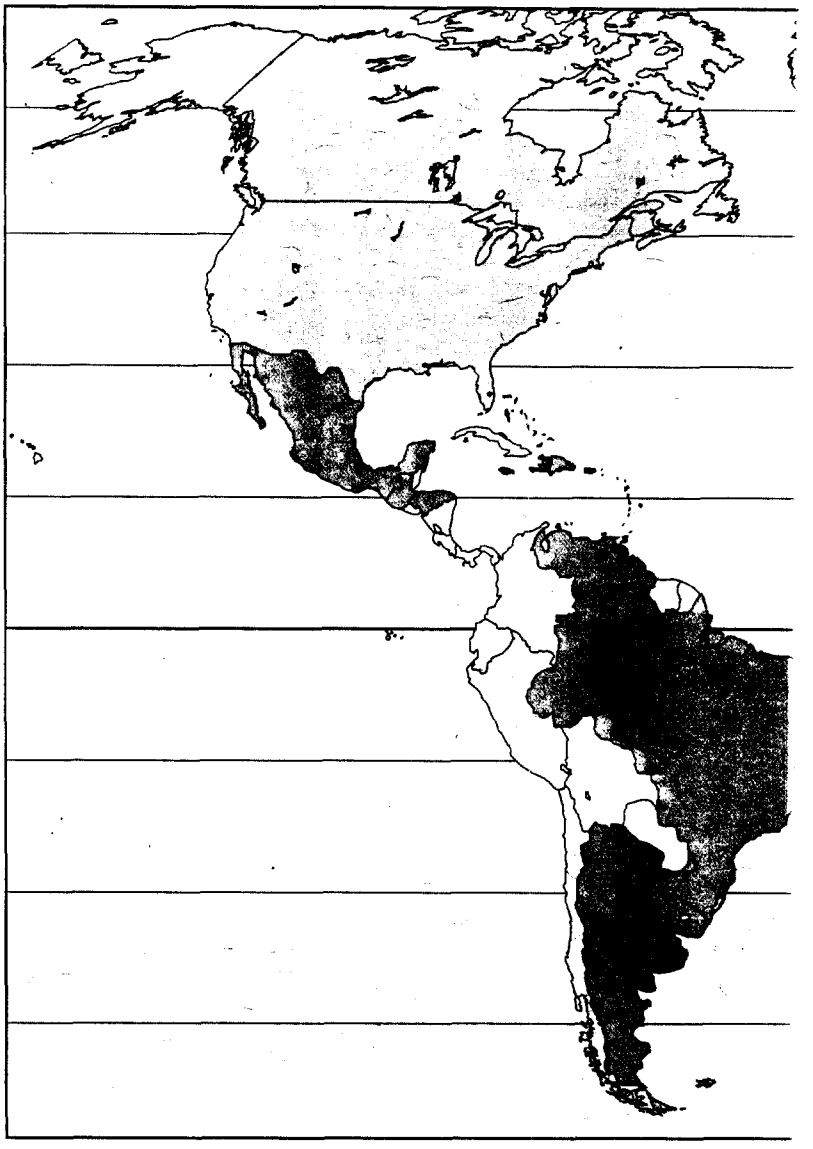
HIV-1 SEROPREVALENCE:* URBAN INDIVIDUALS AT HIGH RISK

The seroprevalence data presented below and in Appendix A are taken from the HIV/AIDS Surveillance Database of the International Programs Center, Population Division of the U.S. Bureau of the Census. They were selected as the best available data on HIV seroprevalence among high-risk populations in urban areas of developing countries. Seroprevalence data are not provided for rural populations because they are not available for many countries. However, it should be noted that HIV seroprevalence rates in rural areas generally are considerably lower than urban rates.

Because surveys of HIV seroprevalence are not based on national samples, seroprevalence estimates have a bias if generalized beyond the sample population. To minimize bias and confusion in using current seroprevalence estimates, the most representative sample estimates were selected according to the following criteria:

- larger samples were generally favored over smaller samples;
- more recent estimates were selected over older estimates; and
- better documented data were selected over poorly documented data; data without documentation were not used.

These criteria only attempt to minimize the biases in the data, not eliminate them. Therefore, all seroprevalence data must be used with caution.



COUNTRIES WITH LOW SEROPREVALENCE RANGE (0.1%–4.9%)

AFRICA	
Gabon	3.7**
Guinea	0.6 – 2.7
Mauritius	0.8**
Madagascar	0.1**
Mozambique	1.2 – 3.0
Senegal	2.3 – 7.3
Sierra Leone	3.3 – 4.8
ASIA AND THE NEAR EAST	
Bahrain	0.0 – 2.9
China, People's Republic	0.0 – 2.7
China, Taiwan	0.0 – 0.4
Egypt	0.8 – 7.6
Korea, Republic of	0.1**
Laos	1.2**
Morocco	1.2 – 7.1
Nepal	1.0 – 1.6
Papua New Guinea	0.0 – 0.3
Philippines	0.1**
Sri Lanka	0.0 – 0.1
Vietnam	0.2 – 8.7

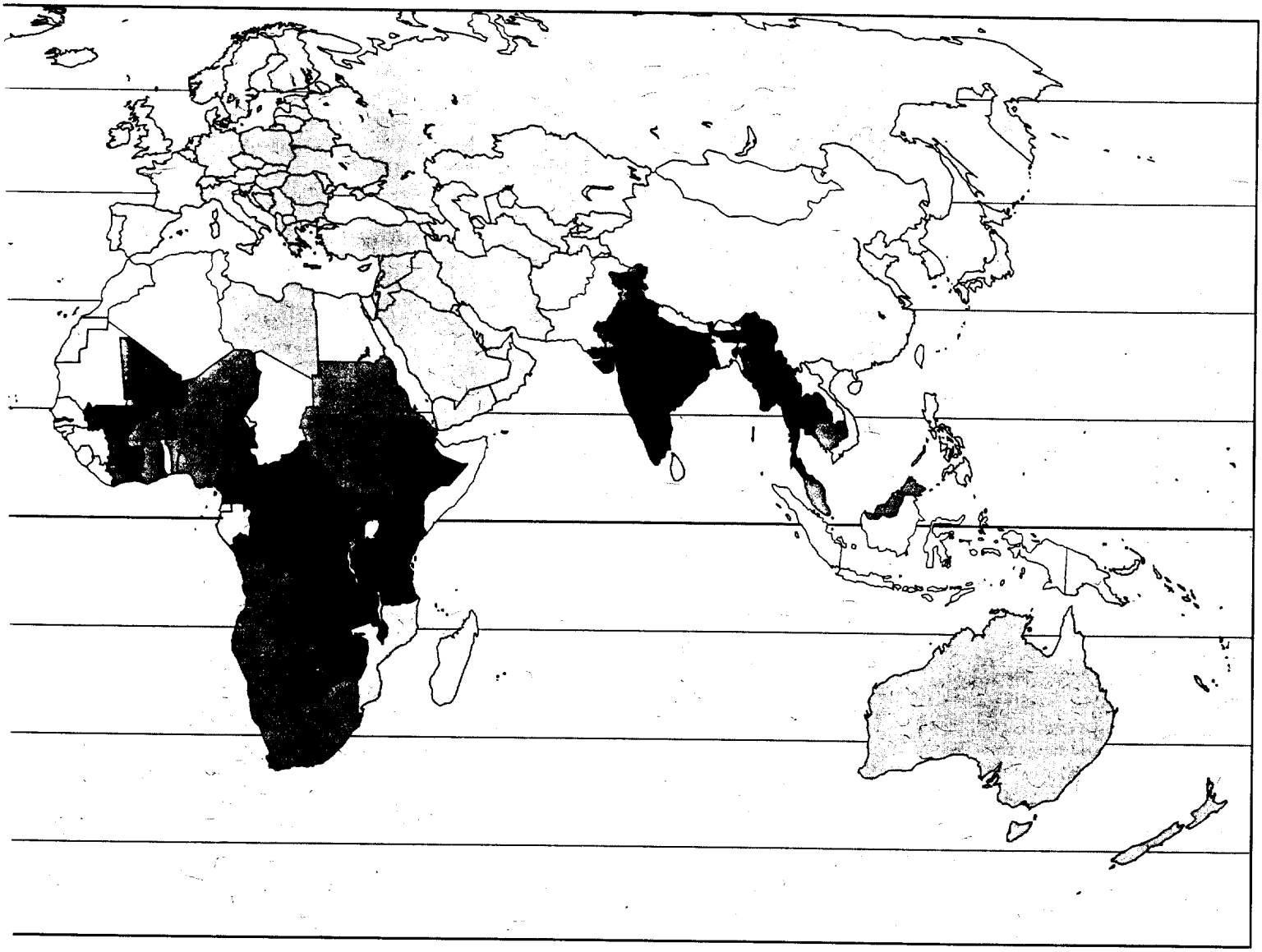
LATIN AMERICA AND THE CARIBBEAN	
Antigua & Barbuda	1.7**
Barbados	4.7**
Chile	1.0**
Colombia	0.1 – 1.1
Costa Rica	0.6 – 2.0
Ecuador	0.5 – 3.6
El Salvador	2.2**
Grenada	0.0 – 2.4
Nicaragua	1.6**
Paraguay	0.1**
Peru	0.3 – 0.6
St. Lucia	1.1 – 4.6
St. Vincent & Grenadines	1.0 – 3.0
Suriname	1.1 – 2.6

COUNTRIES WITH MEDIUM SEROPREVALENCE RANGE (5.0%–24.9%)

AFRICA	
Angola	13.7 – 14.2
Benin	14.3 – 25.3
Burkina Faso	7.9 – 17.2
Burundi	18.5**
Eritrea	5.8 – 31.5
Gambia	4.7 – 13.6
Ghana	8.6 – 37.5
Lesotho	5.2 – 7.1
Namibia	7.2**
Niger	12.6**
Nigeria	8.9 – 17.6
South Africa	16.2 – 24.6
Sudan	17.4 – 24.3
Swaziland	9.9 – 12.6
ASIA AND THE NEAR EAST	
Cambodia	4.1 – 15.0
Malaysia	10.0 – 29.5

LATIN AMERICA AND THE CARIB	
Argentina	6.3
Bahamas	13.4
Brazil	16.1
Dominican Republic	7.8
Guatemala	2.0
Guyana	13.1
Honduras	11.2
Jamaica	4.3
Mexico	5.0
Trinidad & Tobago	10.1
Uruguay	2.6
Venezuela	6.1**

NOTE: Country categories are based on an average of seroprevalence ranges.



COUNTRIES WITH HIGH SEROPREVALENCE RANGES (25.0% AND ABOVE)

AFRICA

Botswana	15.2 – 48.5
Cameroon	26.6 – 45.3
Central African Republic	21.6 – 31.0
Congo	18.5 – 34.3
Côte d'Ivoire	18.4 – 83.7
Djibouti	13.1 – 43.0
Ethiopia	43.6 – 69.4
Kenya	55.9 – 85.5
Malawi	44.1 – 57.2
Mali	41.8 – 74.0
Rwanda	67.2 – 83.1
Tanzania	19.3 – 49.5

AFRICA (continued)

Uganda	41.0 – 52.0
Zaire	30.0 – 35.1
Zambia	58.3**
Zimbabwe	34.4 – 62.5

ASIA AND THE NEAR EAST

Burma	11.4 – 58.0
India	7.6 – 45.0
Thailand	21.8 – 38.2

LATIN AMERICA AND THE CARIBBEAN

Haiti	13.0 – 41.9

* Range of HIV-1 prevalence among samples of urban individuals at high risk, including prostitutes and STD clinic patients. Source: U.S. Bureau of the Census, International Programs Center. (For an explanation of how data were derived, see p. 36.)

** Available data too limited to provide a range.

COUNTRIES WITH NO DATA AVAILABLE

AFRICA

Algeria	Not available
Cape Verde	Not available
Chad	Not available
Equatorial Guinea	Not available
Guinea-Bissau	Not available
Liberia	Not available
Mauritania	Not available
Somalia	Not available
Togo	Not available

ASIA AND THE NEAR EAST

Afghanistan	Not available
Bangladesh	Not available
Bhutan	Not available
French Polynesia	Not available
Indonesia	Not available
Mongolia	Not available
Pakistan	Not available
South Pacific	Not available
Tunisia	Not available

NEW INDEPENDENT STATES

New Independent States	Not available

LATIN AMERICA AND THE CARIBBEAN

Belize	Not available
Bolivia	Not available
British Virgin Islands	Not available
Cuba	Not available
Dominica	Not available
French Guiana	Not available
Montserrat	Not available
Panama	Not available
St. Kitts & Nevis	Not available

Research on Sexual Behavior, Economic Impact and Policy Development
Specialists from the University of Abidjan have completed and published two USAID-funded HIV/AIDS studies. One study assessed the impact of AIDS on major enterprises in Abidjan, and the second provided information about the sexual behavior of youth and young adults in the capital city. Numerous training workshops for selected members of regional AIDS committees and local NGOs were conducted throughout the country to support decentralized HIV/AIDS activities.

ETHIOPIA

SITUATION ANALYSIS

The first AIDS case was reported in Ethiopia in 1987. The number of reported AIDS cases is increasing, although it's thought that there is still gross underreporting. As in other parts of sub-Saharan Africa, the primary mode of transmission is heterosexual. Over 90 percent of cases are in people aged 15 to 49, and the male-to-female ratio of infection is 1.6:1.0. Pediatric AIDS remains largely unrecognized and underreported yet currently represents 1.8 percent of reported cases. HIV seroprevalence among blood donors is 9.7 percent in Addis Ababa, and over the past five years there has been a sharp increase in HIV seropositivity in prenatal patients, with levels of 15.5 percent reported from the preliminary results of a survey conducted in 1993. Among people with multiple sexual partners in several urban centers, HIV rates are 60 to 70 percent.

Reported AIDS cases:* 15,565
Date of last report: 11/94

Increase over 1993 report:** 63%

Total population: 53.75 million

Cumulative incidence:
289.5 per million

HIV-1 seroprevalence in urban areas:*** Not Available

USAID STRATEGY

USAID/Ethiopia's Support to AIDS Control (STAC) Project began in September 1992 and works primarily through the AIDSCAP project. STAC activities are focused on sexually transmitted disease (STD) prevention and control, behavior change communication targeting youth and women practicing high-risk behaviors, condom social marketing, surveillance, training and providing preventive supplies such as disposable syringes and needles, sterile gloves and other protective supplies for health personnel. Intervention teams with public and private sector members are working in four focus urban areas (Awassa, Nazareth, Bahar Dar and Mekele). There is an active nongovernmental organization (NGO) grants program, which encourages grassroots organizations to develop HIV prevention and control activities focusing primarily on out-of-school youth.

USAID-SUPPORTED COUNTRY PROGRAMS

STD Prevention and Control
Working through the National AIDS Control Program and the Regional Health Bureaus, USAID is refurbishing 20 STD clinics nationwide and supporting these clinics with STD drugs and commodities and training in order to improve STD diagnosis and treatment. In the four focus areas, integration of STD services into maternal child health and family planning programs is being promoted. Laboratories have also been strengthened to provide improved diagnostic support.

Condom Social Marketing
Population Services International (PSI) has developed one of the most successful condom social marketing programs on the continent, with sales exceeding 2 million a month. In 1994, over 17 million condoms were sold. It is anticipated that 24 million condoms will be sold in fiscal year 1995.

Behavior Change Communication
AIDSCAP is collaborating with the Ministry of Education to improve and expand HIV/STD communication interventions to reduce risk-associated sexual behavior among youth in Ethiopia. The project targets 25 secondary schools with a total of 100,000 students. Working with students, teachers and guidance counselors, the MOE reviewed and revised existing materials and translated and published 100,000 copies of a new English AIDS booklet called *Know and Act.* 50,000 copies have already been distributed in 15 high schools. The project also offers a referral system for youth seeking treatment for STD-related symptoms. Over 30,000 youth have received AIDS education.

Behavior change communication activities are also being implemented targeting people with multiple sexual partner contacts at four sites and the Addis Ababa region. Nurses and health workers are being trained to train community health agents, group leaders and AIDS communicators to offer HIV/AIDS information and education at worksites. Seminars will be offered for factory managers, government officials, bar owners and other key people at intervention sites to develop institutional and community support.

Working with NGOs for HIV Prevention
Thirteen NGO grants have bee awarded to local and international NGOs. Examples of projects include youth drama groups and video plays, peer educator programs and an AIT hot line. Four training worksho have been held on topics ranging from strategies for behavio change to evaluation skills.

GHANA

SITUATION ANALYSIS

Ghana is at a relatively early sta of the HIV/AIDS epidemic. Tl high rates of sexually transmitt diseases (STDs) in the comme cial sex industry and a tenden toward multiple sex partners, particularly among men, rema major factors in the continuin increase in HIV/AIDS inciden in Ghana. The disease is rapid spreading from the groups, such as commercial sex worke (CSWs), that practice high-ris behaviors into the general po ulation, particularly people ag 15 to 39.

Reported AIDS cases:* 13,709
Date of last report: 6/94

Increase over 1993 report:** 8.2

Total population: 16,000,000

Cumulative incidence:
856.8 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
8.6 to 37.5%
Population at low risk:
4.0 to 6.0 %

USAID STRATEGY

The information, education and communication (IEC) campaign begun in 1991 as a general outreach in AIDS prevention education continued through 1994. Since over 95 percent of Ghanaians are now aware of AIDS and its causes, the campaign has shifted from providing HIV/AIDS information to the general population to promoting sexual behavior change, particularly increasing use of condoms, reducing the number of sex partners and seeking treatment for STDs. Condoms are promoted and distributed by both the public and private sectors. STD treatment is supported through training in both the public and private health sectors.

USAID-SUPPORTED COUNTRY PROGRAM

National AIDS Control Program (NACP)

The NACP provided training in counseling and prevention to health providers and established a national serosurveillance system; in collaboration with the Health Education Unit, coordinated national AIDS awareness month and regional awareness campaigns; and produced and distributed booklets, posters and pamphlets. A total of 5,300,000 condoms were sold by the Ministry of Health through its family planning service delivery points, in fiscal year 1994 (FY 94), more than an 800,000 increase over 1993 sales.

Public Health Laboratories

A national public health reference laboratory and three zonal public health laboratories are being constructed and equipped. Staff are being trained to provide accurate clinical and epidemiological information on the HIV epidemic and STDs. The laboratories should be operational by May 1995.

Ghana Social Marketing Foundation (GSMF)

The GSMF distributed 3,856,000 condoms to the private sector in FY 94. Condoms are sold, at subsidized prices, in all pharmacies and chemists throughout the country. A company-based program is training AIDS counselors as well as distributing condoms for several large industries in Ghana. Condoms are aggressively promoted by the GSMF through mass media, including television, radio, billboards and print advertisements. Raffles, condom nights at night clubs and musical concerts were held to destigmatize condom use. Pharmacists and chemists, identified by the NACP as the primary providers of STD treatment in Ghana, are being trained to provide proper treatment for STDs.

Additional Initiatives

Support was provided to the Noguchi Memorial Biomedical Institute to investigate the use of locally isolated human immunodeficient virus antigen in laboratory diagnosis of HIV/AIDS in Ghana, trace the natural history of HIV-2 infection in Ghanaian infants and children and study the anti-HIV properties of local plants.

KENYA

SITUATION ANALYSIS

HIV prevalence was low in Kenya during the early 1980s, but in the last four years adult HIV prevalence has been increasing rapidly. The National AIDS Control Program estimates that HIV seroprevalence in Kenya's adult population rose from 3.5 percent in 1990 to 5.7 percent in 1993. Findings from preliminary 1994 sentinel surveillance data indicate rates ranging from 11 to 12 percent in urban areas to 4 to 5 percent in rural areas. Within the next decade HIV/AIDS is likely to become Kenya's most serious health problem. Heterosexual contact is the main mode of HIV transmission. Most AIDS cases are among the 25- to 29-year age group for women and the 30- to 34-year age group for men.

Currently there are approximately 160,000 AIDS orphans. Life expectancy is projected to decline from 59 to 43 years for males and from 62 to 44 years for females by the year 2000. The child mortality rate may increase from 115 per 1,000 live births to as much as 137 to 152 per 1,000 within the next few years, reversing three decades of progress. In addition, the burden of treating people with AIDS and HIV-related illnesses in Kenya's hospitals could soon surpass the capacity of facilities to provide adequate treatment. As of August 1993, hospitals were reporting that 40 percent of all hospital beds were occupied by patients with HIV-related infections.

There has been slow but steady progress in the actions of the government, donors and the private sector to undertake effective prevention and control activities and begin to resolve critical policy issues related to HIV/AIDS. Nongovernmental organizations (NGOs), including churches and the private sector, have also begun programs to address the spread of the epidemic and to alleviate the suffering of people with AIDS.

Reported AIDS cases:* 52,000
Date of last report: 10/94

Increase over 1993 report:**
26.3%

Total population: 25.5 million

Cumulative incidence:
2,039.2 per million

HIV-1 seroprevalence in urban areas:*** 11 to 12%

USAID STRATEGY

USAID supports the Government of Kenya's (GOK) HIV/AIDS prevention strategy to reduce the sexual transmission of HIV by changing high-risk sexual behavior; expanding condom promotion, distribution and effective use; and improving the diagnosis, treatment and prevention of sexually transmitted diseases (STDs). For the last 20 years, family planning interventions have constituted a major portion of USAID/Kenya support in the public, private and NGO sectors. HIV/AIDS/STD control efforts funded by USAID will increasingly be built on the strengths of family planning delivery systems. Simulation modeling confirms that integrating HIV/AIDS/STD prevention

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

activities into family planning programs can be an effective strategy—primarily due to the fact that family planning clients are young and sexually active.

USAID-SUPPORTED COUNTRY PROGRAMS

USAID/Kenya works through a number of contractors and grantees, including the AIDS Control and Prevention (AIDS-CAP) Project and various cooperating agencies, to implement the following HIV/AIDS activities:

Policy Dialogue
USAID/Kenya supports interventions that facilitate policy dialogue among political and religious leaders and private sector employers. Technical assistance and training have been provided to planners and policy makers in the private and public sectors to increase awareness of the HIV/AIDS epidemic and its possible impacts on public sector budgets, infant and child mortality rates, and fertility. In particular, USAID has worked to strengthen local capacity to forecast, analyze and use information on the health, demographic and economic impact of AIDS using the AIDS Impact Model. USAID has also supported the development and publication of studies and assessments that review policy implications of the AIDS epidemic at the household, sector and macroeconomic levels.

USAID's support to NGOs includes assistance to a U.S.-based private voluntary organization to strengthen the role of Kenyan churches in the design, implementation, management and evaluation of HIV/AIDS prevention programs and support for the Kenya NGO AIDS Consortium to undertake community-level advocacy and policy work among governmental agencies, NGOs and local organizations in order to promote sustainability.

Capacity Building of NASCP
USAID has worked to build capacity within the National AIDS/STD Control Program (NASCP) and has provided equipment and technical assistance to the NASCP to analyze HIV sentinel surveillance data from 13 urban sites and to support sentinel surveillance in rural sites. USAID has assisted the NASCP secretariat in establishing an HIV/AIDS project database tracking system and has trained staff in use and maintenance of the system.

Behavior Change Communication
USAID-supported activities aimed at changing behaviors include support to a national theater troupe that performs improvisational, interactive plays in worksites, schools and churches; a weekly column in a national newspaper that addresses all aspects of HIV/AIDS prevention and care in a nontechnical format; and the creation and performance of a series of radio soap operas in the form of a situational comedy addressing issues related to HIV and AIDS. In addition, USAID is supporting the initiation of peer education programs at worksites.

Improved STD Diagnosis, Treatment and Prevention
STDs are a serious public health problem that increase the risk of HIV transmission. USAID programs promote improved STD services in family planning clinics and among STD clients. Activities include training family planning providers in syndromic management of STDs, developing a training curricula for an AIDS prevention component in family planning, and upgrading STD treatment services at 10 institutions of higher learning.

Condom Sales
USAID has been the main supplier of condoms to Kenya, providing about 260 million condoms for free distribution through public and private sector channels between 1985 and 1994. In addition, under USAID's social marketing project, a total of 6 million condoms were sold between October 1993 and December 1994. Activities included setting up condom sales points in bars, small shops, supermarkets and pharmacies throughout the country and promoting the purchase and correct use of condoms.

Donor Coordination
USAID/Kenya plays a lead role in coordination with the GOK and other donor-funded projects to avoid duplication of effort and to ensure that resources will be adequate to sustain an expanded HIV/AIDS/STD control program.

LESOTHO

SITUATION ANALYSIS

AIDS was first reported in Lesotho in 1986. There are now 460 reported AIDS cases. Sentinel surveillance data indicate a very rapid spread of HIV infection, not only among high-risk groups such as sexually transmitted disease (STD) patients, but in the general population as well. HIV affects both sexes almost equally, and the level of infection is especially high in people aged 20 to 34. HIV/AIDS is not yet recognized as a problem by the majority of Basotho. In addition, few people know anyone with AIDS or anyone who has died of AIDS. Denial that HIV/AIDS is a problem in Lesotho hinders efforts to prevent and control its transmission.

Reported AIDS cases:* 460
Date of last report: 9/94

Increase over 1991 figures:**
350%

Total population: 1.8 million

Cumulative incidence:
255.5 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
12 to 21%
Population at low risk: 2 to 7%

USAID STRATEGY

USAID/Lesotho, through the centrally funded AIDS Contr and Prevention (AIDSCAP) Project, conducts HIV/AIDS information, education and prevention activities, strength STD services and promotes th sale of condoms in traditiona and nontraditional outlets through a social marketing project. A peer education approach is used to educate youth and community memb about HIV/AIDS and promot behavior change.

USAID-SUPPORTED COUNTRY PROGRAM

Strengthening STD Services Nationwide
USAID supports Ministry of Health (MOH) Disease Cont Unit activities to strengthen Lesotho STD services, includi completion of STD etiology studies, development of STD treatment protocols, training physicians and nurses in new developed STD treatment pr cedures and the development STD materials to support the activities. Establishment of syndromic treatment of STD is expected to reduce rapid increases in the transmission of STDs, including HIV.

Condom Social Marketing
USAID supports a condom social marketing project with a regional approach, promoting a common condom brand, "Lovers Plus," in Lesotho communities as well as South African mines, where a large number of Basotho work. Because of close political and economic ties between Lesotho and South Africa and the fact that Lesotho is totally surrounded by South Africa, the establishment of a regional approach to condom sales and promotion is important. Increased promotion and availability of condoms throughout Lesotho supports all USAID-funded HIV/AIDS interventions.

Prevention of Sexual Transmission of HIV/AIDS through Peer Education
USAID funds two HIV/AIDS prevention through peer education projects in Lesotho. One targets football players and the other targets communities in two districts of the country. Training-of-trainers workshops were conducted in both projects, and the trainers now serve as peer educators in their respective target groups. The football project was launched by the Minister of Health at an exhibition "Footballers Against AIDS" game in conjunction with World AIDS Day activities. The game increased HIV/AIDS awareness, generated interest among young people and was possibly the most visible AIDS activity that has occurred in Lesotho. USAID donated condoms for free distribution at the game. Over 75,000 condoms have been distributed by the two projects, and HIV/AIDS materials have been developed, including a "Captain Condom" comic book that has generated considerable interest among Basotho.

MALAWI

SITUATION ANALYSIS

HIV is spread primarily through heterosexual contact in Malawi. National HIV seroprevalence is estimated at 12 to 14 percent in the adult population. HIV-1 has been detected in all districts, although studies have found higher HIV prevalence among urban populations than in rural areas. One factor contributing to the spread of HIV in Malawi may be the migratory agricultural labor force. Men migrating to urban and semi-urban areas for work are often separated from their spouses for months. Some acquire HIV from commercial sex workers (CSWs) while they are away and transmit it to their wives when they return home.

Reported AIDS cases:* 36,236
Date of last report: 9/94

Decrease over 1993:** 11%

Total population: 9,700,000

Cumulative incidence:
3,735.6 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:****** 30%
Population at low risk: 15%

USAID STRATEGY

The Mission is supporting HIV/STD prevention and family planning services through the bilateral Support to AIDS and Family Health (STAFH) Project. This $45 million project utilizes communication for behavior change, condom promotion and sexually transmitted disease (STD) control as the three principal HIV prevention strategies. Project interventions target youth, STD patients, employed men and bargirls and aim to integrate, where feasible, family planning and HIV prevention services. STAFH uses commercial as well as public channels for service delivery and, through grants, will strengthen the development of HIV prevention and family planning services provided by indigenous nongovernmental organizations (NGOs).

USAID-SUPPORTED COUNTRY PROGRAMS

AIDS Policy and Advocacy
Prior to 1994, when the term of the current government of Malawi began, political leaders rarely mentioned HIV or AIDS. In August 1994, the vice president and president held a national press conference and AIDS briefing and led a public march that gave a high profile to the HIV/AIDS crisis. Both wore red ribbons signifying that they knew someone who had AIDS or who had died of AIDS. The red ribbon campaign is continuing with the assistance of Family Health International (FHI) and Save the Children and has extended beyond urban areas into the countryside.

Strengthening STD services
STDs were the fourth most common complaint of adults visiting outpatient departments in Malawi in 1991. However, a study conducted in 1994 showed that at least one-third of the STD patients received ineffective treatment and 60 to 80 percent of STD clinic clients were HIV-positive. During the last two years, new national STD treatment guidelines have been developed based on cost-effectiveness studies of different antibiotic regimes. The new guidelines use the World Health Organization-recommended syndromic approach to the diagnosis and management of STDs. A national training-of-trainers workshop on this method was held in December 1994. Pilot sites were selected for the use of the new drugs and for the launching of the syndromic approach to the treatment. Training courses will be conducted on a national level in 1995.

Promoting Condom Use
In April 1994 USAID signed a three-year cooperative agreement with Population Services International (PSI). On September 2, 1994, the socially marketed condom, CHISANGO (meaning shield) was introduced to the Malawian market. After only five months, the CHISANGO program had sold 1.2 million

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

condoms, surpassing its annual sales target of 1 million condoms. In 1995 the German Development Bank (KfW) is expected to cofund contraceptive social marketing, which will help expand national coverage.

AIDS Education in Schools
USAID began assisting the Government of Malawi with AIDS education in 1989. Four teacher's guides and nine learner's handbooks were completed in 1990. More visible support of the National AIDS Control Program (NACP) from the current administration has led to a renewal of efforts to implement the AIDS curriculum. With the assistance of FHI, additional supplies were printed in 1994; one-day seminars were planned for January 1995 by the Ministry of Education to orient teachers and headmasters from all of Malawi's 3,000 primary schools. Next steps include assessing data from the evaluation of the teacher training program, training secondary school teachers, working with the Malawi Institute of Education to ensure that HIV/AIDS and STD information is included in the curricula of all relevant subjects for standards 5 to 8, and evaluating the use of the curriculum as well as its impact on knowledge.

Increased Access to HIV/AIDS Education and Counseling
During the past five years, the NACP, NGOs and donors have carried out a number of activities to bring HIV/AIDS to the public's attention and mobilize support at the local level for AIDS prevention and behavior change. USAID has cosponsored training courses for religious communities from 22 different churches and mosques (about 150 participants) with Project Hope; developed a youth-targeted radio soap opera series with HIV/AIDS risk-reduction messages; developed educational materials targeting bargirls, persons with STDs and health workers with FHI and the European Community AIDS Project; held workshops for local musicians, which produced several songs on HIV/AIDS-related topics; and conducted HIV/AIDS workshops held for media personnel, which resulted in an increase from one to four HIV/AIDS-related articles per week in the national newspaper.

MOZAMBIQUE

SITUATION ANALYSIS

As of June 1993 a total of 826 AIDS cases have been reported to the World Health Organization in Mozambique. According to the national coordinator of the AIDS/STD Program, there may be as many as 1,600 AIDS cases and 200,000 HIV-infected people in Mozambique. Currently the number of AIDS cases is doubling every eight months. During the last three years, 47 percent of cases have been found in the central region and 45 percent in the southern provinces. The infection ratio between men and women is roughly equal, suggesting that heterosexual transmission is the prevalent mode of transmission.

Three main population groups are believed to be at risk of HIV infection: soldiers, displaced people and sexually transmitted disease (STD) patients. Mozambique has a much lower number of AIDS cases than its neighboring countries, but this may be because of misdiagnosis and underreporting. The government is trying to address the issue of HIV infection among refugees and populations living near the borders with high-prevalence neighboring countries.

USAID STRATEGY

USAID supports the four-year National AIDS Control Program's focus on preventing sexual transmission of HIV and transmission through blood, care and social support for HIV-infected people, program planning, management, monitoring and evaluation, and STD/AIDS/HIV epidemiological surveillance. The health education component offers information and education not only to patients attending health facilities for diagnosis and treatment of STDs and their partners, but to student groups, health workers, truck drivers and sex workers. Through international private voluntary organizations and nongovernmental organizations, the information and education component also targets displaced and repatriated populations.

USAID-SUPPORTED COUNTRY PROGRAMS

Condom Social Marketing
USAID and the Netherlands are supporting Population Services International's (PSI) two-year condom social marketing and information, education and communication (IEC) project, focused in Maputo City, Beira, Chimoio and Tete. In addition, a collaborative project with the Ministry of Health (MOH) provides the National AIDS Control Program with 5 million condoms a year and supports an IEC advisor to the Mozambican NGO, AMODEFA, for family planning, STDs and HIV/AIDS. This three-year, $29,500,000 Primary Health Care Support Project is due to end in 1997. Design of a family health project that will focus on child survival and reproductive health is planned for fiscal year 1996.

NIGER

SITUATION ANALYSIS

Niger has an estimated population of over 8 million. About 16 percent of the people live in the urban centers. Data from the few HIV prevalence studies conducted in the country show HIV prevalence of less than 1 percent in the general population. A World Bank study conducted in Niamey in 1993 found HIV infection rates of 2.6 percent among pregnant women and 15.4 percent among commercial sex workers. As of 1993, 1,262 AIDS cases had been reported in Niger; 809 of them were in the capital city of Niamey.

Reported AIDS cases:* 1,262
Date of last report: 12/94

Increase over 1993 report:**
Not Available

Total population: 8 million

Cumulative incidence:
157.7 per million

HIV-1 seroprevalence in urban areas:*** Not Available

USAID STRATEGY

Through the AIDS Control and Prevention (AIDSCAP) Project, USAID is developing a comprehensive AIDS and sexually transmitted disease (STD) prevention, counseling, education and behavior change program targeting 1,000 women with multiple partners and 800 truck drivers and STD patients; expand condom distribution; and improve STD treatment and diagnosis at the directorate of epidemiological surveillance in the Ministry of Public Health.

USAID-SUPPORTED COUNTRY PROGRAMS

Peer Education and Community Outreach
Implemented by the Niger

Directorate of Surveillance, Epidemiology and Prevention (DSEP), this project targeted truck drivers, STD patients and commercial sex workers through peer education, condom promotion and distribution and improved STD treatment. Project staff were trained in HIV/AIDS communication and counseling skills, DSEP laboratory technicians were trained in STD diagnostic techniques, and clinic staff were trained in STD diagnosis and treatment. Twenty-nine CSWs in eight urban communities of Niamey were trained as peer educators. With assistance from DSEP trainers, the educators conducted 195 HIV/AIDS education sessions.

The end-of-project knowledge, attitude, behavior and practices survey indicates that 90 percent of CSWs are using condoms with their clients and 50 percent of truck drivers, migrants and STD patients report using a condom with their last occasional partner.

NIGERIA

SITUATION ANALYSIS

Nigeria is at an early stage of the epidemic. The country's low number of AIDS cases are concentrated in urban areas. However, the low number of cases may be a result of underreporting and misdiagnosis. There are some reports of a dramatic increase in the rate of infection: in one region, seropositivity rates of over 50 percent have been reported among commercial sex workers (CSWs). The nation has a long tradition of private voluntary organization activity in the health sector. Nigeria, like much of Africa, struggles with a deteriorating infrastructure and a rapidly growing young population.

Reported AIDS cases:* 1,148
Date of last report: 04/94

Increase over 1993 report:**
216%

Total population: 95,600,000

Cumulative incidence:
12 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk: 21.3%
Population at low risk: 3.35%

USAID STRATEGY

USAID works through the AIDS Control and Prevention (AIDSCAP) Project, continuing a relationship established under the joint AIDS Public Health Communication (AIDSCOM) and AIDS Technical Support (AIDSTECH) Project. The cornerstone strategies are controlling sexually transmitted diseases (STDs), promoting use of condoms (USAID is the primary supplier of condoms in Nigeria), and providing behavioral incentives to limit the number of sex partners. Subgroups of the population practicing high-risk behaviors, including CSWs and long-distance drivers, are the focus of many interventions. Programs are concentrated in three states: Lagos, Cross River and Jigawa. USAID also obtains some technical assistance from the U.S. Centers for Disease Control and Prevention (CDC).

USAID-SUPPORTED COUNTRY PROGRAMS

Calabar Commercial Sex Worker Project

One of the largest continuing projects carried over from the AIDSCOM/AIDSTECH Project, the Calabar Commercial Sex Worker Project has provided HIV/AIDS education to nearly 5,122 commercial sex workers (CSWs) and 200 of their partners since 1989. At the project's onset, 25 percent of the CSWs had never used condoms; after one year of intervention, this figure fell to less than 3 percent. The project distributed 770,000 condoms between 1992 and 1994. It is being expanded under AIDSCAP to include counseling, support groups, peer outreach and education and will reach an estimated 6,000 CSWs and 100,000 of their partners. Similar projects with CSWs are being developed in Lagos and Jigawa states.

Long-Distance Truck Drivers in Jigawa and Cross River

The Jigawa State Long-Distance Drivers Project, implemented by the STOPAIDS Organization, aims to reduce risk-associated behavior among the drivers and motorpark users at two locations—Hadejia and Kazaure—through a peer education program, information dissemination and a condom distribution system. The Society against the Spread of AIDS (SASA) is implementing a similar project in Cross River State among motorpark and boat dock users at 20 different locations. SASA staff and transport union leaders work at health booths in Calabar and Ikom to provide information on HIV/AIDS/STD and promote health-seeking behaviors.

HIV/STD Prevention among Young Adults

Nigeria has a large number of university students, many of whom are sexually active and at risk of acquiring STDs or HIV. The Nigerian Youth AIDS Program of the University of Calabar is implementing a project in Cross River State to reduce risk-associated behaviors among post-secondary school youth through peer education, information dissemination and counseling, information, education and communication (IEC) materials production and distribution, improved STD services and condom distribution. The Jigawa State Youth AIDS Programme of the College of Education at Gumel conducts a similar project in Jigawa State, using peer education to promote safe sex practices, prompt diagnosis and treatment of STDs, and condom use in five post-secondary institutions.

RWANDA

SITUATION ANALYSIS

Rwanda, with a population of over 7 million, has an estimated HIV seroprevalence of 30 percent in the capital of Kigali, 10 percent in large towns and approximately 2 percent in rural areas. Civil war plagues the country. An estimated half million Rwandans have died,

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

2 million have fled to neighboring countries and large segments of the remaining population are displaced.

Following the civil war of April 1994 in Rwanda, U.S. Embassy and USAID Mission operations were suspended.

Reported AIDS cases:* 10,706
Date of last report: 8/93

Increase over 1993 report:**
Not Applicable

Total population: 7 million

Cumulative incidence:
1,529.4 per million

HIV-1 seroprevalence
in urban areas:***
Population at high risk:****
Not Available
Population at low risk:
Not Available

USAID STRATEGY

Many of the experiences gained in Rwanda are being applied to HIV/STD prevention activities within the Rwandan refugee camps in Tanzania. Resumption of activities in Rwanda will depend on improvement of conditions in the country.

USAID-SUPPORTED COUNTRY PROGRAMS

Condom Social Marketing
Population Services International (PSI) implemented a nationwide condom social marketing program, which was exceeding expectations at the time of evacuation. In April 1994, PSI was working in all urban centers and averaging condom sales of over 100,000 a month.

Refugee Program
This intervention in the Benaco camps in Ngara, Tanzania targets the refugee population with community peer education, condom promotion and distribution, and improved management of sexually transmitted diseases (STDs). CARE International has recruited AIDS community educators (ACEs), many of whom had worked in a similar capacity in displaced person camps in Rwanda, from among the refugee population. The ACEs will be mobilized to teach and reinforce messages about AIDS prevention, condom promotion and use, and health-seeking behavior. The AIDS Control and Prevention (AIDSCAP) Project will work with the African Medical Relief Foundation (AMREF) to adapt STD treatment guidelines for use in outpatient departments. Condoms will be available at clinic sites. CARE and PSI will support this activity with condom procurement and distribution both through the clinics and in the community. HIV and STD prevention will be promoted in the adjoining towns as well as in the refugee camps.

SENEGAL

SITUATION ANALYSIS

The HIV/AIDS epidemic is at an early but potentially explosive phase in Senegal. Not only is the country contending with a growing epidemic of HIV-1, but there is also a significant level of HIV-2 infection. Blood donors and women seeking prenatal care in urban areas have levels of HIV-1 and HIV-2 infection below 1 and 2 percent, respectively. Infection levels among people seeking treatment for other sexually transmitted diseases (STDs) range from 1 to 4 percent. The highest rates of HIV infection—an average of 16 percent—are found among commercial sex workers (CSWs).

Reported AIDS cases:* 1,445
Date of last report: 12/94

Increase over 1993 report:** 20%

Total population: 8,100,000

Cumulative incidence:
178.3 per million

HIV-1 seroprevalence
in urban areas:***
Population at high risk:****
2.0 to 7.3%
Population at low risk:
0.1 to 0.3%

USAID STRATEGY

Since 1985, USAID/Senegal has provided more than $2 million in support of AIDS prevention and control efforts in Senegal, primarily through its Family Health and Population Project. In June 1992, USAID/Senegal, working through the AIDS Control and Prevention Project (AIDSCAP), developed a project to provide comprehensive assistance to the National AIDS Prevention Program. The project's purpose is to reduce high-risk behaviors within target groups and strengthen service delivery to reduce the spread of HIV and other STDs. Through the AIDSCAP project, USAID is also acting as a catalyst for governmental and nongovernmental agencies, communities and individuals in setting up a national HIV prevention program.

USAID-SUPPORTED COUNTRY PROGRAMS

Senegal AIDS Control and Prevention Project
The Senegal AIDS Control and Prevention Project was initiated to reduce the rate of sexually transmitted HIV infection among groups whose behavior places them at high risk of infection. AIDSCAP responding to the Government of Senegal's wish to focus in regions with the greatest potential for the spread of the epidemic is implementing prevention activities in Dakar, Kaolack, Ziguinchor and Thies. The project will focus primarily on urban populations, with possible expansion of successful interventions to different geographic settings.

Behavior Change Communication
USAID is funding radio and television spots, distribution of posters and press releases, information and education conferences, sporting and cultural events, and meetings of political, administrative and religious leaders to raise awareness about HIV/AIDS and encourage behavior change to reduce HIV transmission.

Policy Dialogue
AIDSCAP has completed an AIDS opinion study of religious and political leaders. The leaders interviewed expressed their willingness to collaborate in an AIDS awareness campaign targeting the general population. A seminar, "AIDS and Religion: the response of Islam," was also planned as a collaborative effort between USAID, the National AIDS Prevention Committee and a local NGO for March 1995.

Sentinel Surveillance
Eight STD and four HIV/AIDS sentinel surveillance sites have been established to monitor seroprevalence levels. More than 1,500 commercial sex workers are being tracked through STD clinics and laboratories.

STD Control and Condom Social Marketing
Health workers are being trained to use algorithms in STD diagnosis. Since 1985, USAID has provided the National AIDS

Prevention Committee with more than 7 million condoms for distribution to CSWs, STD patients and young adults through clinics and during events such as World AIDS Day.

SOUTH AFRICA

SITUATIONAL ANALYSIS

The first AIDS case in South Africa was reported in 1982. Initial cases were concentrated in the homosexual population and accounted for 66 percent of all AIDS cases from 1982 to December 1989. Since 1988 the number of heterosexually transmitted cases has increased from 23 percent in 1989 to 72 percent in 1992, reflecting the epidemic's shift from a minority population to the majority population of South Africa. Pediatric AIDS cases account for 12 percent of all AIDS cases.

A total of 3,057 AIDS cases have been reported through December 30, 1994, and there are approximately 500 new HIV infections daily. The epidemic is progressing rapidly through the country, and the rate of new infections is estimated to be doubling every 11 to 13 months. Based on annual national surveys of antenatal clinic attenders, the epidemic is most advanced in KwaZulu/Natal where the prevalence was 9.6 percent in November 1993 compared to 4.1 percent in the Orange Free State (OFS), 3.1 percent in Transvaal, and 1.3 percent in the Cape. The virus is spreading most rapidly among youth and young adults ages 15 to 30.

Reported AIDS cases:* 3,057
Date of last report: 12/94

Increase over 1993 report:** 46%

Total Population: 38,000,000

Cumulative Incidence:
80.4 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:****
2 to 20 percent
Population at low risk:
0 to 5 percent

USAID STRATEGY

The Mission's HIV/AIDS strategy has been to support educational efforts in three areas: prevention of HIV/AIDS through sexual transmission; reduction of the impact of HIV/AIDS infection of individuals, groups and societies; and the prevention of perinatal transmission. Due to the Comprehensive Anti-Apartheid Act (CAAA) and Transition to Democracy (TDD) restrictions, USAID has only funded the HIV/AIDS prevention education efforts of local nongovernmental organizations (NGOs). The Mission's Community Outreach and Leadership Development (COLD) Project has provided grant money to a number of NGOs, as well as other organizations involved in management assistance and other capacity building initiatives. Nine national, regional and local NGOs are funded directly by USAID/South Africa for HIV/AIDS prevention education and control activities.

USAID-SUPPORTED COUNTRY PROGRAMS

AIDS Education and Training
The National Progressive Primary Health Care Network (NPPHC) established a National AIDS Program in 1991 and opened offices in eight regions and several subregions in South Africa. Staffed by a cadre of Community AIDS Workers, NPPHC provides training for community leaders in HIV/AIDS prevention and promotes care and support for persons living with HIV/AIDS. The South African Black Social Workers Association (SABSWA) provides training in HIV/AIDS counseling techniques for its members and other community organizations.

Community Outreach
USAID is supporting five NGOs to conduct community outreach and AIDS awareness activities in rural and informal settlement areas. The interventions, designed and implemented by individuals who are members of the communities being served, will target the general population and individuals at increased risk for HIV infection, such as youth and women.

Youth Intervention
Four NGOs provide peer-led HIV/AIDS prevention education to youth in urban, rural and informal settlement areas. The education activities include discussions on sexuality, sexually transmitted diseases (STDs), reproductive health, values clarification and decision making skills. The NGOs have involved youth in the design and implementation of the prevention education activities. Youth are trained as peer educators to conduct workshops and small group presentations in schools, clinics and youth organizations.

Capacity Building and Technical Assistance Support
USAID provides technical assistance support for enhancing the capacity of organizations to design, implement and manage HIV/AIDS prevention efforts. Assistance has mainly taken the form of short-term technical assistance in program planning, implementation and evaluation through a Participating Agency Service Agreement (PASA) with the U.S. Centers for Disease Control and Prevention (CDC). Five USAID-funded NGOs involved in school-focused and community outreach activities attended a series of program planning and evaluation workshops conducted by the CDC in October 1993. Training and technical assistance support in institutional development has been provided through an agreement with Private Agencies Collaborating Together (PACT). PACT assists NGOs in the areas of strategic planning, resource allocation, staff and policy development and fundraising. An agreement with Health Systems Trust will support the infrastructure of the new National Department of Health through training opportunities and staff development.

AIDSCAP Program
In addition to providing assistance in the areas of program design and implementation, AIDSCAP has conducted two

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

major HIV prevention programs: Project CHAMPS, a home-based care and support program for HIV infected mothers and their children, and a HIV/AIDS/STD training program for traditional healers. AIDSCAP will also establish a network of resource centers to distribute educational materials and assist local organizations to prepare and design materials. A small grants program will provide funding to NGOs and community-based organizations to conduct comprehensive integrated HIV prevention activities and establish coalitions to strengthen HIV prevention programs in South Africa.

Strategic and Implementation Plan
The National AIDS Convention of South Africa (NACOSA) was established in 1992 as part of an effort to mobilize and coordinate national efforts to combat HIV/AIDS. NACOSA has representatives from a broad range of government, political, workplace, AIDS service, and civic organizations. The national AIDS strategy, adopted by the Government of National Unity in August 1994, was drafted at a NACOSA conference in July 1994. The overall goal of the plan is to "reduce the transmission of STDs, including HIV, and provide appropriate treatment, care and support for those infected and affected through collaborative efforts within all levels of government and outside of government." NACOSA will promote and monitor the implementation of the National AIDS Plan by AIDS service organizations within South Africa. NACOSA will also facilitate regional coalition development and representation in national policy formulation. Funding from USAID will support the capacity building efforts of NACOSA on national and regional levels.

HIV/AIDS Legal and Ethical Issues
In 1993 the AIDS Consortium, a project of the Center for Applied Legal Studies at the University of the Witwatersrand, developed a charter for AIDS and HIV. The charter was designed to address the basic human and legal rights of individuals living with AIDS and HIV-infected and affected individuals. The charter has been instrumental in establishing the foundation for antidiscriminatory practices and policies for persons living with HIV/AIDS in South Africa.

TANZANIA

SITUATION ANALYSIS

Tanzania's HIV/AIDS epidemic is severe and in many areas of the country has moved from groups practicing high-risk behaviors to the general population. Heterosexual contact is the primary means of transmission. Estimated HIV seroprevalence is 5.6 percent for males and 6.3 for females and ranges from 6.7 to 27.2 percent at antenatal clinics in different regions of the country. Infection rates are as high as 55.7 percent among groups who engage in high-risk behaviors along major trucking routes. The National AIDS Control Program (NACP) projects that there will be 800,000 AIDS cases and 2.4 million HIV-positive Tanzanians by the year 2000.

Tanzania's children are severely affected by the epidemic. Based on conservative assumptions, the NACP estimates that Tanzania could have a total of 1 million orphans by the end of the decade. The U.S. Census Bureau's 1994 projections for Tanzania indicate that by 2010, the infant mortality rate will increase by 30 percent, the child mortality rate will rise by more than 50 percent and life expectancy at birth could decline from 51 to 35 years due to HIV/AIDS.

Reported AIDS cases:* 42,422
Date of last report: 10/93

Increase over 1991 report:** 24%

Total population: 27,500,000

Cumulative incidence:
1,542.6 per million

HIV-1 seroprevalence in urban areas:*
Population at high risk:****
31 to 55.7%
Population at low risk:
6.7 to 27.2%

USAID STRATEGY

The Tanzania AIDS Project (TAP) is a five-year, $20 million contract funded by USAID through the AIDS Control and Prevention (AIDSCAP) Project. Initiated in July 1993, TAP aims to reduce the impact of AIDS on Tanzanian society by increasing practice of HIV preventive measures and ensuring the provision of adequate support services to orphans and their families. TAP is one of the few U.S.-funded, African AIDS projects with programs to alleviate the impact of AIDS on individuals, communities and families.

TAP focuses on increasing condom use, reducing the prevalence of sexually transmitted diseases through improved health-seeking behavior and provider performance, and encouraging sexual risk reduction behavior. Its primary implementation strategy is to develop coordinating networks of groups, or clusters, of nongovernmental organizations (NGOs) in all regions of Tanzania and strengthen their capacity to provide HIV-prevention services to communities and worksites.

USAID is also working with the private sector to provide AIDS education and condom social marketing to people in the workplace. USAID has been the sole source of public sector condoms in Tanzania for the past five years, but condom supply is gradually shifting to the private sector. In 1995, the United Nations Population Fund (UNFPA) will assume responsibility for public sector condom supply in Tanzania.

USAID-SUPPORTED COUNTRY PROGRAMS

Condom Social Marketing
In TAP's first year of operation, national condom social marketing and distribution systems were established throughout the country. Sales totalled 3.8 million by December 31, 1994—almost twice the first-year target. The NACP is also receiving technical assistance to improve the logistics system for public sector condom distribution. Population Services International (PSI), AIDSCAP's subcontractor for condom social marketing, distributes Salama condoms through a local feminine products manufacturer backed by a network of eight regional distributors to supply small shops and stalls. PSI launched the national condom sales campaign on World AIDS Day 1993. The sales campaign is supported by a television, radio and print media campaign launched during the World Cup matches broadcast in Tanzania.

NGO Capacity Building
After completing a national assessment of NGO activities in June 1994, TAP developed a strategy for regional expansion. Through contracts with national and international NGOs, NGO clusters have been initiated in

four regions and will be expanded into four more regions in 1995. The eight regions represent approximately 47 percent of Tanzania's population, but proportionately more people with HIV/AIDS because high prevalence regions were selected. NGO capacity is being developed to provide HIV/AIDS prevention services, administer funds and develop contracts with local businesses. Each cluster is expected to be self-sufficient by the end of the second year of operation. The clusters allow for coordination of geographic and technical coverage and collaboration in addressing training needs and planning for new services.

Worksite Prevention Programs
TAP is working with an independent businessmen's coalition in Iringa and several national business organizations to develop a model to define business HIV/AIDS prevention needs and marketing approaches. A national strategy to market AIDS prevention to business managers will be launched in 1995. TAP is also supporting 46 worksite programs implemented in collaboration with the African Medical Research Foundation (AMREF), the Organization of Tanzanian Trade Unions (OTTU), and the Tanzania Council for Social Development (TACOSODE), an umbrella group of NGOs.

UGANDA

SITUATION ANALYSIS:

Uganda, a landlocked nation with a population of 19 million, is experiencing a severe AIDS epidemic. An estimated 1.5 million citizens are infected with HIV. The government and the people of Uganda have responded with extraordinary openness and candor, and have developed pioneering approaches to HIV prevention and care for people with AIDS.

Largely as a result of AIDS and its effects on adult and infant deaths, the U.S. Census Bureau projects that in Uganda, life expectancy at birth is now 37 and could decline to 31.5 by 2010. It is believed that 1 million children have already lost at least one parent to AIDS. As an increasing number of Ugandans become ill with HIV and AIDS and, as the number of orphans grows, the coming decade will see profound deterioration in the quality of life for many Ugandan families.

In the midst of this catastrophe, encouraging trends are emerging. For several years, there has been some evidence of behavior change, including dramatic increases in the demand for condoms, apparent declines in average number of partners, and changes in social norms to discourage multiple and casual sexual partners.

Reported AIDS cases:* 46,120
Date of last report: 1994

Increase over 1993 report:** 5.12%

Total Population: 19.8 million

Cumulative incidence: 2,329.2 per million

HIV-1 seroprevalence in urban areas:*** 10 to 25%

USAID STRATEGY

USAID's strategy in Uganda has emphasized community-level education, voluntary HIV testing and counseling, condom promotion, STD control, and integration of supportive care and prevention counseling for people living with HIV/AIDS. To implement these interventions, USAID has worked with a wide range of groups, including the Ugandan military, the Ministry of Health, and Protestant and Islamic leaders and organizations. Since 1991 much of USAID activity in Uganda has been managed under an umbrella grant to World Learning, Inc. (WLI), which has supervised a total of 14 grants to local organizations.

Data from USAID-funded projects and from AIDS research in Uganda indicate that women in Uganda are at high risk for HIV infection. Among clients who come for HIV testing and counseling, HIV infection rates are significantly higher in women than in men across all age groups; the difference in infection rates is particularly great among younger clients. USAID-funded projects are working to develop more effective strategies to meet the special needs of women.

USAID-SUPPORTED PROGRAM ACTIVITIES

HIV Testing and Counseling
With USAID's technical and financial support, the first anonymous testing and counseling center in sub-Saharan Africa was established in Kampala in 1990. By the end of 1994, over 195,000 Ugandans had received HIV testing and counseling through the AIDS Information Center (AIC). In 1994 alone, almost 70,000 clients were served. In addition to the original center established in downtown Kampala, centers have now been opened in Jinja, Mbarara and Mbale, and 23 "satellite" centers now offer services one or more days weekly in suburban and rural locations. Condom use has increased dramatically over time. AIC has sponsored "Post-Test Clubs," which are offering counseling, prevention education, limited medical care and social activities designed to reinforce behavior change. Open to all clients regardless of serostatus, these clubs are now active in Kampala, Jinja and Mbarara. Over 10,000 AIC clients have attended at least one function at a club, and over 500 clients attend at least one per month.

Care and Support for Persons living with HIV/AIDS
The AIDS Support Organization (TASO) was founded in 1987 to provide counseling, medical care, and advocacy for people with AIDS. TASO has also provided national leadership to respond to the problems created by the epidemic in Uganda and international leadership to spread these lessons elsewhere in the developing world. This grassroots effort, which started as a group of 16 Ugandans who either had AIDS or had family members with AIDS, is now known throughout the world as

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

one of the leading AIDS service organizations. By the end of 1994, TASO had eight centers throughout the country and had served over 26,000 clients. If one considers the family members of each client, the organization probably has served well over 75,000 Ugandans. TASO uses an innovative approach that emphasizes "living positively with AIDS" and teaches HIV-positive people and their families how to prevent further HIV transmission.

Prevention through Religious Leaders
Since 1992, USAID has provided technical assistance and funding to religious groups initiating HIV/AIDS prevention projects. Protestant and Islamic groups are now training ministers and imams in pilot districts in communication and counseling skills as well as basic AIDS information. Once trained, these religious leaders then train lay workers in their churches and mosques who have consistent contact with families in their areas. By the end of 1994, these lay workers reported over 1 million contacts with community residents.

AIDS Prevention for the Military
In collaboration with WLI, USAID is funding an AIDS prevention project serving the National Resistance Army. USAID support for AIDS prevention in the army dates back to 1988. Under the current project, army personnel and civilians on assignment to WLI are trained as AIDS educators and counselors to serve in the four major divisions in the country in Kampala, Mbarara, Mbale and Gulu. All soldiers, dependents and civilians living in the vicinity of military establishments are eligible to receive services.

Collaboration with the National STD/AIDS Control Programme
USAID has been providing funds and technical assistance since 1988 to the STD/AIDS Control Programme implemented by the Ministry of Health. These funds primarily have been used to support information, education and communication, control of sexually transmitted diseases, HIV surveillance, epidemiology, program management and monitoring, and technical assistance.

ZAMBIA

SITUATION ANALYSIS

Zambia is one of the African countries most affected by HIV/AIDS. At an estimated 24 percent, HIV seroprevalence rates in Zambia rank among the highest in the world. The growing number of people with HIV/AIDS-related illnesses exacerbates problems in the already deficient delivery of health care services and represents a major constraint to the country's economic development prospects.

Seroprevalence among pregnant women, blood donors and new sexually transmitted disease (STD) clinic patients is extremely high. STD patients are particularly at risk, with infection rates ranging from 30 to 71 percent. At least 50 percent of patients in medical wards of major hospitals have AIDS-related diseases. The pandemic further threatens the country's economic stability—which already suffers from a shortage of trained personnel—because HIV infection frequently occurs among the most productive, educated segments of Zambian society. HIV/AIDS has reduced the probability that a Zambian child born in 1994 will survive to age 30 from approximately 90 to 30 percent. It is estimated that by the year 2020, half of all mortality in Zambia will be due to AIDS and life expectancy will drop from 66 to 33 years.

Reported AIDS cases:* 29,734
Date of last report: 10/93

Increase over 1993 report:** 22%

Total population: 7,800,000

Cumulative incidence:
3,812 per million

HIV-1 seroprevalence in urban areas:*
Population at high risk:****
33.0 to 54.0%
Population at low risk:
24.5 to 30.0%

USAID STRATEGY

The Mission supports the Government of Zambia's (GRZ) country-wide strategy developed by the National AIDS Prevention and Control Program (NAPCP) to reduce the incidence of HIV transmission. USAID is implementing a HIV/AIDS prevention project that finances technical assistance, training and commodities through the Ministry of Health (MOH) and various private voluntary organizations (PVOs) and nongovernmental organizations (NGOs). The main project activities, which began in fiscal year 1994, include public health education targeted at workers, youths, traditional healers and the media, voluntary HIV testing and counseling, condom social marketing, STD control and policy development.

USAID-SUPPORTED COUNTRY PROGRAMS

Condom Social Marketing
USAID funding supports a joint-venture between Population Services International (PSI) and the Pharmaceutical Society of Zambia (PSZ), a local NGO that has been doing social marketing in Zambia since 1985. Since the condom project was launched in December 1992, more than 11 million high-quality, low-priced Maximum condoms have been sold in all nine Zambian provinces through traditional outlets such as pharmacies and drug stores and such nontraditional outlets as department stores, grocery stores, hotels, bars, nightclubs, barbershops and filling stations. In calendar year 1994 alone, nearly 7 million condoms were sold. The new mass media advertising campaign focuses on condom use, but also promotes abstinence and mutual fidelity as the best means of avoiding AIDS.

Out-of-School Youth
The Young Women's Christian Association has trained 10 young women as peer educators to conduct door-to-door visits, drama presentations and one-on-one conversations with young people about the dangers of HIV/AIDS. To date, approximately 1,000 youth and 200 key adults have been educated. An additional 36 youth peer educators and eight adult peer educators are being trained.

Traditional Healers
Over 629 traditional healers have participated in three-day workshops and one-day seminars held by two traditional healers' associations. The training will enable them to provide their clients with HIV/AIDS information and education. Thirty-four health workers have been trained to conduct HIV/AIDS workshops with traditional healers, and 30 healers have been trained to conduct workshops with their peers.

Workplace Program
Four GRZ Ministries (Tourism, Information and Broadcasting, Defense and Agriculture) and eight public and private sector organizations have trained 963 managers and supervisors, coordinators, peer educators and community members to implement HIV/AIDS prevention activities in the workplace. Eleven more organizations will begin HIV/AIDS prevention activities in 1995.

STD Prevention and Control
The USAID HIV/AIDS project provides significant quantities of laboratory equipment, reagents, medications and supplies to six MOH STD clinics. Over 1,300 clients have been treated, and patient information forms are being improved.

Media
As a result of USAID HIV/AIDS project activities, the Zambian AIDS Journalists Association and an AIDS Resource Center have been established. Training sessions with selected journalists, in-house training with various media institutions, policy discussions with media managers, and a workshop for GRZ Ministries' AIDS Focal Point persons have been conducted.

Policy Development
Researchers have been engaged to undertake in-depth research on HIV/AIDS in five major policy areas, including employment, training, credit, loans and mortgages, marriage and family welfare, and the media. The USAID/Morehouse School of Medicine policy coordinator participated in a workshop to review the Zambian Employment Act. In addition, the project began collaborating with the Ministry of Education (MOE) on its Girl Child Education Project to integrate HIV-related issues into the MOE programs as well as with the President's Cabinet Office to facilitate the integration of HIV/AIDS concerns in the restructuring of the civil service.

HIV Testing and Counseling
Approximately 2,000 clients have received HIV/AIDS education through educational sessions and voluntary testing and counseling and referral of patients to the MOH TB and STD care sites is being offered through Kara Counseling to people in the workplace. This project targets the Zambian police force through mobile units in the main urban areas of Zambia, people in prisons and the general population through urban walk-in centers.

Small Grants
Thirty-seven small grants under $10,000 totalling $225,000 have been awarded to 25 NGOs, 10 ministry agents and 5 private companies under four thematic areas: research, training, materials development and community response. A recent evaluation of this component found that these small grants provide value for resources invested, leverage significant in-kind contributions and achieve impressive synergy with other project components.

ZIMBABWE

SITUATION ANALYSIS

With a population of 11 million, Zimbabwe has an HIV/AIDS prevalence that is among the highest in sub-Saharan Africa. As of September 1994, 35,000 AIDS cases had been reported. Analysis of seroprevalence data shows that HIV prevalence is highest in small towns along the major transport routes. Seroprevalence is over 30 percent in urban areas and around 15 percent in rural areas.

Reported AIDS cases:* 38,552
Date of last report: 12/94

Increase over 1993 report:** 16%

Total population: 11 million

Cumulative incidence: 3,504.7

HIV-1 seroprevalence in urban areas:*** Not Available

USAID STRATEGY

USAID developed the five-year Zimbabwe AIDS prevention and control (ZAPAC) project in 1993 as a vehicle for supporting HIV-related activities. ZAPAC aims to decrease HIV-related, high-risk behavior within defined target groups and strengthen the delivery services that help reduce the spread of HIV in these groups. These objectives will be achieved through education and motivation for behavior change.

AIDS prevention efforts in Zimbabwe are defined within the context of the Government of Zimbabwe (GOZ) medium-term plan, which officially recognizes AIDS as more than a health issue and gives the epidemic an economic, multisectoral and cross-cutting definition. The ZAPAC Project is designed to complement and support the work of local and community-based groups to implement HIV-prevention programs. The project reinforces Zimbabwean-initiated efforts to ensure that programs are tailored for and by Zimbabweans in response to local conditions.

USAID-SUPPORTED COUNTRY PROGRAMS

Policy Support
USAID supports the national AIDS control program (NACP) in developing an HIV/AIDS policy agenda. A team was engaged to present a range of legal actions and proposed steps ZAPAC could take to develop specific policy areas.

Tertiary Student Interventions
Through UNICEF, HIV/AIDS education activities target college and vocational institution students and teachers. UNICEF uses a broad-based approach, encompassing not only factual information but also relationship issues, life skills, human growth and development, and health issues related to sexual behavior.

Support for High-Risk Occupational Groups
Through the AIDS Control and Prevention (AIDSCAP) Project, USAID's primary focus will be on behavior change communication interventions in the workplace with occupational target groups, including the transport and commercial farming sectors, uniformed services personnel and the families of workers in these sectors. AIDSCAP will also work through the media to disseminate accurate information on the AIDS epidemic.

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

ASIA AND THE NEAR EAST

Home to more than half the world's people, Asia is becoming the new epicenter of HIV/AIDS. The region's vast population and the presence of many factors that foster HIV transmission, including high rates of sexually transmitted diseases (STDs) and injection drug using, low condom use and an active commercial sex industry, suggest that Asian countries will face an explosive epidemic during the next decade.

Cross-border movement by migrant laborers, traders, transport workers and tourists plays an important role in the spread of the virus in the region. Towns on the borders of Burma and Thailand have some of the highest infection rates in the world. Mobile populations between India and its neighbors contribute to HIV transmission in India, Nepal and Bangladesh. In Cambodia, a recent study found an HIV seroprevalence rate of 10 percent among 200 pregnant women living on the border with Thailand.

The Asian epidemic is believed to be most severe in Thailand, India and Burma. In Thailand, where HIV made its first appearance in the region, an estimated 600,000 people are infected with HIV and over 13,000 AIDS cases have been reported. More than 1.5 million Indians are believed to be HIV-positive. Seroprevalence surveys indicate that the epidemic is also advancing in Burma. From 1989 to 1992, seroprevalence among pregnant women tested at antenatal clinics in Burma rose from zero to 2.2 percent, and rates among STD patients increased from almost zero to 8 percent.

However, little is actually known about the level of HIV infection in most countries in Asia. For example, by mid-1994 only 235 HIV infections had been confirmed in Indonesia, but estimates of the actual number of infections range from 25,000 to 40,000. At least 4,000 people are believed to be HIV-positive in Cambodia, where 736 infections were reported in 1994. Without effective prevention programs, the virus could spread rapidly in these and other countries of the region where illicit drug injection, high STD rates, commercial sex and low rates of condom use are common.

Even less is known about the epidemic in the Middle East and northern Africa. Fewer than 1,400 AIDS cases had been reported to the World Health Organization (WHO) by mid-1993, but it is likely that the epidemic is more established in the Near East than official reports indicate. Sample studies conducted between 1989 and 1992 suggest that rapid expansion of HIV/AIDS is fueled by the mobility of the population in the region—where many migrate to seek work or education—and by the presence of social instability, poverty, commercial sex and injection drug use.

REGIONAL INITIATIVES

The HIV/AIDS strategy developed by USAID's Bureau for Asia and the Near East (ANE) in 1993 focuses on limiting cross-border transmission and the spread of the virus into low-prevalence countries. It also addresses regional issues such as labor migration and trafficking of women.

The ANE regional program extends the scope of USAID's bilateral programs in the region by supporting:

- interventions that limit cross-border HIV transmission;
- prevention activities in low-prevalence countries; and
- innovative pilot projects that address regional HIV/AIDS issues.

During fiscal year 1994 the Bureau funded the initiation of a prevention program in Nepal and assessments of cross-border transmission in four areas (see p. 12).

The ANE Bureau also supports regional training, policy and research efforts. Workshops held during fiscal year 1994 included one on HIV/AIDS reporting for Asian journalists and another for government officials and other decision makers from nine countries to build support for HIV/AIDS prevention policies and interventions. Another Bureau-funded policy initiative, a series of "policy tours," brought Indonesian policy makers to Thailand to learn about the impact of the epidemic and the government response. Research on regional issues sponsored by the Bureau includes a study that began in 1994 on the role of Islam in HIV prevention.

The recent merger of USAID's Asia and Near East programs provides an opportunity to expand the Asia regional HIV/AIDS prevention program and address issues that affect the spread of the epidemic in both regions. For example, current interventions for Asian workers who seek employment abroad can be strengthened by complementary activities targeting employers in the Near East. The Bureau is also planning activities to advance prevention programs in the region, including a conference on HIV/AIDS for Arabic states and research on cross-border movement within the Near East.

Marie, a 12-year-old commercial sex worker in a brothel in Bombay, India, hopes that by wearing a wedding dress someone will marry her and rescue her from the brothel.

DAYANITA SINGH / JB PICTURES

BANGLADESH

SITUATION ANALYSIS

Bangladesh, with a reported HIV prevalence rate of about 0.05 percent in sexually active adults, is in the early stages of the HIV/AIDS epidemic. As of the end of 1994, 4 AIDS cases and 34 HIV-positive people had officially been identified in the country. Bangladesh's high sexually transmitted disease (STD) rates, proximity to countries with serious AIDS problems, high rates of migration and large commercial sex worker population contribute to the belief that the country will soon have a significant HIV/AIDS problem. World Bank projections indicate that by the year 2000, there will be close to 300,000 HIV infections and over 30,000 AIDS cases in Bangladesh. In 1985, the Government of Bangladesh (BDG) established a national AIDS committee and in 1991, developed a medium-term plan for HIV/AIDS control. The BDG and local nongovernmental organizations (NGOs) have initiated significant HIV/AIDS activities in the areas of training, epidemiologic surveillance and information, education and communication. However, overall progress has been slow, due to weak leadership of the national AIDS committee, the lack of a designated HIV/AIDS control implementing organization and overall insufficient national commitment to address the epidemic. Important issues have been identified and need to be addressed in order to launch an effective national AIDS control program.

Reported AIDS cases:* 4
Date of last report: 11/94

Increase over 1993 report:**
Not Available

Total population: 116 million

Cumulative incidence:
.034 per million

HIV seroprevalence in urban areas:***
Population at high risk:******
Not Available
Population at low risk:
Not Available

USAID STRATEGY

The major focus of USAID's strategy is to identify groups (such as commercial sex and transport workers) who practice high-risk behavior and to develop condom promotion, and peer and community education programs that target them. In the longer term the program will improve STD services available to these groups. First USAID

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

will assist the Mission-funded social marketing company to launch a program to target commercial sex workers and their clients in the major cities with condom promotion, peer education and community education.

USAID will also assist the social marketing company to expand this targeted intervention to include other groups at high risk of HIV transmission. Working through selected NGOs, USAID will help launch condom promotion and AIDS education programs in areas with significant risk populations. USAID will also assist local NGOs and other organizations to upgrade. the STD treatment services and engage in policy dialogue with the national AIDS committee and other HIV/AIDS-prevention implementing agencies.

USAID-SUPPORTED COUNTRY PROGRAMS

In fiscal year 1994, preparations were completed to conduct an AIDSCAP-sponsored workshop on developing and implementing curricula for HIV/STD prevention and education for employees of NGOs. The workshop took place in December 1994, and a total of 28 people from 17 NGOs participated.

CAMBODIA

SITUATION ANALYSIS

The AIDS epidemic in Cambodia has reached a critical stage and is demonstrating a development pattern strikingly similar to that of Thailand. In 1994, 736 HIV-positive people and 10 AIDS cases were reported to the National AIDS Control Program. A study of commercial sex workers in a southern port city revealed a 38 percent incidence of HIV infection. HIV incidence is expected to be significantly higher in the northwest because this area is adjacent to the Thai border and is the site of much commercial and military activity. Preliminary estimates put levels of infection among the military in the northwest at 10 to 15 percent, and testing of the blood supply in Phnom Penh indicates HIV seroprevalence of 5 percent. As in most Asian countries, heterosexual contact is the predominant mode of transmission.

The Government of Cambodia has established an Interministerial Committee for AIDS and Sexually Transmitted Disease Prevention and Control to address the epidemic at the policy level. Although AIDS is acknowledged to be a serious problem in Cambodia, progress is slow in efforts to control the epidemic because the physical, economic and human resource infrastructures necessary for any systematic and meaningful intervention have been shattered by years of civil war and need rebuilding.

Reported AIDS cases:* 10
Date of last report:2/95

Increase over 1992 report:
Not Available

Total population: 9.7 million

Cumulative incidence:***
1 per million

HIV-1 seroprevalence in urban areas:****
Population at high risk:
Not Available
Population at low risk:
Not Available

USAID STRATEGY

USAID/Phnom Penh has responded to the epidemic primarily through grants to nongovernmental organizations (NGOs). Currently, the Mission funds two specifically HIV/AIDS-targeted NGO projects, but also supports other activities that address HIV/AIDS within broad public health interventions.

USAID-SUPPORTED COUNTRY PROGRAMS

Social Marketing of Condoms
Through a grant to Population Services International (PSI), USAID supports social marketing of condoms and an information, education and communication (IEC) campaign to promote AIDS prevention and birthspacing practices. One of the project's objectives is to promote and demystify condom use by making condoms as accessible as possible. The project recently launched "Number One," the first U.S.-manufactured condom in Cambodia. Local NGOs and existing private sector vendors are actively engaged in the condom distribution and marketing campaign. The IEC component will work through the education system as well as through mass media channels such as radio, television, video and publications.

Reproductive Health Clinics and AIDS Counseling
In conjunction with ongoing reproductive health and birthspacing activities, USAID supports counseling and condom distribution for the prevention of STD and HIV/AIDS. A USAID grant to Family Planning International Assistance (FPIA) helped establish the first reproductive health clinics in Cambodia. Modeled after the Planned Parenthood Clinics of America, the clinics provide family planning services and counseling on STD and AIDS prevention. An FPIA office has opened in Phnom Penh and Svay Rieng province; two others are planned in province of Takeo and Kompong Speu. These clinics target the poor and underserved populations but operate, to the extent possible, on a user-fee basis.

Targeted HIV/AIDS Awareness Activities
In an effort to make condoms readily accessible, USAID will support an education and condom sales program through the Cambodia Conductors' Association whose membership primarily comprises pedicab drivers in Phnom Penh. The drivers will sell condoms, disseminate HIV/AIDS prevention information, and promote condom use at all hours of the day and night. USAID is also supporting AIDS awareness efforts of several local NGOs working with high-risk groups and the general community in Phnom Penh and the northwestern province of Battambang.

INDIA

SITUATION ANALYSIS

The AIDS epidemic in India is at an early stage, but is likely to expand rapidly. Since the first AIDS case was registered in Bombay in 1986, 849 cases have been reported. In 75 percent of these cases, transmission is believed to have been through sexual contact. In the northeastern state of Manipur, however, HIV transmission takes place primarily through injection drug use. Data from 23 sentinel surveillance centers in different regions in India show that there has been a consistent increase in the prevalence of HIV infection from 1985 to 1994. The major concentration of HIV/AIDS remains in the Bombay and Pune areas of Maharashtra State, which contain 5 to 10 percent of the country's infected individuals.

Vellore and Madras in Tamil Nadu State and the northeastern states of Manipur, Mizoram and Nagaland are other regions with high reported rates of HIV/AIDS prevalence.

In response to the growing epidemic, the Government of India (GOI) is implementing a National AIDS Control Program. Started in 1987, the program is funded through a World Bank loan of $85 million and receives technical assistance from the World Health Organization.

Reported AIDS cases:* 849
Date of last report: 9/94

Increase over 1992 report:**
293%

Total population: 940 million

Cumulative incidence:
.9 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
2.7% to 60%
Population at low risk:
0.2% to 1.1 %

USAID STRATEGY

USAID has launched a $10 million AIDS Prevention and Control (APAC) Project in the state of Tamil Nadu. The project complements the GOI's National AIDS Control Program. Working through private voluntary organizations (PVOs) and other private sector groups, APAC aims to change the behavior of people practicing high-risk behaviors. Commercial sex workers, their clients, and sexually transmitted disease (STD) patients will be provided with information, counseling and services to promote increased condom use, reduction of the number of sexual partners and improved treatment-seeking behavior for STDs. Tamil Nadu was chosen because it has shown a rapid increase in the rate of HIV infection among groups practicing high-risk behavior, but also because it has a strong tradition of non-governmental organization (NGO) involvement in public health. Commercial sex in Tamil Nadu, while not as overt and organized as in Bombay, is more representative of other Indian cities and towns. Interventions developed for Tamil Nadu will, therefore, be applicable to the rest of India. The project contract was signed in September 1992, but negotiations with the GOI have only just been successfully completed and project implementation is just beginning.

USAID-SUPPORTED COUNTRY PROGRAMS

Distribution of AIDS Video
To educate policy makers in India about the scope of the AIDS threat, USAID funded duplication and distribution of 1,000 copies of "Talking AIDS, Stopping AIDS," a video produced by the Indian Association of Preventive and Social Medicine and CEDAC Communications Systems, a New Delhi film maker. The video and a pamphlet about AIDS, which were distributed to policy makers, government officials and health care providers in India, were designed to create awareness about the enormity of the potential HIV/AIDS problem and to generate public support for HIV/AIDS-prevention activities.

In-Depth Study of Poor Women in Bombay
The Tata Institute of Social Sciences is studying how urban Indian women perceive their own sexual behavior. Findings from focus group discussions with women from various religious, ethnic and occupational groups in Bombay are helping program planners shape appropriate prevention messages for this population. AIDS interventions will be integrated into maternal and child health services, reproductive and contraceptive health services, and STD control programs.

AIDS Model for Low-income Young Women in Urban India
World Vision Relief and Development is conducting research on a culturally appropriate model for educating low-income young women in Bombay about HIV/STD prevention. Focus groups were conducted and questionnaires distributed to young women, aged 15 to 20, from several Bombay slums. The results are being used to plan interventions.

Equipment for Blood Transfusion Centers
To support India's AIDS control plan, USAID contributed $1.3 million in fiscal year 1991 to enable the government to purchase HIV testing and surveillance equipment for 65 blood transfusion centers.

INDONESIA

SITUATION ANALYSIS

Indonesia, an archipelago of 13,000 islands, is still in the early stages of the epidemic. HIV/AIDS prevalence is relatively low, with 266 reported cases of HIV infection, but there is the potential for a devastating epidemic. Heterosexual contact is the primary mode of transmission, and infection levels are highest in people ages 15 to 39. The Government of Indonesia (GOI) has begun to address HIV/AIDS as a national priority. A presidential decree issued in May 1994 established a new multisectoral National AIDS Commission. A National AIDS Strategy and a five-year plan of action have been developed to guide GOI and donor-funded HIV/AIDS prevention activities.

Reported AIDS cases:* 66
Date of last report: 12/94

Increase over 1993 report:**
958%

Total population: 184.5 million

Cumulative incidence:
0.36 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
Not Available
Population at low risk:
Not Available

USAID STRATEGY

Since 1989, USAID has worked with the GOI to analyze the course of the epidemic and is providing support for the development of effective programs to

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

prevent further transmission of HIV/AIDS. USAID has concentrated its efforts on preventing sexual transmission of HIV by changing risk-associated behaviors and has worked primarily in the areas of policy support and information, education and communication (IEC). Major activities include facilitation of policy study tours, epidemic modeling, IEC training and strategy development, nongovernmental organization (NGO) institutional development and implementation of outreach activities targeting those at highest risk.

USAID-SUPPORTED COUNTRY PROGRAMS

AIDS Prevention and NGO Strengthening

The three-year, $3.1 million Enabling Private Organizations to Combat HIV (EPOCH) Project has provided institutional development and technical assistance to 11 NGOs to enable them to implement HIV/AIDS prevention activities in Jakarta, Surabaya and Bali. Major project components include behavior change communication (BCC) materials development, peer outreach, condom promotion, counseling, training and sexually transmitted disease (STD) prevention and referral. The EPOCH Project is implemented by Project Concern International and Private Agencies Collaborating Together (PACT). A grant of approximately $1.4 million has also been given to Program for Appropriate Technology in Health (PATH)/Indonesia to implement HIV/AIDS prevention and NGO strengthening activities in six locations in Indonesia.

Support for AIDS Program Development

USAID has provided approximately $800,000 over the past two years to fund AIDS Control and Prevention (AIDSCAP) Project activities in Indonesia in support of GOI's National AIDS Program. Activities have focused on policy support and IEC. More than 25 Indonesian policy makers from 16 different ministries have participated in policy study tours. AIDSCAP also supported the development of projection modules to forecast the future course of the epidemic in Indonesia. Training and technical assistance in strategic planning and program development have been provided to the Ministry of Health Center for Health Education for AIDS. Representatives of several ministries have also received training in communications and policy development. The Ministry of Health and AIDSCAP cosponsored the first National AIDS Conference for Provincial AIDS Teams.

Behavioral Study of Commercial Sex Workers and their Clients

In collaboration with AIDSCAP, the Ministry of Health, Udayana University and the University of Michigan conducted a behavioral research study on male and female sex workers and their clients in Bali. Based on the results of the research, a behavioral intervention was developed to increase knowledge and awareness of STDs, HIV/AIDS and condom use among low-priced female sex workers in Bali. Final results of the intervention are currently being analyzed and should be available soon.

Condom Promotion for Those at Highest Risk

With USAID funding, the Social Marketing for Change (SOMARC) Project is implementing a $450,000, two-year pilot condom social marketing project targeting commercial sex workers and clients in Surabaya and Jakarta. The project has promoted condom sales through the mass media and expanded access to condoms by increasing the number of sales outlets for condoms in areas near commercial sex establishments.

Development of the HIV/AIDS Prevention Project

USAID has negotiated a five-year, $20 million HIV/AIDS Prevention Project (HAPP) to be implemented by the Ministry of Health with technical assistance from AIDSCAP in fiscal year 1995. All project activities will be integrated into the Indonesian National AIDS Program, guided by the National AIDS Strategy and five-year plan of action. HAPP is designed as an integrated project with four primary technical components: policy support, IEC for behavior change, STD/HIV control and management, and condom social marketing. Project activities will target people at high risk of HIV infection in two or three demonstration areas and the general population at a national level. Results of the interventions in the demonstration areas will form the basis of a policy initiative to improve the national policy climate about HIV/AIDS prevention.

MOROCCO

SITUATION ANALYSIS

Morocco, like other Maghrebian countries, is still at an early stage in the HIV/AIDS pandemic. Only 249 AIDS cases were reported between 1986 and December 1994, but the number of new cases per year has increased. In response to the high frequency of sexually transmitted diseases (STDs) in the country and the rise in HIV/AIDS cases, the Ministry of Public Health has begun to promote HIV/AIDS prevention messages and has undertaken some pilot activities to screen and treat STD patients at select sites throughout the country. A few indigenous nongovernmental organizations (NGOs) are active in providing counseling and referral services, but not much work is being done in message development and HIV testing and counseling, especially among high-risk groups.

Reported AIDS cases:* 249
Date of last report: 12/94

Increase over 1993 report:**
0.50%

Total population: 26,073,000

Cumulative incidence:
9.5 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
0.83%
Population at low risk: 0.03%

USAID STRATEGY

USAID's strategy is to assist the Ministry of Public Health in Morocco to develop a viable, comprehensive approach to STD management through integration of STD care and prevention into primary health care facilities. Pilot facilities in three provinces will provide complete STD care, including diagnosis, treatment, counseling and quality laboratory support for male and female clients. USAID activities will strengthen services and links among STD referral centers, mother and child health and family planning programs, and the national HIV/AIDS control program.

USAID-SUPPORTED COUNTRY PROGRAMS

Detection and Treatment of STDs

USAID funds, channeled through the AIDSCAP project, are being used to introduce and strengthen STD care in three cities (Tangier,

Marrakech and Agadir). In each city, three levels of service delivery sites are supported: comprehensive STD services are being introduced into one primary health center, a dermatology and venereology reference center and a regional family planning reference and training center. In addition, laboratories in the target cities and the national reference laboratory of the National Institute of Hygiene are receiving support to assure high-level capabilities in STD identification. Participating clinicians are learning an algorithmic approach to STD care, and equipment and a start-up supply of drugs is being provided. A baseline STD study is scheduled for early 1995, and a follow-up prevalence study will be conducted by the end of 1996.

NEPAL

SITUATION ANALYSIS

Nepal is still in the early stages of the epidemic. As of early 1995, there were only 235 reported cases of HIV. World Health Organization estimates indicate that the actual number of HIV infections is probably much higher—approximately 5,000 to 10,000. HIV transmission is predominately heterosexual. The male-to-female ratios of HIV and AIDS are 1:1 and 1:4, respectively. High-risk behaviors among segments of Nepal's population and its geographical location and economic interdependence with India increase Nepal's potential for an explosive HIV/AIDS epidemic in the future.

Both the newly elected government and the National Centre for AIDS and STD Control (NCASC) have given HIV/AIDS a high priority in Nepal. His Majesty's Government's new policy is to integrate AIDS prevention with government public health programs and to work in mutual collaboration with the nongovernmental sector nationwide.

Reported AIDS cases:* 32 (First report)

Total population: 20,000,000

Cumulative incidence: 1.6 per million

HIV-1 seroprevalence in urban areas:
Population at high risk: Not available
Population at low risk: Not available

USAID STRATEGY

USAID supports the NCASC's medium term plan for HIV/AIDS prevention and control and is funding focused prevention initiatives in the Central Development/Terai Region of Nepal. Implemented primarily through the AIDS Control and Prevention (AIDSCAP) Project, USAID's three-year, $1.9 million program aims to increase access of target populations at highest risk—commercial sex workers (CSWs) and their clients—to improved sexually transmitted disease (STD) prevention and treatment services, extend condom distribution to target populations, develop targeted communication interventions to reduce risk behaviors and increase awareness among policy makers of HIV/AIDS/STD issues.

USAID-SUPPORTED COUNTRY PROGRAMS

STD Case Management Training and Education for Physicians in the Private Sector
To improve access to effective STD services, the Nepal Medical Association developed a management training curriculum and trained general practitioners in the private sector in STD case management using the syndromic approach to STD diagnosis and treatment. The training complements Nepal's national STD case management guidelines.

STD/HIV/AIDS Prevention Education for Chemists and Alternative Health Care Providers
The Nepal Chemists and Druggists Association is developing a training curriculum and in mid-1995 will begin training chemists and alternative health providers to strengthen their role as prevention educators and condom promoters in the prevention and control of STD/HIV/AIDS. It is anticipated that the project will train approximately 525 chemists and alternative health care providers.

Condom Social Marketing
Condom social marketing efforts are coordinated through the Futures Group working in collaboration with Nepal's family planning social marketing organization, Nepal Contraceptive Retail Sales Company and a private, Kathmandu-based advertising firm, Stimulus Advertisers. Condom promotion activities include strengthening condom distribution systems and expanding condom sales points beyond pharmacies through peer educators and to nontraditional commercial outlets, including tea shops, hotels, bars and general good stores. A media campaign to raise public awareness of HIV/AIDS and the importance of condoms in HIV and STD prevention will begin in mid-1995. A campaign logo, slogan and print materials, and awareness-raising video and radio messages are being developed as part of the media campaign.

Outreach Education to CSWs and Transient Population Groups in Central Nepal
Two Kathmandu-based nongovernmental organizations, General Welfare Pratisthan and LifeSaving and LifeGiving Society are implementing an outreach education program targeting populations practicing high-risk behaviors along the major transport routes, commercial centers, and communities in nine districts in the Central Development Region. The program is providing direct education outreach to the target groups and peer education support to peer leaders with complementary activities to encourage the participation of established community organizations, businesses and local leaders.

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

A Baseline Survey of CSWs and their Clients on the Land Transportation Routes from Naubise to Janakpur and Birgunj
New Era, a local research organization, has completed a knowledge, attitude and practice survey of 160 CSWs and 300 CSW clients in the Central Development Region. The survey includes information on the client behavior of transport workers, migrant laborers, police, military and students, commercial sex networking, condom availability and STD service infrastructure. Recommendations from the survey include, focusing HIV prevention interventions on specific target groups, using low and no-literate messages, distributing condoms near points of use and encouraging STD treatment.

New Era also conducted a small qualitative survey of 34 pharmacists to examine clients STD service-seeking behavior. The survey findings will be integrated into the training curriculum for chemists and alternative health care providers.

Policy Support
AIDSCAP has provided capacity building support to the NCASC to improve national HIV/AIDS epidemiological estimates and projections. Future activities include HIV/AIDS policy seminars for government, private sector and community leaders, and regional workshops to strengthen the skills of local journalists reporting on STD/HIV/AIDS issues.

THE PHILIPPINES

SITUATION ANALYSIS

As of December 31, 1994, 587 HIV/AIDS infections and 183 AIDS cases had been reported in the Philippines. Epidemiological surveillance data in the Philippines is still very limited and has mostly been collected from population groups that are not considered to be at high risk for acquiring HIV infection. The prevalence of HIV infection in most of these groups was below 0.1 percent in 1993. Seroprevalence studies conducted from 1986 to 1991 among groups practicing high-risk behaviors, particularly female commercial sex workers (CSWs), also indicate HIV prevalence of less than 0.1 percent. Most of these studies of CSWs have been done in two areas adjacent to former U.S. military bases.

During the latter half of 1993, the USAID-supported National HIV Sentinel Serologic Surveillance System of the Philippine Department of Health (DOH) began providing systematic early warning data of increases in HIV-infection rates among groups considered to be at high-risk for acquiring HIV infection in six cities. Data from this system and recent studies on the behavior of selected groups and the sexual practices of the general population reveal a clear potential for HIV infection to increase significantly.

Reported AIDS cases:* 183
Date of last report: 12/94

Increase over 1993 report:**
47.6%

Total population: 65,000,000

Cumulative incidence:
2.8 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
0.1 to 6.3%
Population at low risk:
Not Available

USAID STRATEGY

Because studies have found widespread misconceptions about HIV/AIDS in the Philippines, USAID has concentrated on increasing AIDS awareness by providing accurate information to policy makers, the general public and particularly to groups practicing high-risk behavior. The Mission is focusing on mobilizing the national sentinel surveillance system to track transmission of infection and monitor behavior change among targeted population groups most frequently practicing high-risk behavior. USAID will continue to support private voluntary organization and nongovernmental organization (NGO) efforts to reach people practicing high-risk behaviors.

USAID-SUPPORTED COUNTRY PROGRAMS

The AIDS Surveillance and Education Project (ASEP) was developed in 1992 to assist the National AIDS Prevention and Control Program of the DOH in controlling HIV transmission. ASEP supports the following key components of the overall Philippine strategy:

National HIV Sentinel Serologic Surveillance
ASEP is establishing the National HIV Sentinel Surveillance System at strategically located geographic sites throughout the country to monitor groups likely to practice high-risk behaviors, including male and female CSWs, male STD patients, men who have sex with men and intravenous drug users. Mass media, community-based education and public relations programs encouraging behaviors that reduce the risk of HIV transmission will target groups at risk as well as the population at large in locations identified by the sentinel surveillance system.

Technical Assistance to AIDS/STD Prevention Programs
Through the education component of the ASEP, the Program for Appropriate Technology in Health (PATH) continued to strengthen the capacity of the DOH to develop and oversee implementation of a primary AIDS prevention information, education and communication (IEC) strategy. Plans for implementing activities were developed and initial target groups and geographic areas for HIV education selected. One local NGO, Kabalikat-Metro Manila, will serve as partner to the National AIDS Prevention and Control Program and as sources of technical assistance to other NGOs.

Educational Outreach Projects by NGOs
USAID supports 18 NGO projects, which provide HIV outreach education, behavior change communications and other HIV prevention activities, in Metro Manila, Angeles City, Cebu and Davao.

Multimedia Campaign
In 1994, under the ASEP, Johns Hopkins University, the Program for Applied Technology in Health (PATH) and the Futures Group conceptualized a ten-month campaign directed at the entire Filipino population with particular emphasis on sexually active young adults. This strategy combines mass media and public relations activities to disseminate accurate information on AIDS, publicize the efforts of the DOH, local government units and NGOs to prevent and control HIV/AIDS in the Philippines, and to strengthen the participation of NGOs and other concerned

groups in the national effort to prevent and control the spread of HIV.

Support for an All-Voluntary Blood Banking Program
As a result of a USAID-funded field survey undertaken from September 1993 to January 1994, which confirmed that potentially infected blood was circulating within the national blood supply system, USAID is supporting DOH efforts to develop and implement a safe blood banking program.

Remedios AIDS Information Center
USAID continues to support the Manila Remedios AIDS Information Center (RAIC), which serves as a grassroots, drop-in information and counseling center. The center serves the greater Manila community, presenting lectures and films and operating a telephone hot line. RAIC is collaborating with the DOH to produce and distribute a quarterly AIDS periodical for health workers and NGOs, which encourages them to use RAIC facilities for their own HIV/AIDS prevention initiatives.

SRI LANKA

SITUATION ANALYSIS

Sri Lanka has been classified as a low-prevalence country for HIV/AIDS. However, the potential for an explosive epidemic exists because it has many of the risk factors associated with high prevalence countries in the region, including high levels of cross-border migration with high-prevalence neighboring countries; large populations of commercial sex workers, sailors, transport and port workers, youth, soldiers, people involved in sex tourism and casual laborers; and a high incidence of sexually transmitted diseases (STDs). The government of Sri Lanka has developed a medium-term plan to address HIV/AIDS that focuses on diagnosis, testing and treatment at government facilities. The plan recognizes the importance of nongovernmental institutions in controlling the epidemic through education, prevention and treatment.

Reported AIDS cases:* 41
Date of last report: 11/94

Increase over 1993 report:**
Not Available

Total population: 17,000,000

Cumulative incidence:***
2.4 per million

HIV-1 seroprevalence in urban areas:
Population at high risk:******
Not Available
Population at low risk:
Not Available

USAID STRATEGY

USAID provides support to four international and local private voluntary organizations for programs that create awareness of HIV/AIDS among vulnerable groups. USAID is also considering supporting the establishment of a local office for the International HIV/AIDS Alliance.

USAID-SUPPORTED COUNTRY PROGRAMS

PVO Grants
Through a grant to the Sri Lanka Association for Voluntary Surgical Contraception, USAID is helping to establish training programs for voluntary health workers and counselors in HIV/AIDS and other STDs and to set up centers for counseling of high-risk groups in selected districts.

USAID has given a grant to the Community Front for Prevention of AIDS to establish an outreach health education program targeting high-risk groups with HIV/AIDS information and education.

Community Development Services (CDS) and the Adventist Development and Relief Agency are both being funded to establish education and awareness projects. Both projects will address the nature and significance of HIV/AIDS, how it is spread and how to prevent it. CDS will also set up a blood collection center in Colombo for voluntary HIV testing.

THAILAND

SITUATION ANALYSIS

The HIV/AIDS epidemic in Thailand has continued to spread, primarily through heterosexual transmission, and will increasingly affect the young working population. The thriving commercial sex industry is a significant contributing factor to the rapid spread of the virus. High levels of infection are found particularly in northern and central Thailand. Bangkok, with a large low-income population in the 15-to-29-year age group, has the potential for an explosive HIV/AIDS epidemic in the 1990s. The Royal Thai Government (RTG) is strongly committed, both financially and politically, to HIV/AIDS control. Although seroprevalence data continue to show an increase in HIV infection levels, there are encouraging reports of increased condom use and a decline in sexually transmitted diseases (STDs). With the increasing rate of condom use and the extensive information, education and communication (IEC) programs mounted by both the public and private sectors, it may not be too late to control the epidemic in Thailand.

Reported AIDS cases:* 18,132

Increase over 1993 report:**
Not Available

Total population: 59 million

Cumulative incidence:
307.3 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
27.0%
Population at low risk: 1.8%

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

USAID STRATEGY

USAID's strategy, implemented primarily through AIDSCAP, promotes increased condom use, change of risk-associated behaviors, and reduction of STDs among targeted populations. Project elements include community mobilization, worksite communication, low-income community interventions, mass communication, school-based programs, health service system strengthening, coordination with other programs, policy support and evaluation. Some applied research and intervention activities have a national focus, but the majority of efforts concentrate on Bangkok. Many of these projects will be transferred to the RTG and other donors by 1996.

USAID-SUPPORTED COUNTRY PROGRAMS

Technology Transfer

This project provides financial support to the Program for Appropriate Technology in Health (PATH)/Seattle to transfer the technology for production of the hepatitis B surface antigen (HBSAG) dipsticks to Bangkok Radio Immune Assay (BRIA). The program includes technology assessment, business development and technical support. BRIA is now ready to introduce a simple, sensitive dipstick test for HBSAG into markets in Thailand and the Southeast Asia region. In fiscal year 1994, USAID also supported a field evaluation by PATH, BRIA and Epitope, Inc., a U.S.-based biotechnology company, at four sites in Thailand, three in Bangkok and one in Chiang Mai comparing the use of saliva to the use of serum with an HIV dipstick test.

Thai Women of Tomorrow

This project supports a pilot effort to increase educational and employment opportunities for young women in northern Thailand as a way to divert them from the sex industry. Young girls and their parents are informed of the risk of HIV/AIDS and encouraged to change their attitudes and behavior. The project emphasizes continuation of secondary study, vocational training and job placement.

Laos HIV/AIDS and STD Needs Assessment

Regional Support Missions/East Asia (RSM/EA) staff participated in an assessment that led to the development of a strategic plan to control the spread of sexually transmitted HIV infection in selected regions of the Laos People's Democratic Republic, including a proposal for implementing AIDSCAP interventions in Laos. The proposed program focuses on two districts in each of the five provinces adjacent to the Thai border. Target groups include service workers in restaurants and hotels, border police and other officials, youth and truck drivers.

Youth AIDS Awareness and Prevention Project

The Population and Community Development Association, an activist nongovernmental organization with many years of experience in family planning, community development and HIV/AIDS programs, is using teachers and peers to educate youth aged 11 to 17 about HIV/AIDS. Topics include modes of transmission, high-risk behaviors and development of skills to avoid such behaviors. A mass media component involving popular singers and film personalities is reaching a nationwide audience of young people.

Community Mobilization for AIDS Prevention

The Mahidol University Faculty of Public Health is conducting a community diagnosis in six of Bangkok's 36 districts. University personnel will work with the local AIDS committees to develop master plans, identify and strengthen links with indigenous community networks, provide training for local AIDS committee staff to maintain a strong coordination capacity, and implement a system for sustained interaction between local communities and the district AIDS committees.

HIV/AIDS and STD KAP study in Bangkok

This survey is monitoring knowledge, attitudes and practices (KAP) related to HIV/AIDS and STDs in selected population subgroups (especially young people) in Bangkok, with feedback provided to the AIDS committees set up by the Bangkok Metropolitan Administration. Specific interventions will also be evaluated.

Experimental Interventions among Single Migratory Young Women

This research project tested the effectiveness of HIV/AIDS/STD prevention interventions targeting migratory female factory workers and vocational training students in Chiang Mai between 13 and 19 years old. Findings of the first phase of this project indicate that peer education is an effective way to educate young, unmarried female factory workers and that a young woman's ability to negotiate safe sex is often superseded by her need to establish and maintain an intimate relationship. The next phase will examine how the patterns and content of communication between young women and men, and sexual expectations and concepts of masculinity and femininity contribute to high-risk behavior. Single migratory male and female factory workers between the ages of 15 and 24 will be included in the study.

AIDS Prevention among Adolescents in Northern Thailand

This experimental intervention is examining AIDS-related knowledge, sexual behaviors and communication patterns with peers and family, as well as role perceptions among male and female secondary school students in northern Thailand. Findings will be used to design a peer education and counseling program and supporting educational materials. Program impact will be assessed after six months.

LATIN AMERICA AND THE CARIBBEAN

The Pan American Health Organization (PAHO) believes that official reports underestimate the true number of HIV infections and AIDS cases in Latin America and the Caribbean (LAC) by 10 to 80 percent. More than 2 million people are estimated to have been infected with HIV and about 405,000 of them have developed AIDS.

There are striking differences in levels of HIV/AIDS across Latin America and the Caribbean. HIV rates in the general population range from less than 1 percent in Jamaica and some of the smaller Caribbean islands to 9 to 10 percent in Haiti. Brazil, with the largest population and one of the best reporting systems in the region, has the second largest number of reported AIDS cases in the world. An estimated 500,000 Brazilians out of a population of 53 million have become infected with HIV, and the male-to-female ratio has changed from 9:1 to 4:1 in seven years.

Despite its relatively low HIV prevalence, Jamaica has the potential for a severe HIV/AIDS epidemic because of the country's high rates of sexually transmitted disease (STD), substantial number of migrant workers, and large tourism and commercial sex industries. Young adults between the ages of 15 and 29 account for 50 percent of all Jamaican AIDS cases. Another Caribbean nation, the Dominican Republic, has a well-established HIV/AIDS epidemic, with an estimated 100,000 people with HIV.

Until recently, most HIV prevention efforts have focused on South America and the Caribbean. But from 1988 to 1992, the annual number of AIDS cases in Central America rose by 190 percent. It is estimated that more than 200,000 people have been infected with HIV in the subregion. There is some variation in HIV prevalence from one country to the next—among STD patients it is as high as 14 percent in Costa Rica and Honduras and as low as 0.6 percent in Guatemala—but the epidemic continues to spread rapidly throughout Central America, ignoring borders and artificial boundaries.

REGIONAL INITIATIVES

Recognizing the increasing threat of cross-border HIV transmission in different parts of the region, the Bureau for Latin America and the Caribbean is exploring opportunities to complement its support for national HIV/AIDS programs with regional initiatives to slow the spread of the epidemic.

The first regional HIV/AIDS initiative in the region, the AIDS Communication and Technical Services Project (ACTS), builds the capacity of national AIDS programs in the Caribbean to develop and carry out programs to encourage sexual behavior change. Regional training workshops have focused on strategic planning and program management. In addition, the LAC Bureau has supported development of an automated HIV/AIDS and STD surveillance and tracking system for the Eastern Caribbean.

The LAC Bureau is also planning a regional HIV/AIDS prevention project in Central America. Given the demo-

Women from the area around Chichicastenango, Guatemala, market their goods on the steps of Santo Tomas Church. HIV/AIDS threatens national economies that heavily depend on individual laborers to supply products for local, national and international markets.

THOMAS HOEPKER / MAGNUM

graphic, sociocultural, political, economic and epidemiologic links among the countries of Central America, it is clear that efforts to slow the spread of HIV/AIDS must address cross-border transmission and other regional issues.

During fiscal year 1994, the LAC Bureau worked with the State Department, PAHO and representatives from the governments of other nations in the Americas to include HIV/AIDS in the statement to be adopted at the December 1994 Summit of the Americas in Miami, Florida. Heads of state from 33 nations in the Western Hemisphere endorsed a basic package of child, maternal and reproductive health interventions, including HIV/AIDS prevention, for the region.

BOLIVIA

SITUATION ANALYSIS

The first case of HIV infection was reported in Bolivia in 1985. Initially HIV infection was found mainly among homosexual and bisexual men, but now this group accounts for only 47 percent of documented HIV cases. HIV infection is spreading rapidly among heterosexuals, such as commercial sex workers (CSWs), who practice high-risk behaviors.

Up to 67 percent of Bolivia's HIV and AIDS cases are found in Santa Cruz, with smaller numbers in Trinidad, Sucre, Cochabamba and La Paz. Recently cases have also been detected in several small towns along Bolivia's border with Brazil. Although the total number of HIV infections reported to date remains low, studies indicate that sexually transmitted disease (STD) prevalence in Bolivia is extremely high, suggesting that the country is vulnerable to a widespread HIV/AIDS outbreak.

Reported AIDS cases:* 184
Date of last report: 4/95)

Increase over 1991 report:** 112%

Total population: 6,700,000

Cumulative incidence: 27.4 per million

HIV-1 seroprevalence in urban areas:*** 0.04%

USAID STRATEGY

Through Proyecto Contra el SIDA (the AIDS Control and Prevention Project of Bolivia) USAID is helping the National Secretariat of Health to control STDs and HIV/AIDS in Bolivia. The project focuses on three strategies: early diagnosis and treatment of STDs, behavior change through information, education, communication and counseling (IECC); and social marketing of condoms. To maximize its impact, the project concentrates on population groups at highest risk for HIV infection, such as commercial sex workers and men who have sex with men. USAID emphasizes the transfer of skills and knowledge to national and regional public health authorities and anticipates that the Secretariat of Health will adopt and replicate this project when funding ends in 1998.

USAID-SUPPORTED COUNTRY PROGRAMS

Outreach to Men Who Have Sex with Men in Santa Cruz
USAID supports the HIV/AIDS prevention efforts of UNELDYS (Unidos En La Lucha por la Dignidad y la Salud), a gay organization in the city of Santa Cruz. With approximately 100 members, the organization offers one-on-one and small-group education and conducts outreach activities at the community level. The project also offers sexual health counseling, anonymous HIV testing with pre- and post-test counseling, and a referral system for STD treatment. Condoms are sold at minimum cost. The intervention is being replicated in La Paz and will be developed in Cochabamba in 1996.

AIDS Hot Line "SIDACONSEJO"
Serving the city of Santa Cruz, which has a population of 800,000, the AIDS hot line, "SIDACONSEJO" receives over 200 calls a month. It is staffed by two part-time psychologists and operates from 6 to 11 pm, Monday through Friday. The hot line offers three services: basic STD/HIV information, emotional support and referrals to services. All services offered by the hot line are anonymous and free. All clinics on the referral list have been screened and offer treatment for affordable fees. A second hot line will open in LA Paz in 1995 and in Cochabamba in 1996.

Social Marketing of Condoms
Condom distribution was institutionalized at the national level in 1993. Condoms are distributed through a private sector social marketing project and through the National Secretariat of Health's distribution system in the public sector. Public sector condoms are sold at STD and family planning clinics at subsidized prices, and private sector condoms are sold in pharmacies and neighborhood convenience stores. Approximately 1.3 million condoms were distributed in 1994 and 2 million are programmed for 1995.

Health Sector Training
Interdisciplinary teams (physicians, biochemists, psychologists) provide STD training courses throughout the country but focus on the regions with high levels of HIV infection. The courses offered include syndromic and laboratory diagnosis of STD, treatment modalities, and the psychological management and support of patients. Participants are also trained in HIV and STD prevention counseling and condom negotiation and use.

Creation and Support of Public Sector STD Model Clinics
With technical support from the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta, USAID conducted extensive STD prevalence research and updated treatment protocols as a foundation for establishing three model STD clinics to serve registered CSWs. Implemented in collaboration with Proyecto Contra el SIDA, these fee-for-service clinics are now expected to become self-financing by 1988 and are increasingly used as training centers for health care professionals from all over the country.

Condom Education for Registered Commercial Sex Workers
Teams of psychologists work in STD clinics serving registered CSWs to provide general sexual health counseling with an emphasis on condom use and negotiation. Condoms are available at subsidized prices in the clinics. The project reaches over 4,000 CSWs a year.

Street Commercial Sex Workers
In the cities of La Paz and El Alto, a team of six health promoters educate CSWs on HIV/AIDS at their work sites. The intervention targets groups of women with low socioeconomic status and a high prevalence of STDs. The promoters emphasize condom use and negotiation skills and refer CSWs to STD clinics where low-cost condoms are available.

Owners and Administrators of Brothels
This project supports the interventions targeting CSWs with an educational program for owners and administrators of brothels. The project aims to educate brothel owners and administrators on HIV/AIDS and encourage them to support CSWs in negotiating condom use with their clients.

Sexual Health in Public Jails
Sixty inmates in the San Pedro jail have been selected for training as peer educators for the jail population of 1,600. A condom sales system will support the peer education program. Physicians serving the jail population have received specialized STD diagnosis and treatment training and will receive continuing education through calendar year 1995.

BRAZIL

SITUATION ANALYSIS

Brazil has the second highest number of reported AIDS cases in the world. AIDS in Brazil was first documented in homosexual and bisexual men, but currently the majority of new AIDS cases result from heterosexual transmission of HIV. A dramatic increase in HIV infection has occurred among women and young adults. The country's AIDS cases increased by 10 percent in 1994, and 71 percent of the cases were reported in the states of São Paulo and Rio de Janeiro.

Reported AIDS cases:* 58,500
Date of last report : 12/94

Increase over 1993 report:** 10%

Total population: 159,000,000

Cumulative incidence:
43.2 per 100,000

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
1.25 to 58%
Population at low risk: 0 to 3.7%

USAID STRATEGY

The goal of the USAID program in Brazil is to reduce the rate of sexually transmitted HIV infection among target populations in the states of São Paulo and Rio de Janeiro. The AIDS Control and Prevention (AIDSCAP) Project has developed a comprehensive set of interventions and program assistance in behavior change communication (BCC), condom programming and reduction of sexually transmitted diseases (STDs). Three support strategies, behavioral research, policy development and evaluation, will enhance the effectiveness of the primary components.

The $10 million five-year program consists of 14 projects covering all major components and focusing on four target populations: commercial sex workers (CSWs), people with STDs, men who have sex with men (MWM) and men in the workplace (MWP).

USAID-SUPPORTED COUNTRY PROGRAMS

Interventions for CSWs
AIDSCAP activities focus on female CSWs in São Paulo and Rio de Janeiro but also work with male CSWs wherever possible. Projects are reaching 10,000 to 15,000 CSWs through health agents, peer educators and multifaceted BCC channels, including street theater. Activities aim to inform and educate CSWs about HIV/AIDS and encourage them to make safer sexual choices, including seeking treatment for STDs and using condoms.

Interventions for MWM
Outreach activities target MWM through peer education, information dissemination, condom distribution, referrals for STD treatment, safe-sex workshops and expressionist theater. BCC materials and condoms are being distributed at a total of 410 gay cruising areas and meeting points in Rio de Janeiro and São Paulo.

Interventions for Men in the Workplace
Project activities are being implemented through the central office of the Shell Oil Company in Rio de Janeiro and at the Santos harbor. Behavior change communication interventions have been designed to provide Shell employees in Rio de Janeiro with information about HIV/AIDS. The project will provide information on STD diagnosis and treatment services and promote condom use. AIDSCAP is also conducting a cohort study with the Center for AIDS Prevention Studies (CAPS) of the University of California at San Francisco among port workers in Santos including HIV seroprevalence, behavioral study and prevention intervention.

Interventions for People with STDs
The majority of people with STDs in Brazil seek treatment from the informal sector. Public sector health services are poor, and STD drugs and condoms are often not available. Project activities focus on improving the health-seeking behavior among STD patients in target geographic areas and expanding access to and improving the quality of HIV/AIDS/STD service management, diagnosis and treatment. A total of 150 health care providers have already attended STD training courses.

Condom Social Marketing
In support of AIDSCAP project activities, DKT do Brazil provides low-price condoms to target populations and retail pharmacies in target areas. DKT imports

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

and sells a high-quality, low-cost condom with the objective of increasing condom sales and promoting competition among available condom brands.

Policy Dialogue
USAID/Brazil and AIDSCAP continue to engage Government of Brazil officials at the federal and state levels on issues of policy change to improve AIDS prevention strategies in Brazil. In 1994, import and federal sales taxes on condoms were abolished. Dialogue continues on removing state sales taxes on condoms, testing and obtaining approval of imported condoms, improving logistics systems and developing STD treatment guidelines.

AIDS and Women
In response to the rapid increase in HIV infections in women in Brazil, USAID/Brazil has included in its strategy interventions to promote HIV/AIDS prevention among women not formerly considered at high risk of infection. Through women's clinics and shelters, research was conducted on behavior patterns of low-income and young adult women, especially regarding condom use and attitudes toward safe sex practices. The results of this research are now being used in the design of AIDS prevention activities targeting women.

BEMFAM, the International Planned Parenthood affiliate, has implemented a comprehensive AIDS prevention program in its clinics in public sector service sites and schools. The program includes staff training, counseling, STD prevention, diagnosis, treatment and referral, and condom promotion.

THE DOMINICAN REPUBLIC

SITUATION ANALYSIS

The HIV/AIDS epidemic is well-established in the Dominican Republic (DR). The virus is moving steadily from original core groups—people such as commercial sex workers (CSWs) and men who have sex with men (MWM) who practice high-risk behaviors—into the general population throughout the country. The main mode of transmission is heterosexual sex. The HIV seroprevalence rate is 1 percent, but it is projected to be 5 percent by the end of the decade.

The DR's thriving commercial sex industry, a growing tourist trade, poverty and social inequity, alcohol abuse and migration (largely from Haiti) have all contributed to the growth of the epidemic. Programs are being implemented by the nongovernmental sector to address some of these issues. Financed mainly by international donor agencies and without much governmental support, however, these nongovernmental organization (NGO) interventions have been small scale.

Reported AIDS cases:* 2,589
Date of last report: 1/95

Increase over 1993 report:** 43%

Total population: 7,089,000

Cumulative incidence:
365.2 per million

HIV-1 seroprevalence in urban areas:***
Population at high risk:******
2.6 to 5.0%
Population at low risk:
0.8 to 1.3%

USAID STRATEGY

USAID works primarily through nongovernmental and other organizations that have access to at-risk communities not being served by existing interventions. Most efforts have targeted groups such as young adults, inhabitants of squatter settlements, workers in the tourist industry and industrial park employees. As the disease spreads into the population at large, more attention is being directed toward secondary groups, including working class men and women, and the clients of CSWs.

The main strategic objectives of the USAID program are to raise awareness of sexually transmitted diseases (STDs) and HIV/AIDS to generate and sustain prevention interventions; expand access of the general population to HIV/AIDS/STD prevention; and build the capacity of local institutions to carry out HIV/AIDS/STD prevention. The program, coordinated by the AIDS Control and Prevention (AIDSCAP) Project, is mainly implemented through local nongovernmental organizations (NGOs).

USAID-SUPPORTED COUNTRY PROGRAMS

USAID efforts are focusing on encouraging private sector involvement in HIV/AIDS prevention, improving STD services, and increasing condom availability and accessibility. USAID also collaborates with the Ministry of Health in maintaining a sentinel surveillance program.

Workplace Interventions
Two NGOs, the Centro de Orientación Integral (COIN) and the Comite de Vigilancia Contra el SIDA (COVICOSIDA), have developed workplace HIV-prevention projects in three industrial zones in Santo Domingo and in tourist resort areas in Puerto Plata. One project, implemented by COVICOSIDA, targets hotel employees and managers from 13 hotels in Playa Dorada, Puerto Plata, an area with significant tourist activity. The project is designed to reach hotel employees in and out of the workplace with innovative interventions, including short theater skits at bus stops, discussions during breaks and employee-of-the-month parties, and through face-to-face interaction.

COIN has expanded its workplace program to include three new industrial zones—Haina, Herrera and Nigua—in Santo Domingo. The project targets 45,000 workers and 30 managers. During fiscal year 1994 the project's health messenger network reached approximately 3,300 female and 13,500 male workers with HIV/AIDS messages. They distributed 19,000 condoms and 8,500 educational materials in 20 posts located inside the participating industries. Managers and labor union leaders from these industries are also being encouraged to participate in the project.

Young Adults
Implemented by Coordinadora de Animación Socio-Cultural (CASCO) and Instituto Dominicano de Desarrollo Integral (IDDI), this HIV/AIDS awareness project targets young adults in four marginal urban barrios in Santo Domingo (Herrera, La Zurza, Guaricano and Villa Mella) with information and education about HIV/AIDS. The educational interventions target 4,200 youth directly through in-depth training and follow-up and reach approximately 20,000 young adults indirectly through educational sessions and special events.

The project expects to reach approximately 1,000 parents, 50 teachers and 4,200 other adults who in some way come into contact with these youth. It is expected that 1,600 members of 40 community-based organizations will also be reached through meetings to promote HIV/AIDS/STD awareness and project activities.

Commercial Sex Workers (CSWs)
Implemented by COIN and COVICOSIDA, the Avancemos Project targets CSWs in Santo Domingo, La Romana, Santiago and Puerto Plata with HIV/AIDS/STD prevention messages delivered through a health messenger (HM) network. During fiscal year 1994 COIN's HM network reached approximately 3,500 CSWs in STD clinics and 34,000 CSWs through educational interventions. The network distributed 236,550 condoms and 20,680 educational materials among this target audience. In Puerto Plata the HM network reached approximately 5,000 CSWs and distributed about 78,000 condoms and 28,000 educational materials.

Theater Presentations
During this fiscal year COIN implemented a new strategy called "provocative theater," which involves interactive participation between the cast and the audience. Using this technique, peer educators are more effective at capturing their audience's attention with AIDS prevention messages. The team has begun to implement this strategy amongst CSWs and their clients in the streets surrounding the bars and brothels in Santo Domingo, Santiago, La Romana and Puerto Plata. A select group of CSWs are trained to deliver theater presentations to CSWs and men involved in the commercial sex industry.

Men who have Sex with Men (MWM)
MWM are being targeted with HIV/AIDS/STD prevention in five cities in the Dominican Republic—Santo Domingo, Puerto Plata, Azua, San Pedro de Macoros and Santiago. A health messenger network, comprised of 12 leaders and 120 volunteers, conducts outreach through house visits and mini-workshops among this target audience. Approximately 14,650 MWM were reached through face-to-face sessions. During these activities, 75,000 condoms and 37,000 educational materials were distributed.

Behavior Change Communication (BCC)
USAID has played an active role in providing support to local counterparts in implementing new strategies and in developing and validating new educational materials. The Mission provided technical and financial assistance to the National AIDS Council (CONASIDA) in developing the national information, education and communication (IEC) HIV/AIDS prevention strategy.

Condoms
A national condom retail audit was conducted to clarify national condom distribution and sales needs and to identify ways of improving condoms accessibility. Based on the findings of the audit and other assessments, USAID/DR will define a new condom strategy.

STDs
USAID is improving local capacity to diagnose and treat STDs. This is being done through training and referral system development and by enlisting support from the Ministry of Health (MOH) for adequate drug supply. USAID has provided assistance to develop an STD training-of-trainers program that will be implemented by the Technological Institute of Santo Domingo and the Center for Sexually Transmitted Diseases. A total of 815 clinicians, health educators and lab technicians involved in providing STD services will be trained in STD/AIDS prevention and referral or diagnosis and treatment.

EASTERN CARIBBEAN

Antigua and Barbuda, British Virgin Islands, Dominica, Grenada, Montserrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines

SITUATION ANALYSIS

There is significant variance in the seroprevalance figures from country to country in the Eastern Caribbean region, but sexual transmission remains the dominant mode of infection. From January 1982 through September 1994, 6,046 AIDS cases and 3,842 AIDS- related deaths were reported to the Caribbean Epidemiologic Research Centre (CAREC) by the nineteen CAREC member countries (CMCs). Young adults and men with multiple female or male partners seem to be at highest risk of infection. The virus is found mainly among groups practicing high-risk behaviors but has started spreading into the general population of these island nations.

Reported AIDS cases:* 6,046
Date of last report: 9/94

Increase over 1993 report:**
16.4%

Total population: 6.34 million

Cumulative incidence:
953.6 per million

HIV seroprevalance in urban areas:***
Population at high risk:****** 2.6%
Population at low risk: 1.1%

USAID STRATEGY

Working through the AIDS Communication and Technical Services (ACTS) Project, USAID is assisting in the prevention and control of the spread of AIDS in the Eastern Caribbean by developing local capacity to design and implement cost-effective HIV/AIDS surveillance and information, education and communication strategies and interventions. Specifically USAID is assisting in the establishment and strengthening of epidemiological surveillance and research

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

programs to gather information on the extent and characteristics of STD transmission and AIDS cases in the region and in the design of focused behavioral interventions targeting groups, including commercial sex workers, prisoners, business people and adolescents, who practice high-risk behaviors.

USAID-SUPPORTED COUNTRY PROGRAMS

The focus of technical support in the Eastern Caribbean for fiscal year 1994 was on the British Virgin Islands, Montserrat, Antigua and Dominica to disseminate the findings of knowledge, attitude, behavior and practice studies, interpret data and develop national strategies for communication and behavioral interventions.

Epidemiological Surveillance and Research

The 1993 surveillance report of HIV/AIDS/STD in English-speaking Caribbean countries and Suriname was distributed to national AIDS programs and ministry of health personnel and other audiences such as libraries, universities, research institutes, family planning associations, nongovernmental organizations and other institutions.

The study of HIV seroprevalance in antenatal women continued in three ACTS Project countries—Montserrat, St. Lucia and St. Vincent. A status report for the first year of implementation of the HIV seroprevalance study in antenatal women in St. Lucia was prepared and distributed to relevant study personnel. It is anticipated that the study will be expanded to collect additional data from other groups practicing high-risk behaviors.

System design and programming has been completed for the regional STD module of CARISURV, an automated HIV/AIDS/STD surveillance tracking system with five main components: data gathering, patient and test tracking, laboratory and epidemiological linkages, data import and communications. The first module of the CARISURV system was developed in fiscal year 1994 and is now being tested in Jamaica.

A joint team from CMC conducted assessments of HIV/AIDS/STD surveillance services in Antigua, St. Vincent and the Grenadines and St. Kitts and Nevis as a basis for recommendations on how to improve national AIDS program activities. These assessments have assisted National AIDS Programs to formulate plans that identify priority activities and address unmet needs.

Prevention of Sexual Transmission of HIV Infection

ACTS Project staff worked with a core group of national AIDS coordinators, health educators and others involved in the national AIDS programs' information, education and communication activities in the British Virgin Islands, Montserrat, Antigua and Barbuda, and Dominica. All countries are conducting needs assessments of locally available skills and resources in the area of social marketing in order to plan for future technical assistance needs. Programs are also identifying agencies and organizations with whom they can collaborate to prevent the spread of HIV.

Promotion of Effective Management of National AIDS Programs

National AIDS Programme staff in St. Lucia participated in a four-day project planning workshop. Funded by USAID to strengthen local program management capabilities, the workshop provided training in logical framework and cost analysis. The hierarchy of objectives for the National AIDS Program matrix was also developed during this workshop.

GUATEMALA

SITUATION ANALYSIS

AIDS was first reported in Guatemala in 1984. Through July 1994, 742 cases of HIV infection and 539 AIDS cases had been reported to the National AIDS Prevention and Control Program (NAPCP). According to Pan American Health Organization (PAHO) projections, however, reported cases represent only a fraction of actual cases. Estimates made using EpiModel software indicate that there are approximately 2,700 to 3,700 AIDS cases.

Sexual transmission of HIV is thought to account for about 92 percent of all HIV/AIDS cases reported to date. Heterosexual transmission accounts for 65 percent of transmission, homosexual or bisexual transmission for 27 percent, transmission through blood products for 2.9 percent, injection drug use for 1.3 percent and mother-to-infant transmission for 1 percent. In 1993 women accounted for 30 percent of all HIV infections and AIDS cases. The male-to-female ratio is now reported to be 2:1. Most of the people infected with HIV/AIDS are aged 20 to 39.

HIV/AIDS prevention projects are being implemented by the public and private sectors, nongovernmental organizations (NGOs), international private voluntary organization (PVOs) and donor organizations in Guatemala. The efforts of these groups need to be integrated into a cohesive national program.

USAID STRATEGY

USAID does not have an HIV/AIDS project in Guatemala but has been an important donor for HIV/AIDS prevention. Assistance provided by USAID includes infrastructure support and development of information, education and communication materials and strategies to reach female commercial sex workers and train laboratory personnel in HIV testing. The Mission is providing condoms to the sexually active population and high-risk groups through its implementing agencies: the MOH's Reproductive Health Unit, the Social Security System, Asociación Pro-Bienestar de la Familia (APROFAM), and Importadora de Productos Farmacéuticos, S.A.(IPROFASA). The Mission funds the Centro de Orientación y Diagnóstico de Enfermedades de Transmisión Sexual (CODETS), managed by APROFAM. CODETS provides STD/HIV counseling, testing and prevention education services. During fiscal year 1994, AIDSCAP conducted a national technical assessment of the HIV/AIDS situation in Guatemala. The assessment is being used by the Mission and other donors to improve the quality of HIV programs in Guatemala.

HAITI

SITUATION ANALYSIS

Continuing economic and social instability and high-risk sexual practices have led to high HIV seroprevalence rates among certain populations in Haiti. Seroprevalence among pregnant women living in one Port-au-Prince slum area is approximately 11 percent, and more than 50 percent of commercial sex workers (CSWs) tested in Haiti are HIV-infected. Although AIDS awareness in Haiti is high, adoption of low-risk behaviors is slow.

Reported AIDS cases:* 4,967 (Date of last report: 9/93)

Increase over 1993:** Not Available

Total population: 6,700,000

Cumulative incidence: 482.2 per million

HIV-1 seroprevalence in urban areas:*
Population at high risk:****
21.4 to 41.9%
Population at low risk: 5.5 to 8.5%

USAID STRATEGY

Since the military coup of September 30, 1991, USAID has not worked with the public sector in Haiti; however, the Mission is building a solid base of information about AIDS and skills in HIV/AIDS intervention within the private sector. USAID's strategy focuses on identification, treatment and control of sexually transmitted diseases (STDs), reaching young adults with HIV/AIDS information and education, and social marketing of condoms. Interventions targeting groups practicing high-risk behaviors are continuing on a smaller scale through private sector organizations.

USAID-SUPPORTED COUNTRY PROGRAMS

Women and AIDS
The Centre de Promotion des Femme Ouvières (CPFO) is implementing a program to reduce the transmission of STDs among women from low-income communities, their families and their communities. This project provides support to women, their partners and children by training peer educators, developing educational materials, conducting educational sessions on safe sex, and holding seminars on the impact of HIV/AIDS on families and the society.

Intervention with Adolescents
PERKOMAS, a collaborative AIDS/STD prevention project implemented by the Scouts and the Voluntariat pour le Développement d'Haiti (VDH), has established a peer education program to reach urban and periurban adolescents in the northern and central parts of the country through an extensive youth association network.

AIDS in the Workplace
The Groupe de Lutte Anti-SIDA (GLAS) trains peer educators and supports HIV/AIDS education and condom distribution in approximately 35 factories and five parastatal worksites in greater Port-au-Prince. The project relies on the active participation of factory owners and managers in the establishment of a peer education network and the gradual institution of condom social marketing sales points at worksites.

AIDS Surveillance and Counseling
Preliminary results of a USAID-funded HIV surveillance study conducted by the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO) show an HIV infection rate of 8 percent among adults in Port-au-Prince and 33 percent among STD patients. USAID also supports GHESKIO's program of voluntary HIV testing and counseling for the general community. Social workers have been trained to inform and support individuals with HIV, and a system to coordinate counseling activities with other health service agencies has been established.

PVO Grants Program
Implemented by Save the Children, a U.S.-based private voluntary organization (PVO), with funding from the AIDS Control and Prevention (AIDSCAP) Project competitive grants program, this project brings together a core group of at least seven indigenous community-based organizations working with women in the Central Plateau district of Haiti to train peer educators, medical personnel and traditional healers and birth attendants on AIDS and STD. It addresses improved STD diagnosis, treatment and referral as well as better communication between partners to encourage safer sexual behavior.

STD Services in Community Health Clinics
The Centres pour le Développement et le Santé (CDS) is integrating STD and HIV/AIDS prevention education and counseling, as well as improved STD diagnosis and treatment, into clinic and community outreach efforts serving approximately 544,000 people in impoverished urban areas throughout the country.

Intervention with Youth in Southern Port-au-Prince
In May 1993, with AIDSCAP support, the Centre Haitien de Service Social (CHASS) began implementing a community-based communication and condom promotion project with youth in Port-au-Prince. The project reaches young adults through a system of information posts, peer education sessions and volunteer outreach workers.

Intervention with Commercial Sex Workers and their Clients
The Implementing Agency for Cooperation and Training (IMPACT/ InterAide) uses participative educational techniques and condom social marketing to prevent HIV/STD transmission among CSWs and their clients in seven port cities. The initial target group has been expanded to include women from low-income neighborhoods.

Alert SIDA
Through the Alert SIDA Project, information and educational materials targeting youth

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

were distributed in junior and senior high schools throughout Port-au-Prince. In addition, trained AIDS counselors addressed student groups in schools and established an AIDS hot line to respond to young people's AIDS questions and concerns.

Behavioral Research for AIDS Prevention
USAID is funding joint research by Johns Hopkins University and CDS on the relationship between HIV risk reduction behaviors and culture, health and sexuality. This study of the sexual beliefs, perception and behaviors of men and women is being conducted in Cité Soleil (an urban slum area of Port-au-Prince) and in a low-income town in northern Haiti.

Behavioral Research on Women and HIV/AIDS Interventions
The Haitian Child Health Institute is studying the link between psychosocial factors and women's perceived ability to protect themselves against HIV infection. Capitalizing on previous research evaluating the extent to which Haitian women believe themselves capable of influencing and preventing high-risk behavior, the new results will support efforts to promote women's participation in local campaigns aimed at slowing the spread of AIDS. Similar data collected from men will be used to design messages promoting behavior change among both men and women.

Condom Social Marketing
In collaboration with AIDSCAP and Population Services International (PSI), USAID is assisting a local distributor with a condom marketing initiative. The Pantè condom is promoted widely and currently sells for less than 20 percent of the price of popular commercial condom brands in Haiti. Pantè sales have increased steadily since introduction of the product; more than 8 million condoms have been sold since 1992. The Institut Haitien de Santé Communautaire (INSHAC) provides training to other AIDS-CAP implementing agencies in condom logistics and promotion, project management and monitoring, materials development and communication techniques.

JAMAICA

SITUATION ANALYSIS

Sexual transmission remains the most prevalent mode of HIV infection in Jamaica. To date, the number of full-blown AIDS cases has been relatively low, but HIV seroprevalence is increasing. The growing incidence of other sexually transmitted diseases (STDs), certain types of drug use, and the limited resources of the public health care system might well result in an economically and socially devastating HIV/AIDS epidemic. While Jamaica faces other serious problems, the National HIV/STD Control Program is maintaining its focus on slowing the spread of the disease.

Reported AIDS cases:* 1,028
Date of last report: 12/94

Increase over 1993 report:**
137%

Total population: 2,500,000

Cumulative incidence:***
411.2 per million

HIV-1 seroprevalence in urban areas:
Population at high risk:******
3.1 to 14.6%
Population at low risk:
Not Available

USAID STRATEGY

USAID's strategy to control STDs and HIV/AIDS encompasses educational activities, applied operations research, and improved STD diagnosis and treatment at Ministry of Health (MOH) facilities. The Mission works through the AIDS Control and Prevention (AIDS-CAP) Project to reinforce the institutional capacity of the MOH to design, implement and monitor HIV/AIDS prevention interventions and to stimulate closer collaboration among the various institutions working on AIDS prevention.

USAID-SUPPORTED COUNTRY PROGRAMS

Materials Development and Support for Behavior Change Communication (BCC) Strategy
The communications team within the Epidemiology Unit of the MOH develops BCC strategies and materials for reaching target audiences, including young adults, people with STDs and HIV, and people in the workplace, and coordinates mass media campaigns and production of small media. Project achievements to date include: the production and distribution of over 63,000 educational materials; a 30-minute video on the Targeted Community Intervention Project; two 15-minute television presentations, including an interview with an HIV-positive person and a program on how HIV/AIDS affects Jamaican women; and an HIV/STD musical targeting secondary school students in the western rural areas of Jamaica.

Jamaica AIDS Support
Jamaica AIDS Support (JAS) is working to ensure that men who have sex with men (MWM) are aware of AIDS and safer sexual practices and are practicing safer sex consistently. The project combines the use of educational outreach activities, informal presentations and in-depth, long-term interpersonal sessions for groups of MWM. JAS' innovative approaches include "parties" that feature safer sex skits, discussions, information booths, and provision of educational materials. To date 35 peer counselors have been trained and 3,292 contacts have been made. In addition, 8,620 MWM have been reached through counseling networks in Kingston and the tourist resorts of Ocho Rios and Montego Bay. JAS has also distributed 2,350 pamphlets, 780 posters and 506 stickers. JAS is targeting the general public with outreach activities that include education workshops for police, church members and youth.

AIDS in the Workplace
The AIDS in the Workplace Program of the Epidemiology Unit works with private organizations to develop sustainable, self-funded workplace HIV/AIDS education programs and non-discriminatory policies to protect HIV-infected employees. Twenty major companies, each with 1,000 or more employees, have been targeted to develop workplace programs. In-house coordinators are being trained to provide workers with regular HIV/AIDS and STD informa-

tion and education. To date 54 chief executive officers, 15 in-house coordinators and 1,810 employees have participated in the program.

Targeted Community Intervention
This project targets five marginal communities with group education on STDs, HIV and AIDS; sessions on personal risk assessment, correct condom use, condom negotiating skills, and ways to take charge of one's own health; one-on-one counseling; and individual HIV testing with pre- and post-test counseling. Drama presentations and informal street corner meetings are used to draw an audience for the educational messages and behavioral interventions. Anonymous, aggregate results of the tests are later shared with the community through drama and individual counseling. This project is expected to reach 20,000 people through 300 interpersonal, community-based sessions.

Public Relations HIV/AIDS Risk Reduction Project
Working through trained youth opinion leaders, this project is providing young adults with information and education about HIV/AIDS. It is also creating awareness among national opinion leaders about STD/HIV/AIDS by increasing their knowledge of the national vulnerability and possible consequences of an STD/HIV/AIDS epidemic in Jamaica. Project achievements to date include placement of 234 newspaper articles and columns and distribution of 98 folders with information about the epidemic in Jamaica to journalists. The campaign was also instrumental in attaining extensive media coverage for World AIDS Day.

ACOSTRAD

This project is strengthening ACOSTRAD's capacity to carry out comprehensive HIV/AIDS/STD prevention outreach targeting marginalized groups, CSWs and STD clinic attenders in Kingston. Twenty community members have been trained to conduct outreach work with marginalized groups, motivating them to seek treatment for STDs and adopt safer sex practices. CSWs trained as peer educators encourage CSWs and bar and club owners to attend a weekly drop-in center where AIDS prevention activities and exercises are conducted. STD clinic attenders are reached through 17 trained peer counselors, who conduct group education sessions in clinic waiting areas. STD patients receive free condoms and are encouraged to purchase additional supplies at locally identified vendors. The project has successfully reached over 74,000 women and 47,000 men. In addition, 371,770 condoms and 166,828 educational materials have been distributed.

Face-to-Face Program
The Face-to-Face Program of the Epidemiology Unit targets young adults with multiple sex partners and STD clinic patients. Face-to-Face identifies key young adults in study, work and leisure organizations to participate as community and peer educators. These selected peer educators, as well as classroom teachers, health workers, workplace peer educators, and youth and community group leaders, are trained by Face-to-Face to reach their peers with sustained HIV/AIDS/STD prevention programs. An island-wide network of trained team members is holding small, informal "rap" sessions with groups of young adults in their communities, focusing on HIV/STD information, personal risk perception and skill building. Face-to Face has already trained 94 peer educators who have reached over 90,000 people (40,980 of them are adolescents) and distributed more than 130,000 educational materials.

Counseling and Social Welfare
The Counseling and Social Welfare Program of the Epidemiology Unit increases the effectiveness and utilization of support services provided by both governmental and non-governmental agencies for people with HIV/AIDS. Social service agencies are targeted to become part of the referral network; by the end of the project approximately 300 volunteers and health care personnel will be trained in counseling and support services. As part of the referral network, the Counseling and Social Welfare Program runs a confidential telephone counseling and referral system. This system received 4,750 calls in 1993 and 4,152 in 1994.

Island-Wide HIV/STD Prevention Program in Jamaica
This project, implemented by the American National Red Cross in conjunction with the Jamaica Red Cross, will provide a national training system to support peer educators for youth across the island. Thirty instructors have been trained to train 450 peer educators. Already 69 peer educators have been trained, and they have reached 1,395 young adults. The peer educators are educating youth about HIV and STD prevention, promoting the correct use of condoms, and referring participants to appropriate centers for HIV/STD testing, counseling and treatment. The project expects to reach at least 4,500 young adults. To reinforce the messages of the peer educators, the project is broadcasting two weekly radio dramas about the issues young adults and adults face in preventing HIV/STD.

STD Training of Private Practitioners
The Medical Association of Jamaica, in cooperation with the MOH and the University of North Carolina, conduct continuing education seminars on STDs for private practitioners to improve STD diagnosis and treatment. To date, this project has conducted four workshops for over 800 practitioners.

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

Sentinel Surveillance
Sentinel surveillance is conducted among STD clinic attenders, informal commercial importers, food handlers, CSWs, prisoners, MWM, mental patients, sailors, hospitalized patients, and drug abusers. By the end of the project in 1996, the quality of laboratory testing and reporting for HIV/AIDS cases in at least four public and three private laboratories in Jamaica will be upgraded and an emphasis will be placed on confirmatory testing. Approximately 200 health professional will be trained in selection of target groups, methods of reaching target groups, and collection and labeling of blood samples. In addition, 40 medical records and parish health staff will be trained in detection and reporting of HIV/AIDS cases.

Condom Distribution in Jamaica
This project was designed to promote an expansion of the distribution system to include at least 2,000 small shops, 100 supermarkets and bars. Over 88 percent of supermarkets 72 percent of wholesalers, 66 percent of small services, and 25 percent of bars island-wide now carry Panther condoms.

AIDS-Related Sexual Decision Making
To develop effective behavior change interventions for Jamaica, the University of California at Los Angeles and the University of the West Indies have collaborated on USAID-funded behavioral research to examine how psychosocial and sociocultural factors affect sexual decision making and may increase the risk of HIV infection.

Women's Health Study
The MOH has expanded its research and intervention activities for women at high risk for HIV infection in Kingston. More than 120 CSWs and women visiting STD clinics were surveyed about their sexual practices and their knowledge and beliefs about HIV/AIDS and STDs. Survey data helped the ministry develop community-based interventions and educational initiatives to encourage safer sex. Participants received HIV/AIDS/STD education, condoms, and HIV testing and counseling from peer educators and a contact investigator trained by the Centers for Disease Control and Prevention (CDC). The CDC and AIDSCAP also assisted the Ministry of Health in training laboratory technical assistants at rural STD and antenatal clinics to do rapid screening for syphilis, using the Rapid Plasma Reagent (TRUST) test.

NICARAGUA

SITUATION ANALYSIS

The first HIV and AIDS cases in Nicaragua were diagnosed in 1987. Each year the number of HIV infections in each of the 19 states in the country has increased, though Managua, the capital, accounts for 52 percent of all HIV cases reported. Estimates indicate that reported cases represent only a small proportion of actual HIV infections. The Ministry of Health estimates that there may be as many as 10,000 HIV/AIDS cases in the country.

The ratio of male-to-female infections is approximately 8:2, and the largest number of infections is among those ages 20 to 45. Sexual transmission is the primary means of HIV infection: heterosexual transmission accounts for approximately 51 percent of the cases, homosexual and bisexual transmission for 38 percent, and injection drug use for 8 percent of the cases.

Reported AIDS cases:* 144
Date of last report 12/94

Increase over last report**

Total population: 4,000,000

Cumulative incidence:***
36 per million

HIV seroprevalence in urban areas: Not Available

USAID STRATEGY

USAID/Nicaragua's response has been limited to providing condoms to the Ministry of Health's HIV/AIDS Prevention and Control Program and to local nongovernmental organizations involved in HIV/AIDS activities. USAID has also assisted in obtaining resources to support an assessment of HIV/AIDS in Nicaragua. Findings from this socioeconomic impact study and an ongoing behavioral research study will help in the development of a behavior change communication strategy. The findings of the studies will also update policy makers on the current and impending HIV/AIDS situation in Nicaragua and provide a framework within which the Government of Nicaragua, international donors and the private sector can mobilize resources to implement the interventions necessary to control HIV/AIDS in the country.

* AIDS cases reported to the World Health Organization.

** The increase in AIDS cases reported to the World Health Organization could be due to improvements in diagnosis and reporting of existing AIDS cases as well as to an increase in the spread of HIV.

*** HIV seroprevalence data are collected by the U.S. Bureau of the Census from the most representative studies available.

**** Population at high risk: commercial sex workers and their clients, STD patients or other people with recognized risk factors. Population at low risk: pregnant women attending antenatal clinics, blood donors, general population samples or others with no known risk factors.

THE NEW INDEPENDENT STATES AND EASTERN EUROPE

These regions still have low levels of HIV infection and AIDS, but the potential exists for a devastating epidemic. An ongoing economic crisis, ethnic and religious conflicts, and population displacement which may lead to high-risk behaviors put adults at increased risk. Thousands of children in the former U.S.S.R. and Romania have already been infected with the virus through blood transfusions and the use of unsterilized needles.

USAID-SUPPORTED ACTIVITIES

USAID HIV/AIDS prevention and sexually transmitted disease control activities in the New Independent States and eastern Europe are implemented primarily through family planning, reproductive health, and maternal and child health programs. Activities focus on increasing awareness of HIV/AIDS and improving condom supply. Interventions include a project through World Learning to establish and operate an AIDS information network promoting information sharing among individuals and organizations in Russia, a condom social marketing project through Population Services International promoting condom use, and training of eastern European nurses in women's reproductive health issues and HIV/AIDS through World Vision. In Romania, USAID efforts have focused primarily on cleaning up the blood supply. Through a private voluntary organization grants program USAID is also tackling women and AIDS issues in the urban port regions where 90 percent of HIV infections are found in Romania.

This child, infected with HIV, is one of those who have been brought to the Second Infectious Disease Hospital in Moscow, Russia, by their mothers for examination.

J. B. DIEDERICH/CONTACT

USAID FY 1994 HIV/AIDS OBLIGATIONS BY COUNTRY*

	DEVELOPMENT ASSISTANCE ACCOUNT		DEVELOPMENT FUND FOR AFRICA		POPULATION ACCOUNT	ECONOMIC SUPPORT FUND	FY '94** COUNTRY TOTAL
COUNTRY	MISSION/ BILATERAL	G/PHN/HN/ HIV-AIDS CENTRAL	MISSION/ BILATERAL	G/PHN/HN/ HIV-AIDS CENTRAL			
AFRICA REGION							
Africa Regional	0	2,845,421	1,275,000	2,963,466	0	0	7,083,887
Benin	0	0	0	0	131,246	0	131,246
Botswana	0	0	785,000	0	0	0	785,000
Burkina Faso	0	0	180,000	0	73,962	0	253,962
Cameroon	0	114,445	0	1,428,445	433,334	0	1,976,224
Central African Republic	0	0	463,000	0	89,443	0	552,443
Chad	0	0	20,000	0	0	0	20,000
Côte d'Ivoire	0	112,960	0	0	350,773	0	463,733
Ethiopia	0	373,268	800,000	202,400	961,249	0	2,336,917
Gambia	0	25,000	0	0	16,456	0	41,456
Ghana	0	0	1,586,000	0	395,791	0	1,981,791
Guinea	0	0	1,383,000	0	60,020	0	1,443,020
Guinea-Bissau	0	0	0	0	77,448	0	77,448
Kenya	0	450,722	0	1,400,000	470,524	0	2,321,246
Madagascar	0	0	0	0	75,877	0	75,877
Malawi	0	155,592	1,520,000	0	603,185	0	2,278,777
Mali	0	0	2,881,000	0	270,284	0	3,151,284
Mozambique	0	0	917,000	0	346,167	0	1,263,167
Niger	0	0	0	0	313,661	0	313,661
Nigeria	0	46,532	39,000	10,400	1,854,972	0	1,950,904
Rwanda	0	251,443	0	9,800	162,511	0	423,754
Senegal	0	595,016	3,550,000	10,400	166,424	0	4,321,840
Sierra Leone	0	0	0	0	8,168	0	8,168
South Africa	0	41,441	8,766,000	123,000	0	504,000	9,434,441
Sudan	0	0	0	0	4,055	0	4,055
Swaziland	0	0	100,000	0	51,605	0	151,605
Tanzania	0	130,864	400,000	3,000,000	1,384,778	0	4,915,642
Togo	0	0	0	0	216,994	0	216,994
Uganda	0	0	1,200,000	40,000	1,306,311	0	2,546,311
Zambia	0	0	3,750,000	751,000	426,676	0	4,927,676
Zimbabwe	0	99,728	500,000	3,438,312	0	0	4,038,040
Africa Region Total	0	5,242,432	30,115,000	13,377,223	10,251,914	504,000	59,490,569

* Source: USAID Activity Code/Special Interest System 5/17/95 and USAID Worldwide HIV/AIDS Database.
** The grand total includes 1994 Population Account funding for contraceptive procurement of $ 23,748,580.

USAID FY 1994 HIV/AIDS OBLIGATIONS BY COUNTRY*

COUNTRY	DEVELOPMENT ASSISTANCE ACCOUNT		DEVELOPMENT FUND FOR AFRICA		POPULATION ACCOUNT	ECONOMIC SUPPORT FUND	FY '94** COUNTRY TOTAL
	MISSION/ BILATERAL	G/PHN/HN/ HIV-AIDS CENTRAL	MISSION/ BILATERAL	G/PHN/HN/ HIV-AIDS CENTRAL			
ASIA/NEAR EAST REGION							
Asia Regional	0	1,709,953	0	0	0	0	1,709,953
Bangladesh	0	100,000	0	0	4,346,767	0	4,446,767
Cambodia	0	0	0	0	124,522	0	124,522
Egypt	0	0	0	0	65,988	0	65,988
Fiji	0	0	0	0	2,630	0	2,630
India	0	116,867	0	0	0	0	116,867
Indonesia	0	186,100	0	0	0	0	186,100
Laos	0	148,000	0	0	0	0	148,000
Morocco	0	0	0	0	222,023	0	222,023
Nepal	0	709,731	0	0	1,328,591	0	2,038,322
Oman	0	0	0	0	13,140	0	13,140
Philippines	2,862,000	359	0	0	1,508,766	0	4,371,125
Sri Lanka	81,000	14,881	0	0	0	0	95,881
Thailand	821,000	1,610,126	0	0	0	0	2,431,126
Turkey	0	0	0	0	572,686	0	572,686
Yemen Arab Republic	3,000	0	0	0	0	0	3,000
Asia/Near East Region Total	3,767,000	4,596,017	0	0	8,185,113	0	16,548,130
ENI REGION							
Croatia	0	0	0	0	36,168	0	36,168
NIS Regional	21,000	0	0	0	56,994	0	77,994
ENI Region Total	21,000	0	0	0	93,162	0	114,162
LATIN AMERICA & CARIBBEAN							
Antigua	0	0	0	0	1,081	0	1,081
Aruba	0	0	0	0	2,444	0	2,444
Bahamas	0	0	0	0	450	0	450
Barbados	0	0	0	0	2,423	0	2,423
Belize	0	0	0	0	776	0	776
Bolivia	797,000	0	0	0	74,327	0	871,327
Brazil	0	565,428	0	0	817,855	0	1,383,283
Chile	0	0	0	0	179,055	0	179,055
Colombia	0	0	0	0	55,682	0	55,682
Costa Rica	0	0	0	0	58,127	0	58,127
Curaçao	0	0	0	0	3,727	0	3,727

* Source: USAID Activity Code/Special Interest System 5/17/95 and USAID Worldwide HIV/AIDS Database.
** The grand total includes 1994 Population Account funding for contraceptive procurement of $ 23,748,580.

USAID FY 1994 HIV/AIDS OBLIGATIONS BY COUNTRY*

COUNTRY	DEVELOPMENT ASSISTANCE ACCOUNT MISSION/ BILATERAL	DEVELOPMENT ASSISTANCE ACCOUNT G/PHN/HN/ HIV-AIDS CENTRAL	DEVELOPMENT FUND FOR AFRICA MISSION/ BILATERAL	DEVELOPMENT FUND FOR AFRICA G/PHN/HN/ HIV-AIDS CENTRAL	POPULATION ACCOUNT	ECONOMIC SUPPORT FUND	FY '94** COUNTRY TOTAL
LATIN AMERICA & CARIBBEAN (continued)							
Dominican Republic	1,040,000	269,380	0	0	166,148	0	1,475,528
Ecuador	0	0	0	0	356,037	0	356,037
El Salvador	0	0	0	0	209,606	0	209,606
Guatemala	0	0	0	0	70,457	0	70,457
Haiti	970,000	144,780	0	0	359,723	0	1,474,503
Honduras	1,055,000	156,329	0	0	386,957	0	1,598,286
Jamaica	400,000	1,086,223	0	0	170,576	0	1,656,799
LAC Regional	1,900,000	1,094,457	0	0	37,442	0	3,031,899
Mexico	0	152,079	0	0	911,055	0	1,063,134
Montserrat	0	0	0	0	361	0	361
Nicaragua	0	0	0	0	76,130	0	76,130
Panama	0	0	0	0	170,832	0	170,832
Paraguay	0	0	0	0	12,722	0	12,722
Peru	0	0	0	0	286,405	0	286,405
St. Kitts	0	0	0	0	1,326	0	1,326
St. Lucia	0	0	0	0	13,498	0	13,498
St. Vincent	0	0	0	0	1,436	0	1,436
Suriname	0	0	0	0	25,044	0	25,044
Trinidad & Tobago	0	0	0	0	6,648	0	6,648
Uruguay	0	0	0	0	30,730	0	30,730
Latin America & Caribbean Total	6,162,000	3,468,676	0	0	4,489,080	0	14,119,756
WORLDWIDE							
Interregional	3,378,000 ***	12,100,089	0	0	729,311	0	16,207,400
UNDP	0	1,000,000	0	0	0	0	1,000,000
WHO/GPA	0	28,500,000	0	0	0	0	28,500,000
WID	0	562,000	0	16,000	0	0	578,000
Worldwide Total	3,378,000	42,162,089	0	16,000	729,311	0	46,285,400
Grand Total For FY '94	13,328,000	55,469,214	30,115,000	13,393,223	23,748,580	504,000	136,558,017

* Source: USAID Activity Code/Special Interest System 5/17/95 and USAID Worldwide HIV/AIDS Database.
** The grand total includes 1994 Population Account funding for contraceptive procurement of $ 23,748,580.
*** These are USAID Mission Add-ons to centrally managed projects.

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