

USAID
RESPONDS
TO
HIV/AIDS

*A Report on the
Fiscal Years
1995 AND 1996
HIV/AIDS
Prevention Programs
of the United
States Agency
for International
Development*



Through the AIDS Technical Support Project (ATSP) the following Cooperating Agencies (CAS) are supported by USAID.

The AIDS Control and Prevention Project (AIDSCAP)

AIDSCAP is the principal component of USAID's global HIV/AIDS prevention effort. Implemented by Family Health International (FHI), this five-year project is designed to support the local capacity of developing countries to prevent and control HIV.

International Center for Research on Women (ICRW)

Seventeen behavioral, ethnographic, and operations research projects aimed at identifying ways in which women can be effective agents in reducing their risk of HIV infection.

The International HIV/AIDS Alliance

Promotion of community-level leadership and governance in the development of HIV/AIDS prevention and care programs through working with indigenous NGOs and CBOs.

International Planned Parenthood Federation (IPPF)

The integration of STD and HIV prevention activities, including condom promotion and STD diagnosis and treatment into ongoing family planning services.

National Council for International Health (NCIH)

The participation of PVOs in HIV/AIDS prevention activities. NCIH distributes a newsletter and coordinates semi-annual workshops intended to strengthen the ability of PVOs to assist in the prevention of HIV/AIDS and facilitates networking between these U.S.-based organizations.

National Institute of Allergy and Infectious Diseases (NIAID)

Short-term training of developing country scientists in biomedical and clinical aspects of HIV and AIDS, and technical assistance in designing and conducting biomedical research in HIV/AIDS.

The Population Council

Microbicide research, development, and introduction initiative. This initiative involves screening of potential microbicides and conducting pre-clinical and clinical studies to assess the stability, toxicity, and acceptability of these compounds.

Program for Appropriate Technologies in Health (PATH)

Development of rapid, simple STD diagnostic tests.

United Nations Children's Fund (UNICEF)

Technical assistance in five key UNICEF strategies for HIV/AIDS prevention: community social mobilization, school-based initiatives, youth health development, rural health programs, and family care and counseling. Completed 1996.

United Nations Development Programme (UNDP)

The socioeconomic implications of the epidemic, the promotion of a multi-sectoral response, and the development of indigenous capacity in social action research. Completed 1996.

United States Bureau of the Census (BUCEN)

Maintenance and dissemination of a database on HIV/AIDS prevalence in developing countries. The data are used to prepare reports on trends and impacts of the epidemic.

United States Centers for Disease Control and Prevention (CDC)

Provision of short-term technical assistance in HIV/AIDS prevention. This assistance includes a range of activities, such as ensuring safety of blood supplies, improving surveillance systems, HIV testing, and rapid epidemiologic assessments.

United States Peace Corps

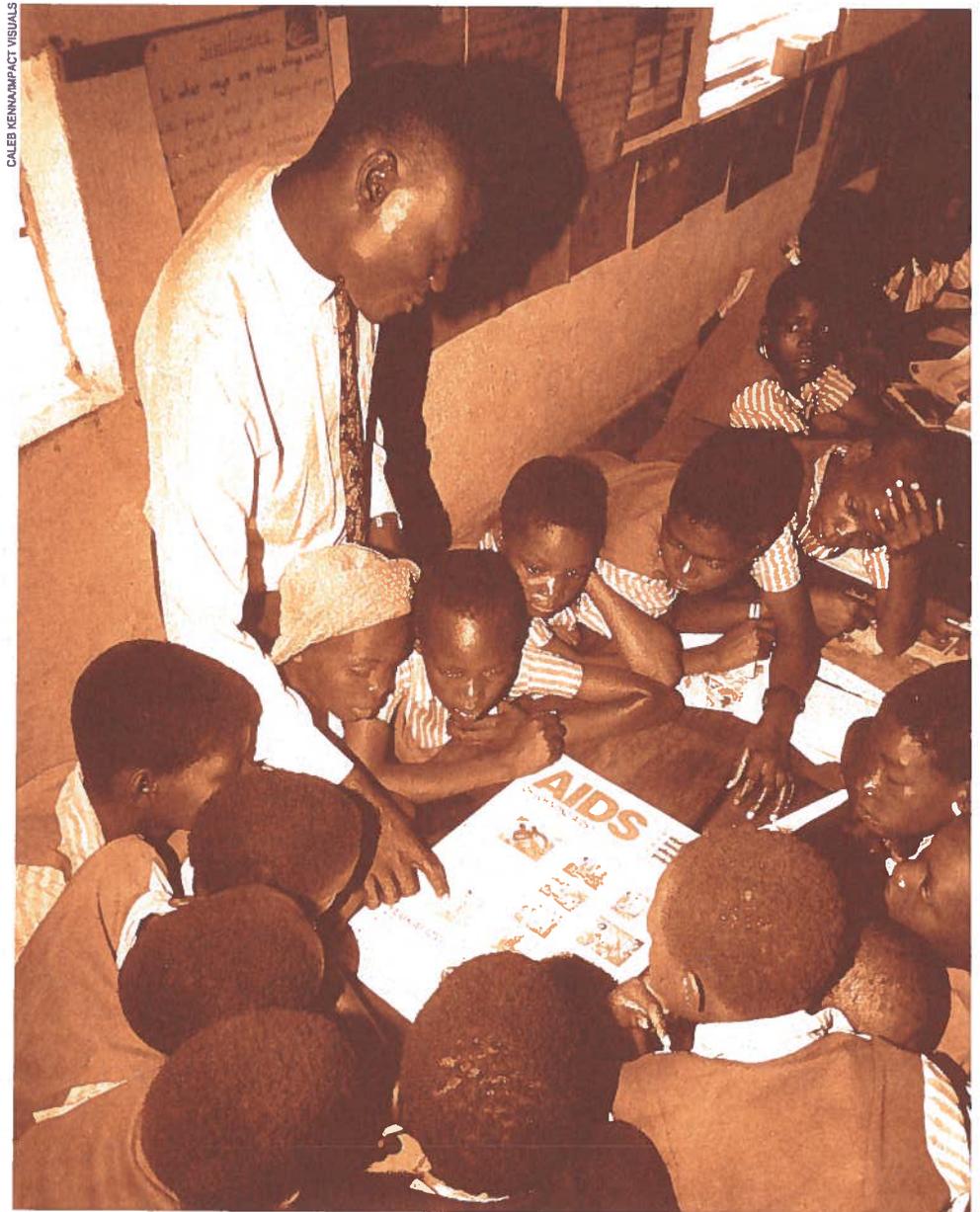
The development of HIV/AIDS prevention projects in eight African countries. These programs are implemented by Peace Corps volunteers and their counterpart and focus on education of youth and HIV prevention and counseling.

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AIDS and Sustainable Development

In the mid-1980s, health experts confronting the deadly new HIV/AIDS epidemic were just beginning to understand its scale and scope and the daunting challenge that lay ahead. An unknown, rapidly mutating virus that proved difficult to isolate, HIV gave scientists few immunological clues as they began the search for a vaccine or cure. Public health professionals and community leaders also faced an uphill battle as they struggled to mobilize threatened communities in an attempt to lessen the devastating impact of the epidemic. Preventing sexual transmission—the primary way HIV is transmitted—requires comprehensive and persuasive education to convince people to change deeply ingrained sexual behaviors, a complex task that forces societies to confront sensitive issues about the most private aspects of people's lives.



In Zimbabwe, students at Raymondale Primary School learn about AIDS as part of a nationwide health education program.

More than a dozen years later, the virus has infected nearly 30 million people worldwide and caused more than 6 million HIV/AIDS-associated deaths—nearly a quarter of them in 1996 alone. Despite these sobering statistics, significant progress has been

made on both the biomedical and behavioral fronts. Several vaccine candidates are now undergoing trials, and new treatments are changing the face of the epidemic. Recently developed drug combina-

tions that include protease inhibitors promise better health and prolonged life for those infected with the virus, and are contributing to lower mortality from HIV/AIDS in wealthier nations that can bear the cost of these expensive therapies.

However, 90 percent of those infected with HIV live in developing countries, where annual public health budgets as low as U.S.\$2 per capita make it impossible to afford these new medications. Instead, the developing world benefits from the growing effectiveness of comprehensive national and regional prevention programs. More than a decade of experience and research has helped prevention programmers improve behavior change communication, expand social marketing of condoms, build the capacity of government health agencies and indigenous NGOs to respond to the epidemic, strengthen prevention and treatment of other sexually transmitted infections that raise vulnerability to HIV, and support policy change to facilitate prevention efforts and care for those already affected by the virus.

These strategies are critically important for developing countries, for whom HIV/AIDS is far more than a public health problem. The epidemic threatens nearly every advance in sustainable development in these regions, where decades of hard-won gains in health, child survival, education, and economic development are losing ground.

The costs of the epidemic and of the secondary infections exacerbated by HIV infection have overwhelmed health systems in many developing countries, which may find themselves using a major portion of their national health budgets to care for those suffering from AIDS or related opportunistic infections, including tuberculosis. This financial burden on struggling health care

1995 PUBLIC HEALTH EXPENDITURES PER CAPITA IN U.S. DOLLARS IN SELECTED COUNTRIES

Bangladesh	3
Belgium	1,866
Burundi	2
Côte d'Ivoire	10
France	1,755
Germany	1,751
Ghana	3
Lao PDR	5
Malawi	3
Nepal	2
Tanzania	4
United States	1,614

Source: The World Bank

systems too often means that other pressing health concerns—infectious diseases, malnutrition, maternal health, child survival, and many more—are neglected.

Basic health indicators in many developing nations also reflect the toll HIV/AIDS has taken. Historic improvements in child health made over the past two decades are threatened by the epidemic. The risk of transmission from HIV-infected mothers to their infants runs as high as 40 percent, and with seroprevalence rising dramatically among women, ever-greater numbers of infants are born infected or are becoming infected after birth from breast milk. In some sub-Saharan African nations, infant and child mortality rates are expected to double and even triple early in the next century if the HIV infection rates aren't reduced. During 1996, more than 400,000 children became infected with HIV.

Life expectancy at birth, another important measurement of health and development, is declining for the first time in decades in many countries with advanced HIV/AIDS epidemics. By the year 2010, life expectancy in some sub-Saharan African countries could decrease by 30 years or more. Because the disease is most prevalent among adults in their years of greatest productivity, HIV's social and economic impact on these nations is almost incalculable. The loss of so many working-age adults to illness and death increases the burden upon impoverished family members left behind and profoundly affects communities, businesses, and nations.

The level of damage sustained by developing nations varies with the maturity of the epidemic and the response of national authorities and local communities to the threat of its spread throughout the population. Early in the epidemic—when the

disease could be most easily controlled—it is often too difficult to mobilize populations and governments. As a result, several Asian countries that were virtually HIV-free only a few years ago now face major HIV epidemics.

governments, and the private sector at levels that keep pace with the expanding epidemic. Although these donors already provide about half of the resources devoted to prevention in developing countries, HIV/AIDS demands an even greater

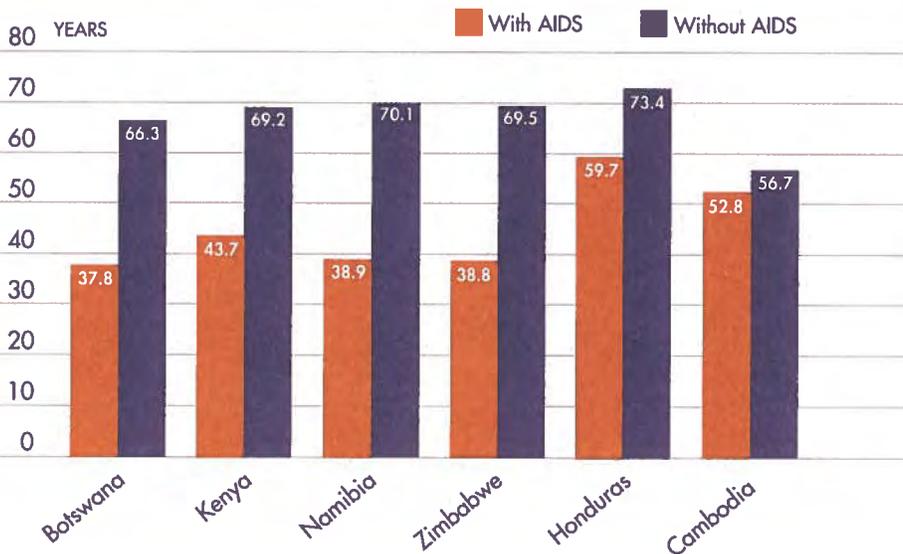
HIV/AIDS. When wage earners become too ill to continue working, income is threatened, forcing family members deep into poverty. Two-thirds of an individual's lifetime income can be lost due to early death from AIDS, a deficit that can endanger a family.

Remaining family funds are often diverted to pay for increasing medical costs, special foods, medications, and other expenses; savings that might have secured future financial stability are often depleted. 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 illness. When family members die, funeral expenses can run as high as a year's income.

High medical and funeral costs are only part of the economic strain HIV/AIDS puts on families. Other family members may give up their jobs to care for those who have AIDS or to replace them as agricultural workers. Rural families may be forced to shift production to less labor-intensive crops, which can result in poorer nutrition or an additional loss of income from cash crops. A study based in Kagera, Tanzania, revealed that low-income households that lost an adult to AIDS were forced to cut food expenditures by nearly a third.*

In many developing countries, nearly 50 percent of the population is under 15 years of age. This group is affected in many direct and indirect ways when those a generation above them are lost to HIV/AIDS. Orphanhood is stigmatized in some cultures, multiplying the already enormous pain of losing one or both parents. Young people also lose role models when they lose parents, and may grow up lacking

LIFE EXPECTANCY FOR 2010 IN SELECTED COUNTRIES WITH AND WITHOUT AIDS



Source: World Population Profile: 1998, U.S. Bureau of the Census, Washington, D.C. 1998

While sub-Saharan Africa struggles with the aftermath of nearly two decades of cataclysmic spread of the infection, many parts of Asia—where HIV/AIDS appeared later in the 1980s—Latin America, and the Caribbean have yet to see their epidemics peak. However, all developing countries at every stage of the epidemic are now benefiting from the considerable body of knowledge and experience in prevention that the international public health community has developed and refined in recent years.

Continuing progress in technical, biomedical, and behavioral prevention strategies depends upon support from international donors,

response to mitigate the impact upon severely affected countries and to prevent the epidemic from expanding into new regions and populations in the developing world. New initiatives for care and psychosocial support for HIV-infected individuals and their survivors are critically needed both to enhance the prevention agenda and to prevent further deterioration of economic and social development.

THE HIV/AIDS BURDEN Families and HIV/AIDS

At all stages of the epidemic, families bear most of the social and economic consequences of

supervision of their own social and sexual behavior, which leaves them vulnerable to HIV infection as well. Children—especially girls—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

Because it predominantly strikes the age sector whose labor drives the economy, HIV/AIDS threatens the commercial sector and by extension the economic health and future of developing nations. By 2010 the epidemic may cause life expectancy to plunge from 70 to just under 35 in Zimbabwe, and from 68 to 49 in Guyana, depriving the economies of those nations of years of worker productivity.

It is estimated that one in seven workers in Nairobi, Kenya, were infected with HIV by 1996 and that this could increase to one in four workers by the year 2000. In the Dominican Republic, as many as 10,000 workers in that nation's free trade zones may be infected by the end of the century.

The high costs of health care and death benefits, absenteeism, and the expense of training new workers to replace those who have died of AIDS are expected to cause the greatest financial losses. One study in Kenya estimated that production losses in the agricultural, service, and industry sectors due to HIV/AIDS could run as high as U.S.\$2.25 billion in 2010—13 to 15 times higher than in 1990. Within the next decade, the cost of labor in Kenya is also expected to rise as much as 8 percent for some firms as a result of reductions in the workforce caused by the epidemic. A study of two factories in Bangkok,

Thailand, showed that each was incurring approximately U.S.\$18,000 in lost revenues and additional expenditures due to HIV/AIDS in 1994, and that those annual losses could rise to more than \$80,000 per company in the next decade.

Such projections have led to increased interest in progressive workplace policies and programs that serve the interests of both employees and employers in the private and public sectors. In Kenya, Thailand, the Dominican Republic, and other countries, businesses have started prevention education and condom distribution in the workplace. Unfortunately, most commercial enterprises have yet to realize that the modest costs of creating such programs are far less than the eventual loss of productivity and revenues that could have been avoided through early prevention.

Nations and HIV/AIDS

AIDS-related illness and the increasing poverty caused by HIV/AIDS have put enormous economic pressure on governments as well. In many countries, the epidemic has led to increased demand for health care and social welfare support, 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

CRISPIN HUGHES/PANOS PICTURES



In Uganda, Harriet nurses her father, who has AIDS.

HIV/AIDS, ranging from hydration and treatment of opportunistic infections to palliative care, 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 one-half of the government's total spending on health. In Malawi, the cost of care for those infected with HIV or suffering from AIDS could be as much as 38 percent of that nation's total health care budget by the year 2000. These costs could rise to 80 percent in parts of Africa and Asia by the year 2010 unless effective models of home-based care can be developed and implemented on a large scale.

In Kenya, for example, the government would have to spend up to U.S.\$170 million annually by the year 2000 to maintain the current level of hospital care for AIDS patients. In contrast, during the early 1990s the Kenyan government spent about two-thirds of that amount (\$120 million per year) on all health care. The cost of meeting the esti-

* Valuable data on the impact of HIV/AIDS on households and families came from *Confronting AIDS: Public Priorities in a Global Epidemic* (World Bank Publications, 1997), and from "Strategies to Support Children Affected by HIV/AIDS," in USAID's *HIV/AIDS Study Series*, written by the Health Technical Services Project (September 1997).



DOHNG/REUTERS

In Tanzania, at the Benaco Refugee Camp, Rwandan refugees line up to receive food. Refugees are at high risk of contracting HIV.

mated demand for HIV/AIDS treatment in the public sector could grow from 17 percent of Kenya's health budget in 1990 to 79 percent in 2010.

Health care costs are the most easily quantifiable economic burden imposed by the epidemic. Less is known about the indirect costs of AIDS—which at the national level can include decreases in productivity and tax revenues, tourism losses, and reduced investment—and their impact on national and regional economies. While relatively few studies have examined the overall impact of the epidemic on the economic well-being of developing countries, some startling data have been reported in recent years.

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. In Kenya, another study shows that AIDS could reduce the gross domestic product by 14.5 percent by 2005, with per capita income

declining by 10 percent. In Thailand, the direct and indirect costs of AIDS in 1991 were estimated to be about U.S.\$100 million; projections for the year 2000 raise that annual cost to around \$2 billion. A similar study for South Africa shows direct costs rising from around \$30 million in 1991 to nearly \$3 billion in 2000.

The HIV/AIDS epidemic also represents a potential security threat in many countries because of high HIV prevalence among military personnel. Some estimate an average HIV seroprevalence of 20 to 40 percent throughout the military sectors of sub-Saharan Africa. In Zimbabwe, half of the country's 50,000 soldiers are thought to be infected with HIV, and in Cambodia, an Asian country with a burgeoning epidemic, 21 percent of the soldiers from one of the northwest provinces were found to be HIV-positive in the early 1990s. The prevalence of HIV in the armed forces has been found to be inversely proportional to rank, suggesting that control and command structures may be especially vulnerable in coming years.

THE GLOBAL EPIDEMIC

Dire predictions from the 1980s have become the reality of the 1990s, as HIV moves from the latent stage to active disease in an increasing number of people around the world. The cumulative number of those infected has nearly tripled from the 10 million infections estimated in 1990.

But the statistics in today's headlines can only warn of the challenges still to come. Approximately 21 million people around the world are now infected and living with HIV—an estimated 11.6 million men, 8.5 million women, and 900,000 children—and the overwhelming majority of these will progress to AIDS itself. Near the end of the second decade of the epidemic, an estimated 8.4 million people have developed AIDS and 6.4 million of these have died, yielding a cumulative total of almost 30 million HIV infections since the start of the epidemic. According to current estimates, at least 10 million more will become infected with HIV during the next three years alone, bringing the total to more than 40 million in 2000. By then, about 8 million people will have died of an AIDS-related illness.

The vast majority of HIV infections and AIDS cases occur in the developing regions of Africa, Asia, Latin America, and the Caribbean. A true pandemic—an epidemic of global proportions—HIV/AIDS is actually a collection of distinct, evolving regional epidemics, with different distribution dynamics, histories, affected populations, modes of transmission, and virus strains. In some populations, the epidemic began only recently, while it has been spreading among other populations for more than 15 years. In

some regions and among some populations, the epidemic begins slowly and stays at low levels. For example, the prevalence of HIV among female sex workers attending testing and treatment centers in Mexico City has remained under 2 percent for nearly a decade. In other settings, there is an acute, explosive rise in prevalence in only a few years, or even months. In 1988, the HIV prevalence of populations of injecting drug users in Bangkok went from less than half of a percent to more than 30 percent within a year. Countries with “mature” epidemics, such as Malawi, have weathered the early explosive phases and are now struggling with HIV as a widespread, endemic problem.

The spread of HIV has been exacerbated in many developing countries by a high background prevalence of other sexually transmitted infections (STIs). The presence of an STI dramatically enhances the efficiency of HIV transmission, increasing the likelihood of infection from exposure to HIV as much as tenfold. Of course, the same behaviors put people at risk of acquiring or transmitting HIV and other STIs; in 1995, an estimated 333 million cases of curable STIs were contracted through unprotected sexual intercourse. Globally, STIs (excluding HIV) are second only to maternal morbidity and mortality as a cause of healthy years of life lost for women between the ages of 15 and 44. Thus STI prevention, detection, and treatment are also important health goals in their own right.

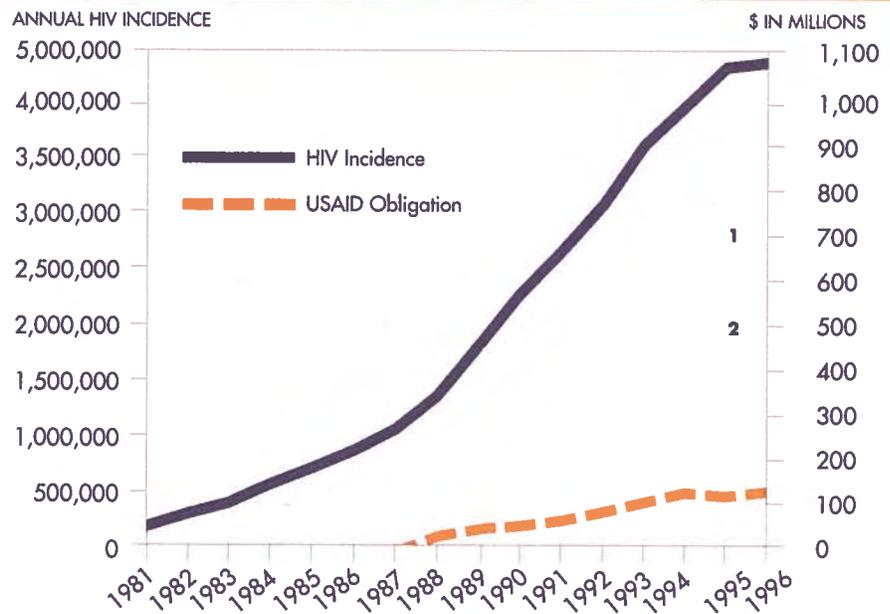
Sub-Saharan Africa

With less than 10 percent of the world’s population, sub-Saharan Africa has more than 60 percent of the world’s people living with HIV, approximately 14 million people. Since HIV/AIDS appeared in this

region nearly two decades ago, the primary mode of transmission has been through heterosexual activity, and more than half of those infected have been women. Because HIV infection rates for women in other regions of the world have been relatively low until recent years,

demographic, such as Tanzania and Kenya, have areas where adult prevalence is more than 20 percent, although national prevalence is 10 percent or less. Commercial sex workers are at especially high risk; infections in this sector are as high as 80 percent in Nairobi and 55 percent in Abidjan.

ANNUAL HIV INCIDENCE (# OF NEW HIV INFECTIONS/YEAR) COMPARED TO ANNUAL USAID \$ OBLIGATION FOR HIV/AIDS PREVENTION PROGRAMS



¹ Annual \$ expended in US for prevention (\$700 million in 1996)
² Annual total \$ expended in developing world for prevention (\$500 million in 1996)
 1996 Global HIV Incidences: 4.8 million
 1996 USAID HIV/AIDS Prevention Obligation: \$117.5 million

Source: USAID and UNAIDS

90 percent of all children born with HIV— nearly 3 million— have been African.

A decade ago the epidemic in Africa was concentrated in East and Central Africa, but it has since spread widely throughout the continent, to the south and west as well. The most severely affected countries are Malawi (17.4 percent adult HIV prevalence), Zambia (21.0 percent), and Zimbabwe (20.2 percent), where an estimated 2.6 million people were HIV-positive in 1995. Other countries at the African “epicenter” of the epi-

Infant and child mortality is on the rise in a number of countries. By the year 2010, the child mortality rate for Zimbabwe may quadruple.

The high incidence of curable STIs (65 million cases in 1995) contributes significantly to the HIV/AIDS epidemic in sub-Saharan Africa. STIs were responsible for 6 percent of the total burden of disease in sub-Saharan Africa in 1990, and for a third of the morbidity in women of reproductive age.

As epidemics mature, an increasing proportion of young people are affected, with the highest incidence beginning in the early teen years and peaking before age 25. Prevalence in these younger groups tends to be substantially higher for females. In Masaka, Uganda, for example, the prevalence is 20 times greater for 13- to 19-year-old girls than it is for boys. This is due in part to early sexual initiation and cultural patterns of sexual mixing, where young women tend to have sex with older men, either within marriage or in exchange for money or other benefits.

Sub-Saharan Africa is also characterized by explosions of infection driven by migration, population displacement, and rapid urbanization. Bloody civil conflicts, low-intensity wars, natural disasters, and environmental degradation have created political instability, economic stress, and large numbers of refugees, who are subject to social conditions where HIV transmission rates are high.

Asia

Another important trend of the 1990s has been the shift of the epicenter of the global HIV/AIDS pandemic from Africa to Asia, which will soon have more new HIV infections than any other region of the world. There are 5.2 million people with HIV/AIDS throughout the region, more than twice the number in the entire industrialized world. India, with nearly 900 million people, already has more HIV infections than any other country: between 2 and 5 million.

As in Africa, the primary mode of transmission is heterosexual contact. But the Asian epidemic also presents new challenges of its own, including small but explosive epidemics in injecting drug users and in

mobile populations. These epidemics play a role in the rapid spread of the virus across the continent and have focused attention on the need for regional approaches to HIV/AIDS prevention. With 60 percent of the world's population, Asia has become a critical focal point for current and future prevention efforts. Even though Africa currently has more people living with HIV/AIDS and greater HIV prevalence, the higher incidence of new infections in Asia points to an enormous regional problem in the coming years.

Patterns and rates of HIV transmission are extremely diverse throughout Asia, as was the case in Africa a decade ago when the epidemic was taking hold. A map of the epidemic across the continent shows a complex mix of high- and low-prevalence countries. A few, such as India, Thailand, Cambodia, and Burma, already have explosively high prevalence rates, especially among injecting drug users. Although fewer than 30 percent of those living with HIV/AIDS are female, the fact that increasing numbers of women attending antenatal clinics in many sentinel sites are testing HIV-positive indicates that the epidemic has spread widely throughout the populations of these countries.

While Thailand was the first Asian country to experience a severe HIV/AIDS epidemic, that nation's aggressive response—perhaps the most effective anywhere in the world—provides some hope for the future. Nonetheless, two percent of all Thais between 15 and 49 years old are infected with HIV, and by the year 2000, some 1.8 million Thais will be infected, with more than 50,000 AIDS deaths projected each year. More than 200,000 children under age 15 have mothers infected with HIV. Because of prevention efforts, however, the annual rates of new infections continue to drop.

DECIPHERING THE EPIDEMIC: WHAT SOUTHEAST ASIA CAN TEACH US ABOUT HETEROSEXUAL TRANSMISSION OF HIV

In North America and Western Europe in the early and mid-1980s, HIV spread quickly among injecting drug users and men who have sex with men, populations whose behavior puts them at high risk. During the same years, the virus ravaged broad regions of East and Central Africa, transmitted primarily through heterosexual intercourse and exacerbated by multi-partner sexual networking patterns. When the epidemic hit Thailand a few years later, moving through injecting drug users and sex workers into the broader population, many expected a similarly explosive spread across Asia, which they warned would very soon replace Africa as the epidemic's "epicenter."

But nearly a decade later, the virus appears to have defied many of the predictions and cut a far less uniform path across the Asian continent. In India and elsewhere in South Asia, transmission rates have skyrocketed; India is now the Asian epicenter of the epidemic, with more infections than any other country in the world. But in Southeast Asia, the epidemic differs greatly from country to country in the way it has spread and the impact it has had, despite the many cultural, social and public health similarities found throughout the region. Thailand, Cambodia, and Burma are considered high prevalence countries (HPCs), with about 2 percent of the most sexually

active age group (15-49 years) estimated to be HIV-positive. In contrast, the Philippines, Laos, and Indonesia are low prevalence countries (LPCs), where infection rates in this age group are significantly lower—.01 percent or less.

Why did the predicted “explosion” occur in some of these countries and not in others? Why—given the fact that commercial sex is widespread throughout the entire region—have heterosexual transmission rates varied so dramatically between HPCs and LPCs? Exploring these issues has helped lead health experts to valuable new insights about the dynamics of HIV transmission and where to focus attention in preventing the virus’ spread.

One leading hypothesis is based on the difference in the frequency of heterosexual commercial sex acts in HPCs and LPCs. While commercial sex is a highly visible fact of social life throughout the region, research shows that on average considerably less of it was transacted in LPCs than in HPCs during the years when the virus spread most rapidly. In Thailand, for example, nationwide data collected during the late 1980s show that low-fee sex workers had an average of 14 to 21 male partners per week. In the Philippines, that average was less than 7 clients per week. Smaller studies conducted in the region confirm comparable dif-

ferences in commercial sex partner exchange rates for Cambodia, an HPC, and Indonesia, an LPC.

But comparing these rates is not enough to explain why the epidemic spread so rapidly in heterosexual population of HPCs but far more slowly in LPCs. How did the virus expand beyond the world of commercial sex—sex workers and their clients—to become such a threat to the general population in HPCs?

One explanation is “bridging,” a term that describes the connection between those who practice high-risk behavior (such as patronizing sex workers) and those who don’t. In this case, men who have sex with sex workers and then have sex with their monogamous wives or steady female partners “bridge” the gap between high-risk and low-risk behavior groups. Although it’s difficult to collect data on the frequency and extent of this behavior, qualitative research has revealed that the level of bridging activity varies greatly throughout these six Southeast Asian countries.

In Thailand, for example, the data show that many Thai men patronize commercial sex workers both before and after marriage; Thai women practicing low-risk, monogamous behavior are thus much in danger of infection from their husbands and steady boyfriends. Similar sexual networking patterns exist in both Cambodia and Burma, also

HPCs. But in the Philippine capital, Manila, the percentage of 20- to 24-year-old men who have commercial sex in a single year is about one-third that of Thai men of the same age. In Indonesia, even lower rates persist, while in Laos, where commercial sex is expensive relative to income, commercial sex patronage is also low. These figures illustrate the great variability in bridging behavior among male populations between HPC and LPC nations in Southeast Asia, and may ultimately explain the differences in the direction and intensity of the HIV/AIDS epidemic from country to country in the region.

What might this hypothesis imply for prevention programmers and policymakers? Health experts warn against using this explanation to decrease funding for LPCs in favor of HPCs, pointing out that while the epidemic may be moving more slowly through LPCs, hundreds of thousands of lives are still at stake. Instead, they recommend that, after the validity of these insights is confirmed by definitive research, prevention programming should be targeted to the most vulnerable sectors of a given population in all regions, to ensure that the epidemic is confronted where and when it presents the greatest and most immediate danger to both high-risk groups and the population as a whole.

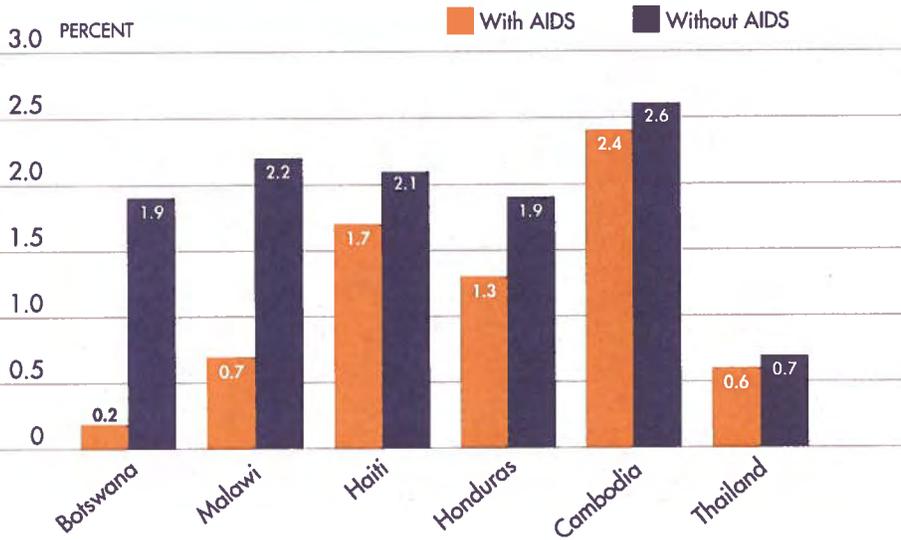
Elsewhere in the region, cultural patterns similar to those that originally fueled the epidemic in Thailand and the lack of concerted prevention efforts suggest that several neighboring countries face dramatic increases in HIV/AIDS. In

While urban populations and trade and transportation centers harbor the greatest concentration of people with HIV/AIDS, little is known about the extent of the problem in the vast rural areas of China and India, which may also be

prevalence in the region; while urban rates there have remained stable at 10-12 percent, rural rates are on the rise from 4 percent. In Guyana, projections indicate HIV prevalence will increase from 2 percent in 1992 to 13 percent in 2010, resulting in impacts similar to those in some sub-Saharan African countries.

Sexual contact is the dominant mode of HIV transmission in the region, with 41 percent of infections found in men who have sex with men. Sexual contact with injecting drug users has also become a major mode of transmission. In Brazil, where injecting drug use is a significant mode of HIV transmission, the epidemic has progressed from one predominantly due to homosexual and bisexual contact in the early 1980s to one with an increasing heterosexual component. Epidemiological evidence also signals a rapid shift of new infections to younger ages, particularly those 15 to 24. HIV infection continues to rise among women, children, the poor, and rural populations.

POPULATION GROWTH RATES FOR 2010 IN SELECTED COUNTRIES WITH AND WITHOUT AIDS



HIV/AIDS epidemics will slow population growth, but negative population growth is unlikely in most countries and will result only when a moderate to strong epidemic is combined with low fertility levels. Even in the face of reduced growth, family planning programs are needed to enable couples to choose the size of their families, to provide the important maternal and child health benefits of lower fertility, and to give HIV-positive women the option of avoiding the possibility of bearing children who are also HIV-positive.

Source: World Population Profile: 1998, U.S. Bureau of the Census, Washington, D.C. 1998

1996, sentinel surveillance in 18 of Cambodia's 21 provinces revealed a pattern of increasing HIV prevalence both in high-risk groups such as sex workers and in the general population. Researchers believe that widespread and relatively frequent commercial sex patronage by Cambodian men may be a principal cause. High levels of STIs and low awareness of the threat they pose, combined with a scarcity of STI treatment services, exacerbate the risk.

susceptible to rapid, extensive, and uncontrolled spread of the virus.

Latin America and the Caribbean

Almost 1.3 million people are living with HIV/AIDS in the 44 countries and territories of Latin America and the Caribbean. The proportion of the adult population that is infected with HIV is about 5 in 1,000, comparable to current seroprevalence in Asia.

In Latin America, more than 70 percent of all HIV infections have occurred in Mexico and Brazil. Haiti continues to have the highest sero-

An Emerging Threat: HIV in the Newly Independent States (NIS)

Before 1995, the incidence of HIV/AIDS in the former Soviet Union and Eastern Europe was very low. Ukraine, for example, never exceeded 100 reported cases annually until the mid-1990s. But 8,000 new HIV cases were reported in that country during 1995-96, and in 1995 alone, more than 3,000 drug users were found to be HIV-positive. In Russia, the number of new HIV cases reported escalated to 1,495 in 1996, and 2,223 cases were recorded during the first six months of 1997. These increases reflect both improved case detection by authorities who are learning to recognize the problem and the explosive

potential of transmission through injecting drug use in a politically and economically tumultuous environment.

STI surveillance in the independent republics of the former Soviet Union indicates a sharp rise in unsafe sex. Beginning in about 1992, dramatic increases in syphilis and other STIs have been recorded, with rates rising by more than tenfold in some regions. In 1990, the syphilis rate was as low as five per 100,000 in countries of the NIS, but by 1996, it was as high as 254 per 100,000. The STI rate is 200 times greater in many of the NIS than in Western Europe.

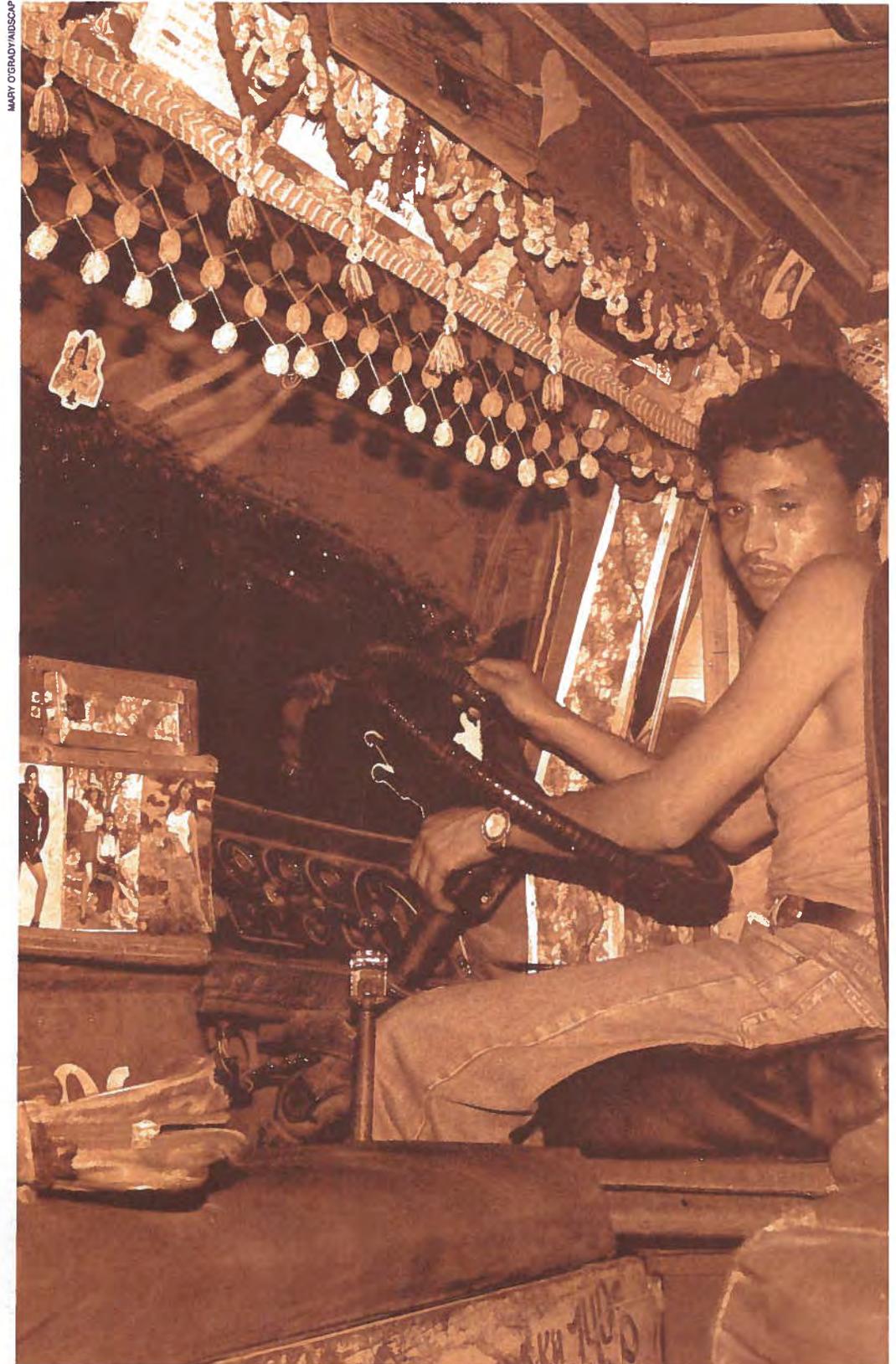
Increasing STI rates and HIV prevalence among drug users are early signs that have preceded major HIV/AIDS epidemics in other parts of the world. HIV/AIDS research and treatment facilities in the region are ill prepared to respond to large numbers of new infections, and it is believed that the actual number of those infected is already much higher than reported. By the year 2000, as many as 1 million Russians could be infected with HIV.

GLOBAL TRENDS

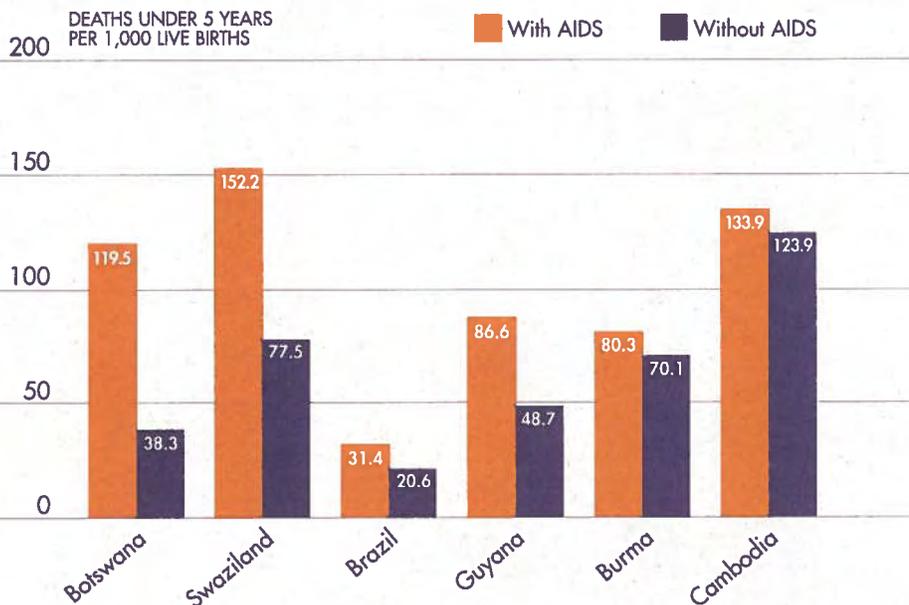
Women and HIV/AIDS

One of the most striking trends in the epidemic during the past decade has been its rapid spread among women. Worldwide, women are becoming infected at faster rates than men, and the total number of HIV-positive women is fast approaching that of men. Young women are particularly vulnerable: it is estimated that 70 percent of women infected 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 four times more efficient from men to women than from women to



A Nepalese truck driver whose truck functions as a home away from home stops at "Bridge Number 3," a town that has sprouted up as a truck stop along the highway between India and Kathmandu to sell food and commercial sex to the drivers.

CHILD MORTALITY FOR 2010 IN SELECTED COUNTRIES WITH AND WITHOUT AIDS

Source: World Population Profile: 1998, U.S. Bureau of the Census, Washington, D.C. 1998

men; the immaturity of the sex organs of girls and younger women raises their biological vulnerability even higher. Nine in ten women are becoming infected through heterosexual intercourse. Higher levels of asymptomatic STIs among women that remain undiagnosed and untreated also increase their susceptibility to HIV/AIDS.

But social and economic forces can 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 to accept sexual partnerships that put them at high risk of contracting the virus and are unable to insist on condom use by their partners. Adolescent girls face the greatest threat, as their extreme

biological vulnerability is often amplified by their psychosocial and cultural subordination and their lack of access to reproductive health information and services.

Without wider access to effective women's empowerment strategies and broader educational opportunities for women, the prognosis is poor for curbing infection in women. Women now account for about 42 percent of all HIV infections, but by the end of the decade, there will be as many women as men living with HIV/AIDS. The number of HIV infections among women is expected to increase from 9.2 million at the end of 1996 to 15.9 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. Nearly 1,500

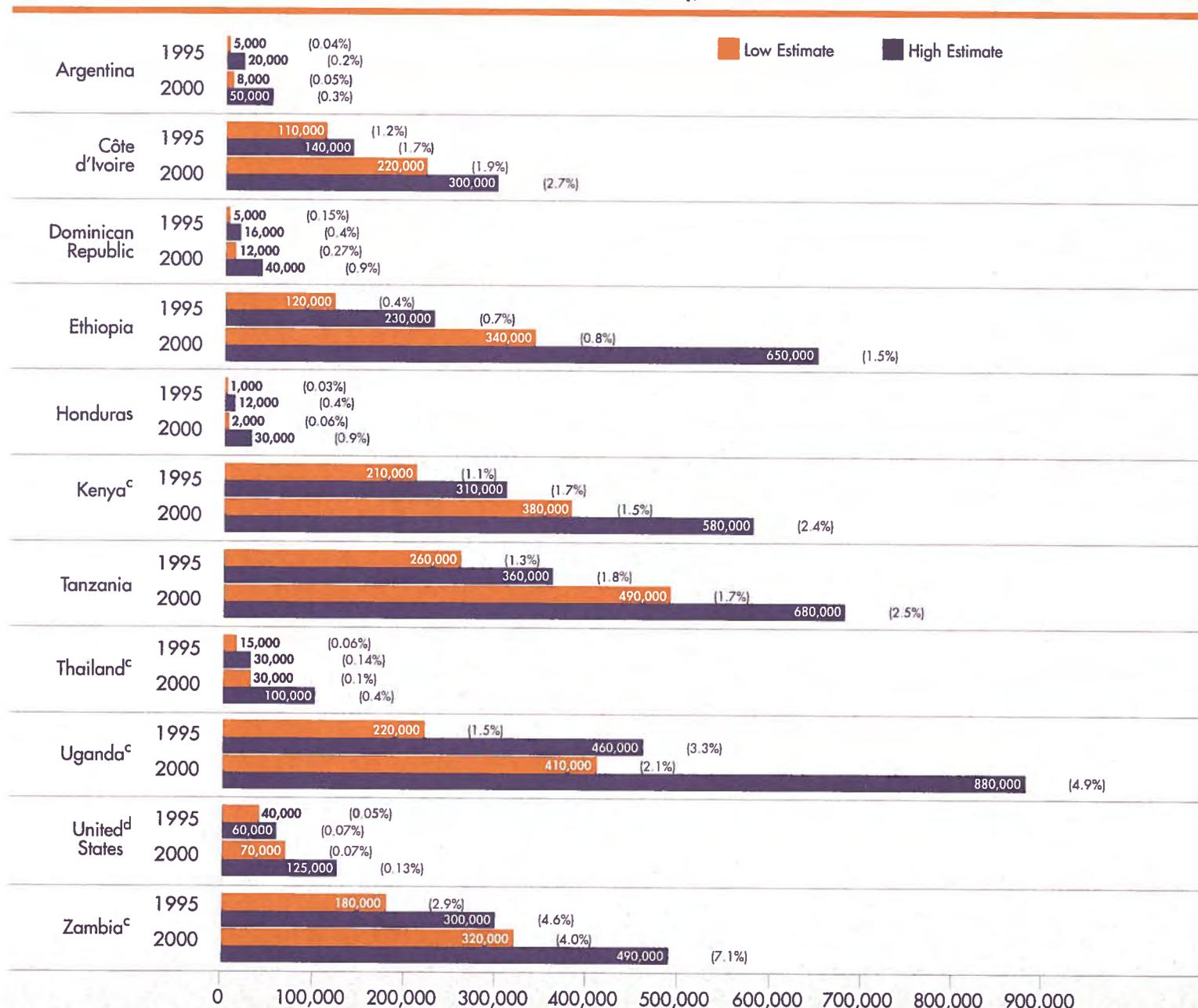
children around the world are infected every day, and by the end of 1997 an estimated 1 million children under the age of 15 will be living with HIV/AIDS.

In the industrialized world, pregnant women who are HIV-positive have access to AZT therapy, which can reduce perinatal transmission by as much as two-thirds. In the developing world, where access to AZT prophylaxis is rare, just under one-third of infants born to HIV-positive mothers become infected. A cumulative total of almost 2.5 million babies have contracted HIV from their mothers. While adults live an average of ten years with HIV infection, one-half of children infected with HIV die by age two. By the time infected children reach the age of five, their mortality rate is 80 percent. Infant mortality rates for all children are more than 25 percent higher in Zambia than they would have been without AIDS. In Botswana, child mortality will more than triple by 2010 if the HIV infection rate isn't reduced.

Most children born to HIV-positive mothers who are not themselves infected through maternal transmission ultimately become orphans. The World Health Organization estimates that more than 9 million children worldwide have already lost their mothers to AIDS. Ninety percent of these children live in sub-Saharan Africa, but by 2020, the majority of AIDS orphans will live in South and Southeast Asia. By 2010, nearly 23 million children under age 15 will have lost their mothers to AIDS in the 23 countries most severely affected by the epidemic.

In some of these nations, AIDS orphans will eventually comprise up to a quarter of the population under

ESTIMATED NUMBERS OF CHILDREN WHO HAVE LOST THEIR MOTHERS TO AIDS IN SELECTED COUNTRIES (AND APPROXIMATE PROPORTION OF AIDS ORPHANS IN ENTIRE POPULATION < 15 YEARS OLD), 1995 AND 2000^{a,b}



^a Except for the United States, estimates were derived using the *Demographic Projection Model (DemProj)* and *AIDS Impact Model (AIM)* software programs. These programs employ demographic data (population size and age distribution, total fertility rates, infant mortality rates, life expectancy) obtained from the Population Council Databank System, which compiled country-specific information from the Population Division of The United Nations Department of International and Economic and Social Affairs; and from N. Keyfitz and W. Flieger, *World Population Growth and Aging: Demographic Trends in the Late Twentieth Century* (Chicago: University of Chicago Press, 1990). Estimates on the rate at which people who are infected with HIV develop AIDS and progression to death among people with AIDS were supplied by the Global AIDS Policy Coalition.

^b For the years 1995 and 2000, 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 (in parentheses) the estimated proportion of all children in the population age-group 0–14 who are AIDS orphans.

^c Projections for the Dominican Republic, Kenya, Thailand, Uganda, and Zambia were originally calculated for publication in WHO and UNICEF, *Action for Children Affected by AIDS* (Geneva and New York: WHO and UNICEF, 1994).

^d The estimated numbers and proportions for the United States were calculated for children and youth younger than 18 years old.

15, potentially creating what one authoritative report calls a “lost generation of disadvantaged, under-educated, and less-than-healthy youths.” This is because children orphaned by AIDS, particularly those in developing countries, too frequently grow up disadvantaged. Many suffer from depression, stigmatization, loss of identity, and disinheritance. If their extended

Today, as many as 3 million around the world succumb to TB annually, the vast majority of them in developing countries. In these countries, as many as 50 percent of adults are infected with the TB mycobacteria, many of whom develop active disease. In densely populated cities with high levels of poverty, that figure can rise to 80 percent.

TB entered a deadly era in the developing world with the emergence of HIV/AIDS. HIV infection compromises the immune system, increasing the likelihood that a person who harbors an inactive TB infection will develop active, life-threatening disease. Worldwide, one-third of those infected with HIV die of TB.

But HIV-positive people are not the only ones at higher risk. By dramatically increasing the number of people with active, infectious TB, HIV/AIDS also increases the risk of TB transmission to HIV-negative individuals who will be exposed to the airborne bacilli. Of the many opportunistic infections to which HIV-positive people are most vulnerable, TB is most easily spread to the rest of the population.

TB and HIV/AIDS thus interact as dual epidemics that fuel each other’s growth: HIV hastens the spread of TB, while TB attacks HIV-positive people with weakened immune systems and shortens their life spans. In Africa, more than 5

million of the 13 million Africans now living with HIV will develop TB, and 80 percent of those will die early deaths from the disease. In Asia, HIV/AIDS will be responsible for 14 percent of all TB cases by the end of the century, up from only 2 percent at the start of the decade. Among AIDS patients in India, 68 percent also suffer from tuberculosis infection.

Outbreaks of multidrug-resistant tuberculosis in HIV-positive patients in the United States and Europe have raised concerns that TB deaths could increase dramatically due to mutations in the bacilli that cause the disease. If these strains that are resistant to the commonly used drugs become widespread, a diagnosis of TB will once again be a virtual death sentence. A study conducted by the World Health Organization, the Centers for Disease Control and Prevention, and the International Union Against Tuberculosis and Lung Disease with support from USAID has documented the growth of this new threat throughout the world and identified areas that are foci of resistant disease. It also showed that drug resistance is low in areas where proper TB treatment is available, confirming that the only way to prevent further spread of multidrug-resistant tuberculosis is to strengthen health systems and provide appropriate treatment regimens to those who are ill with the disease.



This mother and child in Fortaleza, Brazil, both have AIDS.

families or the communities in which they live cannot adequately support them, they are also vulnerable to homelessness, malnutrition, reduced access to health care and education, increased demands for their labor, and—if their poverty makes it difficult to refuse sexual demands from others—higher exposure to HIV infection.

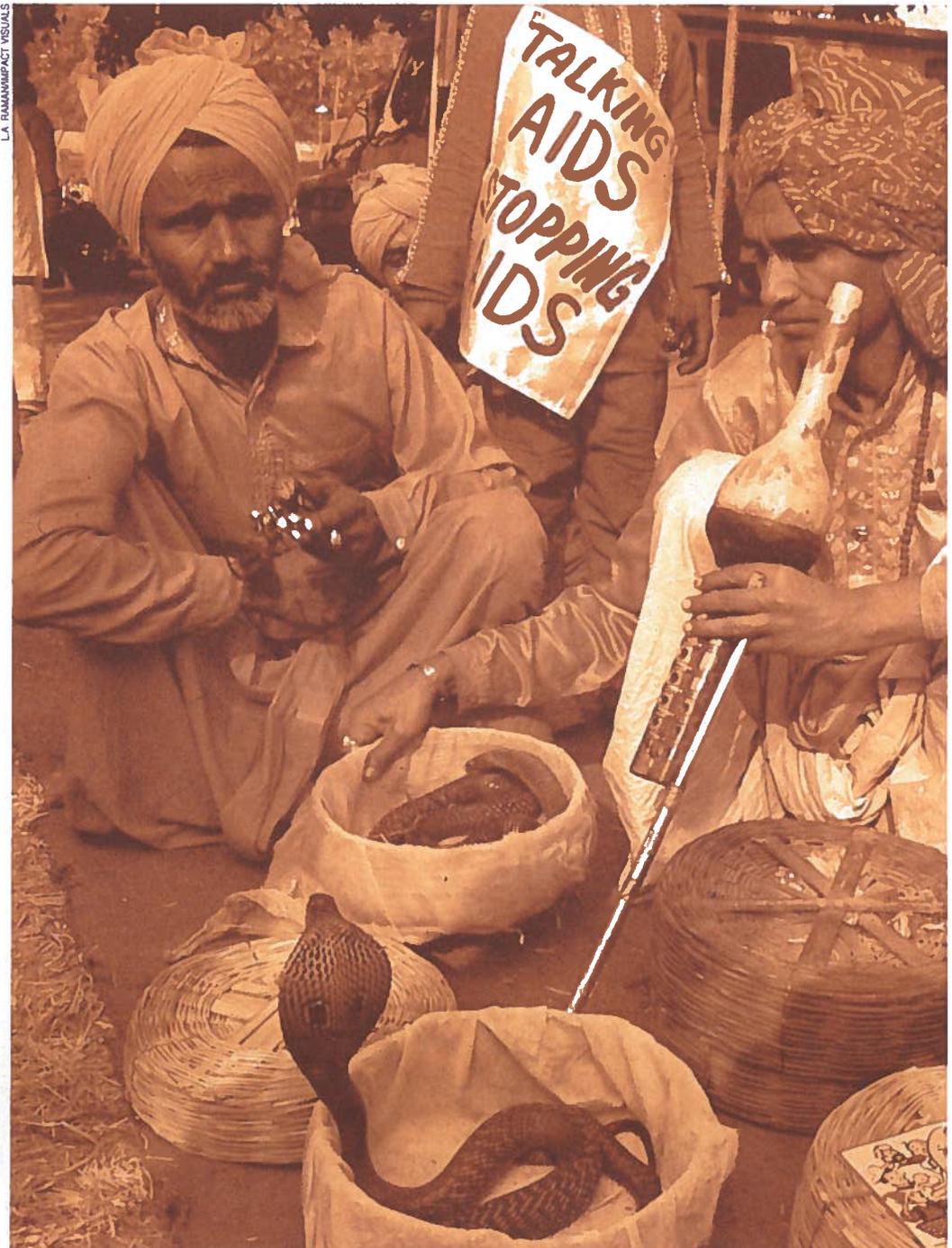
AIDS and Tuberculosis Deaths

Tuberculosis has long been a global killer, claiming hundreds of millions of lives over the centuries.

The USAID Response: Prevention and Care Initiatives

For more than a decade, the U.S. Agency for International Development (USAID) has made a major commitment of resources, staff, and funding—nearly U.S.\$1 billion—to counter the spread of HIV/AIDS in the developing world. This crucial investment in HIV/AIDS prevention as a key to sustainable development has put the Agency in the forefront of the global response to the epidemic.

Preventing sexual transmission—which is responsible for about 80 percent of HIV infections—is central to USAID's widespread efforts in service delivery, capacity building, biomedical and behavioral research, and policy formulation. Until a vaccine or affordable treatment becomes available, developing and expanding successful HIV/AIDS prevention strategies remain a priority mission for USAID, its counterparts in the international health community, and its local partners who work together in more than 75 countries around the world to create effective responses to one of the world's most complex and devastating health crises.



A snake charmer in New Delhi, India, uses cobras to talk about AIDS.

**U.S. AND JAPAN LAUNCH A
"COMMON AGENDA" AGAINST HIV/AIDS**

In 1993, an international bilateral partnership for global problem solving was created between the United States and Japan. One of the major initiatives of the U.S.-Japan Common Agenda involves cooperative efforts in population and HIV/AIDS in the developing world. Each country devotes considerable funding and technical assistance to selected countries, with the goal of improving HIV/AIDS prevention and family planning programs, training and capacity building, child survival, policy dialogue, and other important health activities. USAID coordinates the U.S. response and funding function for the Agenda through its Global Bureau's Center for Population, Health and Nutrition.

The Common Agenda's HIV/AIDS prevention activities for 1996 included support for condom social marketing and special funding provided by the Japanese for UNAIDS programs in Bangladesh; behavior change communication (BBC) efforts in Ghana; policy dialogue, capacity building, and condom social marketing in Guatemala; policy development, improved STD management, condom social marketing, and BCC in Indonesia; and similar projects in Kenya, Madagascar, Mexico, Malawi, Peru, the Philippines, Senegal, Tanzania, and Zambia.

Recently, a Common Agenda team made up of USAID staff and their Japanese counterparts traveled to Vietnam to develop plans to help the government implement improved blood testing and blood safety procedures, design behavior change communication campaigns, and support various community-based organizations involved in HIV/AIDS prevention. Because Vietnam appears to be at a relatively early stage of the epidemic, team members are optimistic that interventions of this kind, particularly those targeted at high-risk groups, will help slow the spread of HIV.

**PARTNERSHIPS
FOR PREVENTION**

Collaboration is, in fact, the hallmark of all USAID activity in HIV/AIDS prevention, from the global to the village level. As the epidemic evolves and demand for new approaches in research and programming grows, USAID seeks out collaborators who possess the experience and expertise to design, develop, and manage both comprehensive and specialized projects. In each of the developing countries that requests USAID assistance in HIV/AIDS prevention, the Agency creates part-

nerships with government agencies, indigenous nongovernmental organizations (NGOs), local technical experts, policymakers, and key community leaders. For global initiatives, the Agency works in cooperation with other donors to coordinate international responses and refine new technical strategies with worldwide applications.

This extensive network of partnerships includes such internationally prominent organizations as the Pan American Health Organization, the World Bank, and the Joint United Nations Programme

on HIV/AIDS (UNAIDS), founded in January 1996 by the World Bank and five United Nations agencies: the World Health Organization, UNICEF, the United Nations Development Programme, UNESCO, and the United Nations Population Fund. USAID continues to be the major donor supporting the work of UNAIDS and serves on its Programme Coordinating Board.

USAID's own regional and bilateral programs in developing countries require close working relationships with subcontractors funded to carry out design and management of country-based programs and research activities. Since 1991, the AIDS Control and Prevention (AIDSCAP) Project, administered by Family Health International (FHI), has been USAID's single largest comprehensive prevention program, with projects in 45 countries. Another important partner in prevention programming is the Academy for Educational Development (AED), which, in collaboration with the International Planned Parenthood Federation and the Futures Group, manages the Central American HIV/AIDS Prevention Project, a regional effort covering five nations. Technical expertise important to USAID's mission is provided by specialists from the Program for Appropriate Technology in Health (PATH), the University of Alabama, the University of Washington, Harvard University, Tulane University, Johns Hopkins University, and the University of North Carolina. In biomedical research, USAID works with some of the most prominent institutions in the United States, including the U.S. Centers for Disease Control and Prevention, the National Institute of Allergy and Infectious Diseases of the National Institutes of Health, the Population Council, and numerous universities. Under an

interagency agreement, the U.S. Bureau of the Census gathers, analyzes, and publishes valuable data on HIV seroprevalence and other health indicators in developing countries.

But many of USAID's most fruitful partnerships grow at the community level, among leading national and local organizations in developing countries. Committed to building the capacity of each country to sustain and expand prevention programming, USAID involves indigenous institutions and gatekeepers from the planning stages on, and continues to help build their skills through training and involvement in decision-making. From a tiny village-based NGO on the Maasai Plain of northern Tanzania to the powerful institutions of the Brazilian business community, these links to local leadership ensure the cultural and social appropriateness of programs, create broad-based community support, and build lasting institutions and structures so that nations that benefit from USAID programs today will be able to sustain them on their own tomorrow.

PREVENTION STRATEGIES THAT WORK

Ten years of global experience in HIV/AIDS prevention have provided the Agency with many lessons learned, but perhaps one is most fundamental: there is no single, standardized set of interventions in HIV/AIDS prevention programming. The combination of approaches that works well in one region or country may not be the best in another. The goal for program designers is to develop and fine-tune the right mix of strategies appropriate for vulnerable populations, while considering available resources, local patterns of risk behaviors, cultural attitudes and belief systems, and other unique characteristics of each setting.

Achieving an effective balance of approaches can be quite challenging. For example, on a major trucking route crossing the border between India and Nepal, drivers of both

government health agencies, bilingual materials, and a coordinated logo design that took into account the cultural sensitivities and preferences of both nationalities.

IMPORTANT NEW DATA CONFIRM THE EFFECTIVENESS OF USAID'S THREE KEY PREVENTION STRATEGIES

In the past two years, results from research projects and sentinel surveillance appear to confirm the value of three key prevention strategies promoted by USAID: behavior change communication, condom social marketing, and control of sexually transmitted infections.

In Uganda, sentinel surveillance indicates a 35 percent decrease in HIV prevalence among young women in the 15 to 19 and 20 to 24 age groups. Population surveys reveal that these declines could be largely due to increased monogamy, fewer sexual partners, increased condom use, delayed onset of sexual activity, and other reductions in high-risk behavior—precisely the messages promoted by behavior change communication campaigns conducted in the country over the last several years.

In Thailand, the government's 100 Percent Condom Policy, which strictly enforces consistent condom use in all commercial brothels, is credited in part for significant decreases in HIV prevalence among populations such as military conscripts, whose HIV prevalence dropped from 12.3 percent in 1993 to 6.7 percent in northern Thailand in 1995. This decrease appears to confirm that condom use lowers HIV transmission, and validates investment in condom social marketing as a prevention strategy.

In Tanzania, the groundbreaking "Mwanza study," funded by the European Union, showed that using simple, realistic syndromic management to treat sexually transmitted infections within a study population reduced the number of new HIV infections by an impressive 42 percent. In Malawi, another important study funded by USAID yielded strong biological evidence that treatment of gonorrhea can make HIV-infected men less infectious. Results such as these are strong arguments for making affordable STI treatment widely available throughout the developing world.

nationalities receive coordinated behavior change communication materials and education as well as similarly packaged condoms to reinforce safe-sex messages and remind them that the danger of HIV infection does not disappear at the frontier. This campaign required the cooperation of two sets of gov-

USAID and its partners have identified three prevention strategies that, in synergy with supporting strategies, are key to success in HIV/AIDS prevention: behavior change communication, condom social marketing, and control of sexually transmitted infections.

YOUTH RESPOND TO PREVENTION PROGRAMMING THAT REFLECTS THEIR LIVES AND CONCERNS

Around the world, adolescence is a time of transformation. In some cultures the passage to maturity may be rockier than in others, but all young people face the uncertainty and confusion of leaving childhood to face the new responsibilities and concerns of adulthood. Understanding and learning how to handle one's growing sexuality is one of the most important aspects of this universal human process.

Unfortunately, the spread of HIV/AIDS around the world has made growing up a far more dangerous experience than it's ever been before. As young people approach an age when many want—or feel pressured—to experiment with sex, too few understand HIV's threat to their health and futures. Sex education for young people, where it exists at all around the world, is often inadequate to meet their needs. In many societies in both the industrialized and developing world, young people find it difficult to approach their parents, teachers, or even health care providers with questions about sex. And too few young people know how to use or have money for and access to condoms.

The vulnerability of young people is evident in the HIV seroprevalence data from many developing nations, where some of the highest rates of infection occur in girls between the ages of 15 and 24. In many countries, seroprevalence data point to the likelihood that up to 60 percent of all new HIV infections will occur in this age group, with females outnumbering males by a ratio of two to one. Girls and young women are at especially high

risk for both biological and social reasons. The immature female reproductive tract is biologically far more vulnerable to infection, and women's social subordination makes it difficult for girls to negotiate with prospective male partners. In many settings where the epidemic is severe, girls may also become the sexual prey of older men, who hope to avoid infection themselves by sleeping with younger, "unblemished" women.

Protecting the next generation has become a high priority for HIV/AIDS prevention program managers, and most USAID-funded programs have developed special interventions for youth. At this stage of the epidemic, many also recognize the importance of creating targeted interventions designed not only for young people but by young people. By participating in project design and even managing their own prevention activities, youth ensure that their concerns are addressed and that other youth will take notice.

Some of the many examples of youth-participatory prevention programming around the world stand out for their ability to reach young people with their frankness and youthful perspective. One such effort is the youth newspaper *Straight Talk*, created in 1993 as part of the media campaign Safeguard Youth From AIDS (SYFA), a collaboration between UNICEF and the Government of Uganda. *Straight Talk*, which includes very frank features about sex, emotional difficulties and relationships, HIV, STIs, and other areas of concern to adoles-

cents, now publishes editions in Kenya and in Tanzania, which is supported by the USAID-funded Tanzania AIDS Project of AIDSCAP. The Tanzanian edition's young editors—the editor-in-chief is 22 years old—cover a wide range of vital issues, including the advantages of postponing sex, the importance of avoiding gender stereotypes, and the value of treating the opposite sex with respect. Explicit advice on STI symptoms, how to avoid HIV infection, and how to use condoms is provided for young people who are already sexually active. The paper is interactive and includes articles and letters from young readers, who often respond to each other's concerns.

Another example of a successful youth-participatory project is the Save Your Generation Association (SYGA) in Ethiopia, founded by five young university students who witnessed too many of their friends succumbing to AIDS. SYGA, now a registered NGO with a paid staff of 14 and more than 6,000 dues-paying members, receives support from AIDSCAP for its efforts to bring HIV/AIDS prevention education to out-of-school youth in urban areas, many of whom are un- or underemployed and thus difficult to reach. SYGA works with local governments and community organizations to identify these young people and to organize street drama, puppet shows, video showings, sports events, and other entertainment to attract young people to their meetings. Peer educators give one-on-one counseling and provide condoms for free or at specially subsidized low prices.

To support and improve the work of youth-oriented NGOs like SYGA, research into the health and prevention needs of young people has been critically important. The Women and AIDS Research Program of the International Center for Research on Women has been a leader in revealing the dynamics of the epidemic's threat to young people, particularly girls and young women. Its recent research paper, "Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World," summarizes insights gleaned from qualitative, participatory research in Africa, Southeast Asia, and Latin America to analyze the vulnerabilities of young people, illuminate the coercive economic and social pressures that plague girls in particular, examine why many efforts to get young people to adopt safer sexual behaviors have failed, and propose new models for youth prevention approaches that "address the root causes of young women's vulnerability."

The mandate of a special USAID project, FOCUS on Young Adults, is to expand the awareness and application of these lessons by gathering and distributing up-to-date information about the reproductive health of young people. FOCUS approaches HIV/AIDS and STI prevention in a broader reproductive health context, offering technical advice, resources, and skills to Agency bureaus, USAID's partners, and youth prevention programmers.

Behavior Change Communication

Educating people about HIV/AIDS and the deadly threat it poses to them, their partners, and their children is a fundamental component of prevention programming. Years of experience have shown, though, that merely imparting facts to a passive audience is seldom enough to change people's risky behaviors, especially sexual behaviors. Even in places where HIV/AIDS information is so widespread that more than 90 percent of the adult population understand how to avoid infection, too few take the important next step of acting on their knowledge by adopting safer sexual behavior.

But the art and science of prevention education have evolved significantly in recent years, hastened by a fast-moving, deadly epidemic that can only be curbed by convincing millions of individuals—one by one—that how they behave sexually can make the difference between life and death. USAID-supported programs have been pioneers in behavior change communication (BCC), which uses interactive, community-based educational and skill-building approaches that personalize risk by incorporating the daily realities of targeted populations into HIV/AIDS prevention messages and activities. Using a wide variety of media and formats—from radio soap operas to workplace discussion groups to newspaper columns to street theater—comprehensive BCC projects link these techniques together to create multilayered, mutually reinforcing messages that build a supportive environment for widespread, sustained adoption of safer sex behaviors.

In the Dominican Republic, an award-winning TV ad campaign targeting youth has had a powerful impact. The four-part ad series,

created by the Dominican advertising agency Cumbre as part of AIDSCAP's comprehensive youth-focused BCC program, features attractive young actors dealing with issues of sexuality and faithfulness. As each ad draws young viewers into story lines that resemble their own lives, the scripts educate their audience about personal risk behavior, reminding hundreds of thousands of young people that they cannot know beforehand which of their partners might carry the virus. The campaign began in September 1995 with a march of young NGO volunteers through the streets of Santo Domingo, ending at a launch ceremony that included influential government, church, and cultural leaders as speakers. Contrary to standard practice in the Dominican Republic, media executives aired the ads thousands of times for free, making it possible for the campaign to expand its efforts to include workshops and a telephone referral network for youth with questions about HIV/AIDS. In Brazil, similar leveraging of private sector resources resulted in the provision of valuable space in *Claudia*, one of the nation's most popular women's magazines, for monthly articles about women and AIDS.

Peer educators trained in the fine art of building rapport can be powerful mentors for behavior change. In southern India, peer educators trained by the regional NGO MYRADA, in collaboration with the U.S.-based organization, PLAN International, used a wide variety of approaches—including a village-to-village bike marathon—to approach their neighbors with life-saving information about prevention. This two-year partnership, funded by USAID through AIDSCAP's

NGO/PVO Initiative, accomplished an extraordinary amount of community sensitization in a very short time. While adapting messages to local audiences continues to be a core principle of BCC, AIDSCAP discovered that some materials have very wide appeal. A comic book series created by AIDSCAP featuring a sympathetic community

Availability and affordability may also limit their use in developing countries, especially outside major urban areas.

To increase the acceptability of condoms and make these life-saving devices accessible to many more people, USAID partners apply the techniques of condom social marketing (CSM) throughout the devel-

efforts are responsible for significant increases in condom sales around the world; more than 275 million condoms were distributed globally in 1996 through USAID projects.

As an AIDSCAP partner, Population Services International (PSI) created an extraordinarily successful CSM program in Haiti that increased condom sales a hundredfold in less than two years, even though political and economic chaos overcame the country soon after the campaign began. Despite an international fuel embargo and ongoing street violence, the program conducted a popular advertising campaign and extended wholesale and retail networks for condom sales deep into rural areas where they had never been available before. One particularly innovative component of the program was the training of community-based salespeople who, motivated by their ability to earn extra income during a period of extremely low employment, helped open hundreds of new points of sale around Haiti.

Community-based CSM strategies have been similarly successful in other parts of the world. In Tanzania, PSI trained more than 1,000 independent itinerant condom sales agents throughout the country to promote and sell condoms, ensuring 24-hour-a-day condom availability to friends and neighbors. In Brazil, DKT International increased condom sales by 44 percent in 1996 through its very visible campaign in the streets during Carnival season, on the beaches of Rio, in bars and social clubs, and in other locales where HIV transmission is a real threat and the need for condoms can be immediate. And in Rwanda, PSI produced a powerful film that is extremely popular with a population still recovering from a devastating period of civil strife. It depicts a war widow



Dhaaley Dai, the condom cartoon that serves as the logo for AIDSCAP's program in Nepal, is displayed prominently on a bus stop stall on the highway between the Indian border and Kathmandu.

HIV/AIDS activist named Emma offers prevention and care education in French, English, Swahili, Haitian Creole, and other languages to diverse audiences in the Caribbean and throughout Africa, saving many thousands of dollars in materials development costs for each site.

Condom Social Marketing

Throughout the world, condoms remain the only commonly available device that prevents sexual transmission of HIV. Yet even in regions where the epidemic is severe and risk is high, cultural prejudices and sensitive interpersonal issues often make it difficult for couples to use them.

oping world. CSM uses commercial marketing and advertising techniques and the distribution infrastructure of the private sector to make condoms attractive to the public, to train people to use them correctly, and to ensure their wide availability. CSM programs have created viable distribution networks in areas—such as the countryside—where they were previously unreliable or nonexistent and during times of social stress. Prices are set at levels that even low-income people can afford, often at only pennies apiece. USAID-supported CSM

MARY O'GRADY/AIDSCAP

hoping to rebuild her emotional life with a neighbor who also lost his spouse to violence and addresses such issues as negotiating safer sexual practices and condom use.

Sexually Transmitted Infection Control

Sexually transmitted infections (STIs) are widespread throughout the developing world, and women and men who suffer from them are as much as ten times more vulnerable to HIV infection and are also more likely to spread HIV to others. A recent study showed that having a sexually transmitted infection, such as gonorrhea, significantly increases the amount of infectious virus transmitted in body fluids. Controlling the spread of STIs through health education, prevention, and treatment is thus a priority in preventing HIV transmission. Unfortunately, STI services in many developing countries have long been inadequate, and many STI cases are never diagnosed and treated, or are self-treated with ineffective and sometimes even dangerous drugs. Even where STI treatment facilities exist, many people in need do not use them. Women may remain untreated because they are often asymptomatic and not aware that they need treatment. Others who suspect they might have an STI may delay or avoid care at a specialized facility because of stigma associated with STIs, a concern that is especially acute for women and girls.

Recognizing that full-service STI treatment programs based on access to costly laboratory services are simply too expensive for many developing country settings, USAID-funded HIV/AIDS prevention programs support an alternative treatment system developed in collaboration with the World Health Organization's Global Programme

on AIDS (WHO/GPA). Syndromic management of STIs is a public health approach that makes it possible for primary health care facilities to diagnose and treat most symptomatic STIs effectively without costly lab tests or staff with advanced medical training. Using easy-to-understand diagnostic guidelines tailored to the STI prevalence and antibiotic resistance patterns of each region, health practitioners analyze their patients' symptoms and dispense medication for all possible STIs that could cause those symptoms. Patients receive full treatment and prevention counseling at the point of first encounter with the health care system, and rarely need to return for follow-up. One of the key components of the syndromic approach, partner referral, can help identify women whose asymptomatic STIs would not otherwise prompt them to seek treatment.

USAID-funded programs are implementing syndromic management training in 22 countries. In Tanzania, AIDSCAP's Tanzania AIDS Program (TAP) has incorporated such training as a primary component of its HIV/AIDS prevention mission, conducting workshops for public and private sector medical practitioners at all skill levels. Jamaica's Ministry of Health is an enthusiastic proponent of STI syndromic management, which it has successfully integrated into its network of public clinics with new diagnostic guidelines specific to STI prevalence in Jamaica. In 1996, regional management training courses to improve syndromic management were conducted in South Africa, the Dominican Republic, and Kenya, organized through the collaboration of international and national

health organizations. To ensure an effective treatment protocol, USAID supports research on antibiotic resistance and STI prevalence that are the first baseline prevalence and resistance studies ever conducted in some countries.

Integrating STI treatment into primary health care, family planning, and maternal-child health services is seen by many in prevention programming as an important and cost-effective step to curbing the spread of STIs. Unfortunately, tight budgets and reluctance on the part of some health care and family planning practitioners to associate their clinics with STIs have slowed integration and expansion of STI services. The International Planned Parenthood Federation/Western Hemisphere has launched successful pilot programs in Honduras, Jamaica, and Brazil to demonstrate how affordable, sustainable programs that integrate STI treatment can help stem the spread of HIV/AIDS. By the middle of 1995, the Jamaica program had reached nearly 20,000 people and increased condom distribution by more than 350 percent.

Other STI treatment methodologies developed and promoted by USAID-funded programs include pilot training projects in syndromic management for pharmacists—often the first people to whom those suffering from STIs turn for advice—in Nepal and Thailand. Pharmacists in Cameroon were also recruited to participate in pilot sales of pre-packaged STI treatments. And in 1996, WHO and AIDSCAP produced several important publications designed to build capacity for syndromic management, including case management workbooks for the training of health providers and a state-of-the-art manual, *Control of Sexually Transmitted Diseases: A*

Handbook for the Design and Management of Programs, targeted to STI program managers.

STRATEGIES THAT SUPPORT PREVENTION

Behavioral and Social Research

Understanding why individuals practice risky behaviors, despite their knowledge of the possible consequences, is critical to formulating effective solutions in HIV/AIDS prevention. USAID supports well-designed behavioral research that helps explain the determinants of sexual behavior that may endanger people and increase transmission of HIV/AIDS.

Since 1990 USAID's Office of Health and Nutrition and Office of Women in Development have funded the Women and AIDS Research Program of the International Center for Research on Women (ICRW) to investigate these determinants and their program and policy implications. ICRW launched a small grants competition, funding 17 descriptive and operations research projects in 13 countries in Africa, Latin America, and Asia to focus on the needs of vulnerable women, and to identify needs and strategies for making HIV/STI interventions more responsive to the economic, sociocultural, and political realities of women's sexual lives. Policy and program recommendations were developed from these global findings, and were rapidly and widely disseminated through a variety of channels. In a second phase of the program, eight of the projects were selected for implementation based on their Phase I findings, and an additional two projects were funded to evaluate the benefits of participatory, gender-responsive sexual health interven-

tions. The program has contributed to validating qualitative studies as a crucial component in behavioral research, and to awareness of the importance of gender issues in HIV/STI policy and program circles.

One important behavioral study nearing completion is the HIV Counseling and Testing Efficacy Study (C&T) conducted by AIDSCAP and UNAIDS and coordinated by the Center for AIDS Prevention Studies (CAPS) at the University of California, San Francisco. At study sites in Tanzania, Kenya, and Trinidad, researchers hope to determine whether personalized risk assessment and behavior change counseling combined with HIV testing is a cost-effective way to influence individuals to adopt safer sex practices.

Policy

Legal, social, economic, and regulatory barriers often inhibit the effectiveness of HIV/AIDS prevention efforts. To engage policymakers and enlist the participation of community leaders in prevention, USAID supports policy dialogue and reform at the international, national, regional, and local levels. USAID partners also seek to involve the private sector in designing prevention programs for the workplace.

With USAID funding, the Policy Project of the Futures Group has developed the AIDS Impact Model (AIM), which has successfully helped policymakers and other leaders assess the future impact of the epidemic on their nations, develop policies to enhance the effectiveness of prevention programs, and understand the importance of eliminating discriminatory laws and practices. Policy Project staff have trained small groups of local experts—epidemiologists, demographers, economists, and policymakers—to identify

the best available data on HIV and AIDS prevalence and impact, to enter those data into the model, and to tailor their presentations and policy recommendations to the concerns and interests of specific policy-making audiences. In 1995 and 1996, the Policy Project presented AIM to leaders in Kenya, Ethiopia, Ghana, and Madagascar; in some countries—notably Kenya—the presentation has been offered multiple times to local and provincial leaders. The Policy Project also serves developing country governments in a consultative capacity, working with counterparts to develop projections on the future socioeconomic and health impacts of the epidemic.

AIDSCAP also incorporates policy activities into its comprehensive prevention projects, offering technical assistance to government agencies and NGOs in developing countries in their efforts to influence national and local HIV/AIDS-related policies. Other technical assistance takes the form of socioeconomic impact analysis of HIV/AIDS on families, communities, and national economies. In 1996, AIDSCAP collaborated with the Policy Project to train leaders from three Central American nations in developing impact analyses. AIDSCAP's Policy Unit collaborated with Thai prevention programmers in a cost analysis of BCC and STI interventions in Bangkok that helped decision makers decide how best to allocate HIV/AIDS program resources. AIDSCAP also focuses on HIV prevention opportunities in the private sector, and in 1996 used its Private Sector AIDS Policy (PSAP) Kit to engage business, government, and labor leaders in more than ten countries to consider the value of HIV prevention at their work sites.

The Support for Analysis and Research in Africa (SARA) Project, funded by USAID's Africa Bureau and managed by AED, conducts workshops and other training and information-sharing activities to inform African governments about research results in seroprevalence, behavior change, economic impact, and other issues that could influence policy directions. In 1997, the SARA Project supported collaboration between the Morehouse School of Medicine and the International Foundation for Education and Self Help to ensure that HIV and TB were on the agenda at the African-African American Summit in Harare, Zimbabwe. This biannual meeting attracts government, business, and other civic leaders from all over sub-Saharan Africa and the U.S. to foster mutual understanding and expand opportunities for collaboration in development.

In addition to its research on gender issues, the ICRW's Women and AIDS Research Program also conducts public forums, assists in-country researchers to engage in policy dialogue, and publishes a policy series that recommends policy reform strategies to enhance the ability of women and girls to protect themselves from HIV/AIDS and end discriminatory practices and laws that endanger women.

Evaluation

To judge the effectiveness of different HIV/AIDS prevention approaches, ongoing monitoring and evaluation are integrated into the design of every USAID-funded project. The ability to determine which aspects of which interventions make a difference drives much of the evolution in HIV/AIDS programming and helps create new

building blocks for future projects.

The AIDSCAP Project has been a global leader in the development of effective evaluation approaches and the application of evaluation results to improve HIV/AIDS interventions. The project emphasized the use of multiple data collection methods, both quantitative and qualitative, to monitor and evaluate HIV/AIDS programs and to identify ways to refine prevention strategies and methods.

One of AIDSCAP's most important contributions to HIV/AIDS evaluation is the behavioral surveillance survey (BSS) methodology, which enables evaluators to track trends in HIV risk behavior among target groups through a series of cross-sectional surveys. In Bangkok, AIDSCAP and the Bangkok Metropolitan Administration (BMA) established a

In Gokak, India, midwives gather to hear a MYRADA/PLAN presentation on AIDS funded by the AIDSCAP Project so they can disseminate the information as respected elders in the village.



LENE PERLIAN/IMPACT VISUALS

BSS system that interviewed more than 3,000 people from six different socioeconomic and occupational groups every six months. When compared over time, the BSS results identify which target groups are

country's provinces. AIDSCAP has also begun behavioral surveillance surveys in Cambodia, Indonesia, India, Nepal, and Senegal.

Another new evaluation tool designed by AIDSCAP is the AVERT computer spreadsheet model. AVERT uses available data on HIV and STI prevalence and on levels of risk behaviors to estimate the number of HIV infections that could be averted through prevention outcomes, such as increased use of condoms, improved STI treatment, and sexual behavior change. Created for users in developing countries with limited modeling experience and no access to extensive databases, the software is user-friendly and requires only behavioral variables commonly found in program data. In late 1996, AIDSCAP used the AVERT model to study the effectiveness of peer education and periodic presumptive treatment for STIs for women at high risk in a South African mining community. The AVERT data estimated that 235 new HIV

infections—40 among the 400 women who used the service and 195 among their estimated 4,000 male miner clients and partners—had been averted over the course of the year. These results were used to calculate that for every dollar spent on prevention, eight dollars could be saved in HIV-related health care costs, which convinced the local mining company to sponsor and expand the intervention.

Biomedical Research and Diagnostics Development

USAID, often in partnership with the National Institute of Allergy and Infectious Diseases (NIAID),

funds biomedical research through its cooperating agencies, such as the Contraceptive Research and Development (CONRAD) group and Family Health International, to develop low-tech, affordable HIV/AIDS prevention devices, pharmaceuticals, and diagnostics. One landmark study in this series, carried out in Cameroon by FHI, found that use of a contraceptive film containing nonoxynol-9 conferred no additional protection against HIV and other STIs beyond the protection provided by male condoms. These agencies, along with the Population Council, continue the search for a low-cost, safe, vaginal microbicide that women can use to protect themselves from HIV and other sexually transmitted infections. A female-controlled microbicide, complementing growing use of the male condom, would clearly have an enormous impact on international efforts to contain the epidemic.

USAID maintains an interagency agreement with NIAID for access to valuable microbiological information resources, and also provides seed money to NIAID scientists to undertake research in HIV-related research questions that are of particular importance in the developing world. Several of these important research efforts supported by USAID focused on tuberculosis and HIV infection. One study examined the causes of multiple drug-resistant TB in areas with high HIV prevalence. USAID is also supporting collaboration between WHO, the Centers for Disease Control and Prevention, and the ministries of health in six sub-Saharan African countries to develop models for improved home-based TB care.

USAID supported a study in Malawi into the effectiveness of washing the vagina with an anti-



PHOTO: NIAID/COMMUNICABLE DISEASES

In the Philippines, Joy, 16, left home when she was 14 to work on the streets of Manila as a sex worker and has used "Shabu," known as the poor man's cocaine.

responding to prevention interventions and which are not, and can help redirect prevention efforts to those that lag behind in behavior change.

Although AIDSCAP ended its Bangkok activities in September 1996, the BMA, recognizing the value of BSS data, continued it using local resources. The success of the BSS in Bangkok has generated interest throughout the rest of Thailand, where behavioral surveillance modeled after the BSS is now administered in most of the

FEMALE CONDOM RESEARCH GROWS AS A FOCUS OF GENDER-BASED PREVENTION EFFORTS

Because traditional gender roles deprive many women of control over their sexual and economic lives, seroprevalence among women has skyrocketed as the epidemic develops. Despite much lower HIV seroprevalence for women than for men at the beginning of the epidemic, female infection rates are now equal to or higher than those of men in many regions. In both industrialized nations such as the United States, where AIDS is the single greatest killer of African American women in their most productive years, and developing regions such as sub-Saharan Africa, where more than 7 million women are now HIV-infected, the world is finally becoming aware that HIV/AIDS is very much a women's issue.

In response to this frightening trend, empowering women to protect themselves from HIV has been the goal of intensive gender-based research, analysis, and prevention programming in recent years. Thanks to the efforts of such organizations as USAID's Office of Women in Development, the International Center for Research on Women, UNAIDS, and the AIDSCAP Women's Initiative (AWI), an agenda for women and HIV/AIDS has become an integral component of the larger campaign to prevent the spread of the epidemic.

One important effort has been the search for prevention methods that, unlike the male condom, women themselves can control. As research to develop a vaginal microbicide continues, another woman-controlled device—the female condom—has been the object of much attention in the past two years. Initial studies have found the device to be as safe and effective as male condoms if used correctly, offering an alternative method of preventing heterosexually acquired infections.

Because the female condom—a loose-fitting polyurethane sheath with two flexible rings—is so different from other prophylactic devices, its acceptability to both women and men has been the subject of several studies. In 1995, USAID distributed female condoms to 19 countries for use in Agency-sponsored acceptability trials and operations research on introducing the device into reproductive health services and social marketing programs.

Several important issues—chief among them affordability—remain to be resolved. The lowest price thus far negotiated by the public sector is U.S.\$0.63, compared to a public sector sale price of \$0.05 for the male condom. Will the female condom meet critical cost-benefit standards? Is the device appropriate for social marketing? Will developing countries with limited health budget be able to sustain female condom programs if major donors start them? Ongoing research and

analysis in the next few years should answer many of these questions.

At a recent AWI conference in suburban Washington, "The Female Condom: From Research to Marketplace," participants discussed the cost barrier and other important issues. One subject of considerable interest was whether a reusable female condom can be developed, thus lowering the cost per use considerably. Another important topic was the question of targeting: should these products be targeted only to high-risk groups or to the general public? Should targeting be to couples rather than just to women, to raise acceptance by men? The final recommendations from conference participants encourage ongoing study of the cost, targeting, policy, and interpersonal issues involved in making the female condom as powerful a prevention tool as possible.

One developing nation has decided to invest in the female condom to increase access. Zimbabwe, prompted by a petition campaign that included 30,000 women's signatures, launched the first large-scale effort in the developing world to make female condoms available to the general population throughout the country. In some poor rural regions where people cannot afford the female condom even at subsidized prices, it's likely that many of the several hundred thousand condoms purchased by the Zimbabwean government will be given away free.

septic agent to prevent maternal transmission of HIV to newborns. Conducted by the National Cancer Institute and Johns Hopkins University, the study showed that while vaginal washing offers no protection from HIV except in special cases, it does reduce infant deaths from neonatal sepsis and from meningitis by two-thirds. These

where medical practitioners might reuse needles and thus spread HIV and other infectious diseases. PATH is now focusing on the development of rapid, simple, and inexpensive diagnostic tests for sexually transmitted infections that would improve the treatment of both symptomatic and asymptomatic women.

technical and management skills building, management systems development, and networking.

USAID has long supported the involvement of community-level NGOs and private voluntary organizations (PVOs) in all stages of planning, design, and implementation of HIV and STI prevention programs. USAID is one of the founders of the International HIV/AIDS Alliance (IHAA), an international NGO whose mission is to mobilize nongovernmental and community groups, increase their access to resources at the local level, and enhance their technical and organizational skills to enable communities in developing countries to play full and effective roles in the global response to HIV/AIDS. Since 1993, the IHAA has assisted more than 450 local, community-based organizations and NGOs in developing, implementing, evaluating, and sustaining advanced HIV prevention programs at the grassroots level.

In all of the AIDSCAP Project's country programs, capacity building is an integral part of the design of each subproject. Worldwide, more than 500 nongovernmental organizations—from small village-based groups to influential organizations with international profiles—plan and administer AIDSCAP-supported prevention activities while they receive ongoing training in technical, organizational, and financial skills. Two AIDSCAP programs provide special funding opportunities to strengthen community-based NGO activities. The first has linked nine NGOs in developing countries with U.S.-based private voluntary organizations and supports their innovative prevention projects with three-



In Gokak, India, a MYRADA/PLAN International van funded by the AIDSCAP Project operates as a condom distribution outlet in the village.

unexpected but encouraging findings can now be applied throughout the world at very low cost to reduce the risk of infant death.

The Program for Appropriate Technology in Health (PATH) has used USAID funds to develop a low-tech, low-cost diagnostic dipstick that tests for HIV infection. Although it is as accurate as the standard tests used in industrialized nations, each dipstick test costs less than a dollar and delivers results in only 20 minutes. PATH has also designed effective single-use syringes to use in resource-poor regions

Community Mobilization and Capacity Building

Mobilizing and building the capacity of communities to respond to the epidemic is perhaps the single most important way to sustain prevention efforts over time. Building on lessons learned from research and from the experiences of activist communities, USAID partners have developed expertise in motivating and training communities to build a social environment for safer sex behavior and risk reduction, raising the odds for success in curbing HIV transmission. USAID supports projects that encompass the three major approaches to capacity building:

year, U.S.\$400,000 grants. And the Rapid-Response Fund has awarded more than 220 small grants to community-based organizations involved in client-centered HIV/AIDS prevention services.

Another innovation in capacity building with particularly broad impact is AIDSCAP's Regional AIDS Training and Education (RATE) Program, which offers skills training in BCC, STI management, policy development, and training of trainers to professionals in health, policy, communications, and journalism from all over Asia. Based in Bangkok, RATE created centers of excellence at three Thai universities that will continue to provide regional leadership and sustain this valuable training function after AIDSCAP ends in 1997. For Cambodia, Laos, Mongolia, Sri Lanka, Indonesia, and other Asian nations that are just beginning to confront the epidemic, RATE training offers an enormous head start in prevention planning.

Since 1991, USAID has built a valuable partnership with the Peace Corps, working with volunteers to build capacity for ongoing prevention activities in 26 developing countries. Peace Corps volunteers use the training they receive in HIV/AIDS prevention, behavior change communication, and community mobilization to assist indigenous NGOs and other community members, providing low-cost technical assistance to build sustainable prevention programs. One particularly creative and successful enterprise was the "Teach English/Prevent AIDS" program, which brought together Peace Corps volunteers, educators, and public health specialists to draft lesson plans that meld English instruction with

JEREMY HORNER/PANGS PICTURES



12-year-old girls at Pang Lao School in Chiang Rai Province, Thailand, play a game to illustrate how sexual networking can increase the risk of HIV transmission.

HIV/AIDS prevention messages. Begun in Cameroon, the program has been adapted for use in Chad, the Central African Republic, Gabon, and Ethiopia. The Peace Corps also provides NGOs and other community organizations in Thailand with training in home-based care.

The National Council for International Health (NCIH), under an agreement with USAID, provides valuable support to NGO networks through its prevention training workshops, a bimonthly newsletter, and international conferences that address NGO concerns.

Care and Support

As the epidemic matures and the number of people stricken with AIDS grows, developing nations find themselves overwhelmed by the demand for care and support services. Where HIV/AIDS care consumes much of the health budget, leaving little for other pressing medical concerns, both public health and economic development are endangered. Understanding the relationship between the need for care and a sustainable future has helped breach the conceptual barrier between prevention and care, highlight the importance of cost-effectiveness, and put care and support squarely on the programming agenda.

With so much at stake, USAID and many of its partners have become more involved in HIV/AIDS care and support. All USAID programs in high-prevalence countries are seeking appropriate and sustainable approaches to meet this increasing need. Both USAID and

UNAIDS have identified HIV/AIDS care as one of the key areas for research and testing to develop and disseminate best practices.

AIDSCAP's Care and Management Small Grants Program seeks to develop affordable and sustainable care models through seed grants to NGOs in developing countries. The program supports approaches that create innovative community-based care activities and that leverage resources from communities, the public or private sectors, and donors. In Haiti, for example, three hospitals received funds to extend HIV/AIDS care—medical services, counseling, and prevention education—into outpatient clinics and patients' homes.

Some AIDSCAP country programs have long incorporated care into their activities, notably Tanzania, where even small village NGOs associated with AIDSCAP's Tanzania AIDS Program take on significant care and support responsibilities. Tanzania is also the site of an important AIDSCAP research effort to determine whether intensive, personalized counseling and care of HIV-positive people can influence them to change their sexual behaviors and lower their risk of infecting others. The study reflects a new global interest in uncovering linkages between HIV/AIDS prevention and care by examining the hypothesis that caregiving can prompt both the caregiver and care receiver to take prevention seriously.

TANZANIAN NGO "CLUSTERS" OFFER MODEL COMMUNITY-BASED RESPONSE TO HIV/AIDS

The East African nation of Tanzania, with an average per capita income of U.S.\$90, is one of the most impoverished in the world. With its western provinces situated in the African epicenter of the AIDS epidemic, it has also been one of the hardest hit by HIV. Seroprevalence among low-risk urban populations reached 13.7 percent in 1995; in studies of people at high risk, the rate was nearly 50 percent. The epidemic continues to have an enormous impact on the country's health, economy, and social fabric, overtaxing the health care and welfare systems and other sectors' budgets, depriving Tanzanian farms and factories of skilled workers in their most productive years, and leaving thousands of children orphaned and in need of care.

Yet despite its poverty, Tanzania has long had formidable weapons with which to fight back: talented and committed women and men, and a political culture that has for decades encouraged citizen participation and community cooperation in solving the nation's problems. The country's wealth of human resources and its spirit of engagement, combined with financial and technical assistance from international donors, have turned Tanzania's efforts against the epidemic into a global model of decentralized participation.

AIDSCAP's Tanzania AIDS Project (TAP), a five-year USAID-funded program that began in 1993, has built success through its involvement with hundreds of community-based NGOs, from the national to the village level. To support these groups and make best use of limited resources, TAP created

NGO “clusters” in nine different high-transmission regions of the country, a unique approach to capacity building. These networks bring together carefully selected NGOs of different sizes, mandates, and levels of expertise, many of whom hadn’t worked together before, to benefit from each other’s resources and skills and to avoid duplication of regional prevention efforts. Each cluster also includes the regional and district AIDS coordinators working for the Ministry of Health, a beneficial linkage between NGOs and the government.

The cluster formation concentrates formerly isolated NGO talent and energies, strengthens the NGOs’ political influence, and provides support and feedback for their often overextended members. Clusters plan activities and educational campaigns together, refer clients to each other, and receive technical assistance from TAP as a group. All nine clusters have opened offices that also serve as drop-in community education centers, where counseling is available and prevention activities such as video showings and drama performances take place on a regular—and often daily—basis.

In addition to regional activities, clusters are also involved in many of TAP’s national prevention activities, including behavior change communication, condom social marketing, and policy dialogue. After group training in behavior change communication development, each cluster takes charge of creating its own prevention messages, designing its own materials, and organizing its own public prevention activities, using approaches and materials most appropriate for its region. Many clusters also participate

in the condom social marketing campaign of TAP’s Social Marketing Unit (SMU), integrating condom instruction into their prevention education and, in many cases, serving as sales outlets for the subsidized Salaama brand condom at their community centers. At the TAP office in Dar es Salaam, the SMU directs its national advertising and promotion efforts for Salaama and manages a complex national distribution system that reaches deep into rural areas of the country where condoms have traditionally been hard to find. Sales of Salaama have skyrocketed since they began in 1993; in 1996, sales figures of 8 million were double those of the year before.

Another important national strategy that benefits enormously from cluster participation is policy dialogue. Just as TAP serves as an advocate for policy changes at the national level, the clusters advocate to strengthen HIV/AIDS prevention and care programming and promote legal reform to end discrimination against those who are infected at the regional and local levels. Nationally and regionally, a great deal of effort goes into educating policymakers, elected officials, government ministers, business managers, trade union directors, and community and religious leaders about the dangers of the epidemic and their responsibility to support policies that promote prevention and care.

Control and treatment of STI—a severe problem throughout the country—is another priority for TAP, which sponsors training in syndromic management and other cost-effective strategies. Managed by such outstanding national institutions as

Muhimbili University, extensive courses are scheduled throughout the country for clinic and hospital personnel at all levels, from physicians to nurses to health educators to support staff. Syndromic management is now the official practice in public hospitals and health clinics in Tanzania.

Given their commitment to the communities in which they’re based, it’s hardly surprising that TAP’s clusters are deeply involved in providing care and support for families and individuals affected by HIV/AIDS. Counseling, home-based care, orphan support, and income generation opportunities are among the many services that most clusters offer. In the Dar es Salaam cluster, one NGO provides legal advice to HIV-infected people and their families on how to protect their rights and secure their property for their survivors by writing simple wills and avoiding probate. These care and support efforts benefit more than just individual families, for by their example they sensitize the larger community to the threat that HIV/AIDS poses to all and help end stigmatization of those who are infected.

TAP’s unique cluster structure has proven to be a powerful means of involving an entire nation—from the grassroots to the nation’s top decision makers—to work together to end the suffering and economic hardship the epidemic has caused. Many also believe that this model of community-level mobilization could also evolve into a model of sustainability for the rest of the world, a potential lesson learned in the value of cooperative action and community involvement.

Focusing on the Future

Since USAID initiated its first HIV/AIDS prevention efforts more than ten years ago, the pandemic has, with sobering speed, become a global phenomenon that continues to expand and intensify. Its metamorphosis into a persistent, many-faceted, and often unpredictable threat to human health and security calls for a response on the part of the international community that is similarly flexible and comprehensive.

To maintain its international leadership role in the response to HIV/AIDS, the Agency recently undertook a comprehensive review of its strategy, leading to a thorough redesign that will guide its worldwide programs well into the next century. Consistent with the Agency's guiding principles, this three-part, collaborative process relied upon the active participation of all potential "stakeholders": host country health ministries and AIDS control agencies, policymakers, PVOs, NGOs, organizations representing people living with HIV and AIDS, the international donor community, and U.S. government agencies.



In the Philippines, exhausted children who work at night as sex workers on the streets of Manila sleep during the day at the Children's Laboratory for Drama in Education.

A NEW STRATEGY **Developing a Common Vision**

During the first stage of the redesign process, beginning in August 1995, USAID organized public meetings to encourage stakeholder groups to develop a shared vision of the ideal worldwide response to HIV/AIDS. These meetings included the Third USAID HIV/AIDS Prevention Conference in Washington, D.C.; satellite meetings at the 1995 regional meetings on HIV/AIDS in Thailand, Israel, Chile, and Uganda; a satellite meeting at the U.N.'s Fourth World Conference on Women in Beijing; and a "Town Meeting" in Washington, D.C. In addition, questionnaires were distributed to international and indigenous NGOs, Ministry of Health officials, national AIDS control program managers, and USAID missions worldwide.

Participants firmly placed HIV/AIDS in its development context and reconciled biomedical and behavioral perspectives. They also emphasized the importance of HIV/AIDS care and support, multisectoral coordination, the need for sustainability, and reducing stigmatization of and discrimination against people vulnerable to, and living with, HIV/AIDS. Stakeholders constructed a universal framework of objectives that recognizes that prevention, care, local ownership of HIV/AIDS program objectives, human rights protection, and maintaining the productivity of the infected are mutually reinforcing objectives.

Identifying Priorities

The second stage of the participatory redesign process sought to involve stakeholders in building a

consensus for USAID's future priorities in HIV/AIDS. Participants at USAID-sponsored workshops in Washington confirmed the value and validity of the framework developed in stage one and established criteria for selecting USAID's priority objectives from that framework. Among the criteria are magnitude of impact on the epidemic, feasibility of attaining the objective, potential for capacity building and sustainability, and the degree to which the welfare and empowerment of women and other vulnerable groups are promoted.

Using these criteria, USAID identified the six areas of programmatic focus for its HIV/AIDS strategy for 1998-2005. Expressed as results to be achieved by USAID programs, these six foci are designed to help the Agency reach the overall objective of "increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic."

- Increased quality, availability, and demand for information and services to change sexual risk behaviors and cultural norms in order to reduce transmission of HIV.
- Enhanced quality, availability, and demand for STI prevention and management services.
- Improved knowledge about, and capacity to address, the key policy, cultural, financial, and other contextual constraints to preventing and mitigating the impacts of HIV/AIDS.
- Strengthened and expanded private sector organization responses in delivering HIV/AIDS information and services.
- Improved availability of, and capacity to generate and use, data to monitor and evaluate HIV/AIDS

and STI prevalence, trends, and program impacts.

- High-quality, timely assistance provided to USAID's regional bureaus and missions, international organizations, and other partners to ensure effective and coordinated implementation of HIV/AIDS programs.

Designing Strategies

In stage three of the redesign process, USAID staff worked to translate the stakeholder-identified priorities into a series of specific strategies. For each programmatic focus selected in stage two, the design team outlined the activities that would make it possible to achieve the desired result and identified performance indicators to measure the Agency's progress toward achieving that result. It also worked to highlight and reaffirm the Agency's commitment to addressing essential cross-cutting issues, such as HIV/AIDS care and support, NGO capacity building, policy reform, and a focus on youth.

STRATEGIC APPROACHES

The strategic objective and long-range strategy that emerged from the review process were built on two overarching themes: (1) the need for continued and expanded emphasis on sustainable responses to prevent HIV transmission, and (2) a new emphasis on mitigating the epidemic's impact on people and communities while more closely studying its social, economic, and policy impacts.

Prevention and mitigation efforts will be undertaken in a selected set of emphasis countries, enabling the Agency to focus more effectively on achieving results and building capacity in the countries it does target so that they can sustain implementation once foreign assis-

tance has ended. A more focused response will also heighten opportunities for impact and increase opportunities for demonstrating successful program models.

Prevention

Since 1987, USAID's strategy has centered around three approaches to HIV/AIDS prevention: increasing distribution of condoms, changing high-risk behaviors through behavior change communication, and improving the diagnosis, treatment, and control of sexually transmitted infections. Each approach, over time, has had demonstrable impact in the field.

Roughly 70 percent of USAID's overall budget for HIV/AIDS programs will be spent to continue prevention activities. These prevention efforts will build on successes achieved to date and will concentrate on strengthening the long-term sustainability of HIV/AIDS programs.

Mitigating Impact

To enhance its prevention agenda, USAID's expanded portfolio will embrace new efforts to mitigate the effect of the epidemic on individual lives and communities. Activities will include:

- Improving basic care and psychosocial support for people living with HIV/AIDS and their survivors.
- Improving and expanding HIV/STI surveillance systems.
- Promoting operations research to identify "best practices."
- Assisting PVOs and NGOs, including community-based organizations, involved in HIV/AIDS activities.

THE PREVENTION-TO-CARE CONTINUUM

For more than a decade, HIV/AIDS programs in developing countries have focused on prevention. With no effective, affordable treatment available, many donors and nongovernmental organizations invest their resources in protecting people from HIV infection rather than caring for those already infected.

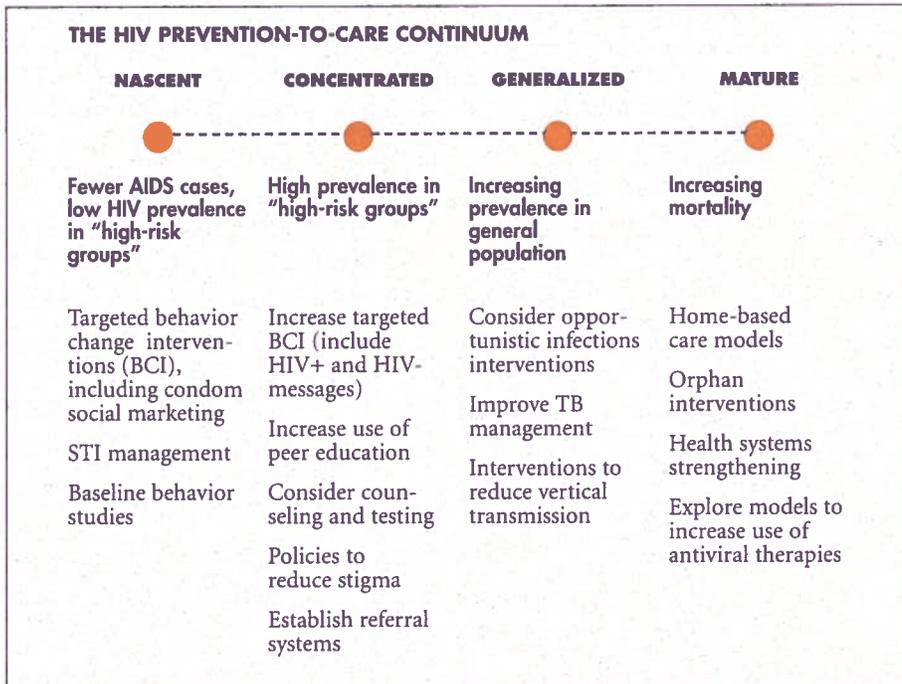
But health care providers, outreach workers, and community volunteers are finding it increasingly

need for HIV/AIDS care and support would drain precious dollars from effective prevention efforts, making it impossible to slow the spread of the epidemic. Even in sub-Saharan African countries where few have access to antiviral treatments such as AZT or the new drug “cocktails,” the cost of basic hospital inpatient care for one AIDS patient ranges from U.S.\$210 to \$936. In contrast, a comprehensive HIV/AIDS prevention and STI

grounds. They argue that a single-minded focus on prevention undermines the credibility of an HIV/AIDS program among the very people it is intended to help, especially in countries with high HIV prevalence. At the same time, tending to people living with HIV/AIDS and their families and communities without using their experience to reinforce prevention messages is to miss the most obvious of motivational opportunities.

Experience suggests that providing HIV/AIDS care and support enables prevention programs to reach those most likely to transmit the virus. And one recent study provided powerful evidence of the importance of providing STI treatment for those living with HIV/AIDS. In Malawi researchers from the University of North Carolina at Chapel Hill, with support from AIDSCAP, found that treating gonorrhea in HIV-positive men reduced the amount of virus in their semen eight- to tenfold, making them far less likely to infect others.

Few studies, however, have examined the relationship between HIV prevention and provision of care and support. A USAID-AIDSCAP-UNAIDS study underway in Tanzania, Kenya, and Trinidad—the first randomized controlled trial of the impact of voluntary HIV counseling and testing on sexual risk behavior in the developing world—is expected to yield widely applicable answers



difficult to maintain this artificial separation between prevention and care, particularly in countries with mature epidemics. And many believe that an exclusive focus on preventing further transmission actually weakens prevention efforts.

Those who support the emphasis on prevention fear that any attempt to meet the burgeoning

management program in a workplace in one of these countries would cost U.S.\$15 to \$25 per person reached. In the case of HIV/AIDS, an ounce of prevention may truly be worth a pound of “cure.”

However, many now believe that integration of HIV/AIDS care and prevention is essential on both humanitarian and practical

about the cost-effectiveness of such services as a prevention intervention. And a small USAID-sponsored study by AIDSCAP in Tanzania will shed light on how psychosocial support affects the behavior of individuals during the first few months after they learn that they are HIV-positive.

Although questions remain about the most cost-effective ways to link prevention and care, a consensus is slowly emerging that AIDS care and support do have a role to play in prevention efforts. The figure on page 32 illustrates how mitigation of some of the epidemic's impacts can complement prevention efforts at different points along the continuum representing the increasing prevalence of HIV/AIDS in many countries.

This continuum is all too familiar to USAID staff working in high-prevalence countries where the pressure on government services, community resources, and family survival threatens the very social fabric. While the majority of USAID's HIV/AIDS programming will continue to focus on prevention, the Agency has broadened its strategy to incorporate new initiatives promoting a more holistic approach to the pandemic. USAID's contribution will be to identify ways to improve care for those living with HIV/AIDS and psychological, social, and legal support for all those affected by the epidemic.

FROM STRATEGY TO ACTION

USAID's approach to achieving its strategic objectives is built around five core activity areas: operations research, regional and country interventions, social marketing, evaluation and dissemination, and multi-lateral assistance.

The Agency's *global leadership, research and development* activity will place renewed emphasis on advancing the state-of-the-art in responding to HIV/AIDS through operations research, field tests of interventions, and promotion of best practices. Topics of research will include STI management and prevention, integration of HIV prevention into public and private sector health services, and analysis of policies governing delivery of care and support services to people living with HIV/AIDS and their families and communities.

Operations research in behavior change communication is particularly critical in order to improve strategies for influencing individual sexual risk behaviors and social norms in specific countries. A substantial need remains for leadership in developing expertise and networks on which national programs can draw in tailoring prevention messages for different segments of their populations.

Lessons learned through global leadership initiatives will be quickly put into practice through dissemination of best practices and in USAID's *regional and country interventions*. Through this activity, the Agency will continue to provide the technical assistance, training, logistical and other support required by field programs and USAID missions to implement HIV/AIDS and STI prevention programs.

Country and regional support will include assistance in developing strategies and structures for inte-

grating HIV/AIDS interventions into other primary care and reproductive health initiatives. Methods of providing such assistance are contingent upon what is most appropriate for a country or region, but could include long-term technical advisors, short-term consultants, and cooperating agencies.

The third core activity, *social marketing*, has proved effectiveness in making STI/HIV prevention information and condoms widely accessible at nominal cost to the consumer. Under USAID's new strategy, the role of social marketing as a mainstay of prevention programming will expand to include additional public health products such as the female condom, prepackaged therapy for STIs, and a vaginal microbicide when it becomes available. The Agency will also focus on expanding social marketing interventions to national or regional scale and evaluating their impact.

Through its *design, monitoring, evaluation, and dissemination* activity, USAID will provide its missions and other partners in HIV/AIDS prevention with access to technical assistance in program design and evaluation and to the lessons learned from all the activities under its portfolio. Effective dissemination of such lessons builds informed interest, encourages partnerships, and helps programs and their implementers avoid the pitfalls that other programs have already encountered. USAID will place renewed emphasis on developing systems that provide missions, cooperating agencies, international donors, and governments regular access to current technical, descriptive, and evaluative information on active and completed HIV/AIDS programs.

Finally, USAID will continue providing *multilateral assistance* to United Nations partners and others engaged in international HIV/AIDS programming. Through this activity, the Agency will support UNAIDS, the successor to the WHO Global Programme on AIDS. The international leadership of such an organization is increasingly important at a time when, notwithstanding the inexorable growth of the HIV/AIDS pandemic, a degree of “donor fatigue” is weakening the resolve of many multilateral and bilateral funders. USAID will look to UNAIDS to play an increasingly prominent role in coordinating the HIV/STI/AIDS activities of international donors at the country level.

CROSS-CUTTING ISSUES

In addition to its core activities, USAID will undertake a series of new, exploratory initiatives intended to provide cutting-edge support to the priority elements of its portfolio. Such cross-cutting issues as the linkages between care and prevention, NGO capacity building, young people’s access to information and services, and integration of programs will influence all aspects of HIV/AIDS prevention and mitigation, thus making them particularly important to the improved effectiveness of all programs.

With the new priority given to efforts to mitigate the impact of HIV/AIDS, *research on the prevention-to-care continuum* assumes critical importance. Operations research in this area will investigate how best to create reinforcing linkages between prevention and care. Research that leads to appropriate, workable definitions of care, followed by guidelines for providers engaged in home and community

THE COMMUNITY AS A LOCUS FOR ACTION

Community action has been an essential part of the response to HIV/AIDS since the early days of the epidemic, when community-based organizations (CBOs) were created to fill the gaps in often inadequate public and private services for people with HIV/AIDS. Many of the most respected and effective HIV/AIDS organizations, such as The AIDS Service Organization (TASO) in Uganda and Jamaica AIDS Support (JAS), began as support groups for the family and friends of those who had died of AIDS. Responding to the evolving needs of their communities, these CBOs gradually expanded their efforts to HIV/AIDS care, prevention, and advocacy.

USAID has recognized the importance of community action in HIV/AIDS prevention and care and has channeled much of its funding for HIV/AIDS to CBOs and other local nongovernmental organizations. About 70 percent of the activities of the AIDSCAP Project, for example, were carried out by more than 500 NGOs and CBOs. Since some of these groups were fledgling organizations and many others were already experienced in health or development but were new to the HIV/AIDS field, AIDSCAP’s technical assistance, training, and institution-building support were critical to the success of these partnerships.

The Agency has also helped fund the NGO capacity building and network strengthening efforts of the International HIV/AIDS Alliance, the National Council for International Health, and the International Council of AIDS Service Organizations. In addition, USAID’s support for groups involved in advocacy, such as the Kenya AIDS NGOs Consortium, fostered the creation of successful grass-roots movements to influence national HIV/AIDS policies in a number of countries.

This reliance on organizations with deep roots in their communities has enabled USAID to reach millions of people with prevention messages and services that are truly responsive to their needs. It also offers the potential to leave behind a sustainable indigenous response to the epidemic in countries that eventually “graduate” from U.S. support.

USAID’s new strategy calls for an even greater emphasis on community action for HIV/AIDS prevention and care. In addition to strengthening NGO capacity building efforts, the Agency will create links with other USAID programs, such as democracy and governance initiatives, that promote community empowerment. The ultimate goal will be sustainability: enhancing technical and management skills and building strong networks among community organizations to ensure that they can continue HIV/AIDS prevention, care, and advocacy efforts in the future.

support, will make a major contribution to the mitigation effort in USAID-assisted countries. Other areas for country-specific study include guidance on psychosocial

and legal support for infected individuals and their families, laws and policies that may restrict care givers, and innovative approaches to meeting the needs of AIDS orphans.

Mitigation efforts must be complemented by *biomedical research* to develop methods for preventing further HIV transmission. Using its own resources and leveraging those of others, USAID will continue to play a leading role in sponsoring research into key new technologies, such as vaginal microbicides, inexpensive STI diagnostics, methods to reduce mother-to-child transmission, and vaccines for use in resource-limited settings.

The Agency will also collaborate with other development partners to help governments build and strengthen *HIV/AIDS surveillance systems*. USAID has supported the U.S. Bureau of the Census (BUCEN) HIV/AIDS Surveillance Database since 1987 and recently began working with UNAIDS to develop guidelines for biological and behavioral surveillance in developing countries. Recognizing the growing need to understand the dynamics of HIV transmission and the results of STI/HIV/AIDS prevention interventions, USAID will continue working with UNAIDS, BUCEN, and the Centers for Disease Control and Prevention to develop state-of-the-art systems for STI/HIV surveillance.

Another activity that cuts across all aspects of HIV/AIDS programs is *NGO capacity building*. Non-governmental organizations are becoming increasingly important in developing countries for mobilizing resources at the community level and developing programs that are both appropriate and cost-effective. Yet many of these NGOs are relatively new and inexperienced, and most need technical assistance and training to meet the technical, programmatic, and managerial challenges of the epidemic.

USAID will place major emphasis on building the capacity of indigenous NGOs to play permanent

roles in the design, implementation, and evaluation of HIV/AIDS prevention and care programs. These roles could range from serving as focal points for community-based social marketing activities, to organizing model private sector care and service organizations, to recruiting and training volunteers to assist families affected by the epidemic, to exploring the potential for mutually supportive activities between themselves and U.S. HIV/AIDS NGOs.

Providing *access to information and services for youth* will remain an important element of USAID-supported HIV/AIDS programs. Youth volunteers, young peoples' associations, and school groups have been some of the most enthusiastic promoters of responsible sexual behavior in the age of AIDS. Models of successful in-school and out-of-school programs are available to be adapted and replicated.

USAID will support the adaptation and replication of these successful programs through operations research to determine which approaches are most effective for different ages in different settings. Educating youth on how to prevent HIV infection must start at an early age, and experiences to date with programs for youth audiences will be instructive.

As the epidemic has matured, *policy reform* has moved beyond dialogue to generate government commitment to HIV/AIDS prevention and care. A more advanced set of policy issues now includes seeking direct governmental contributions to the effort, decision making on resource allocation, addressing discrimination and stigma, and identifying the appropriate care and support interventions for people living with HIV/AIDS, survivors,

and affected communities. To address these issues in the policy arena, USAID will support behavioral research and the generation of more sophisticated policy tools, such as simulation models to assist policymakers in making resource allocation decisions.

A final cross-cutting issue and a continuing USAID priority is the *integration* of various reproductive health and primary care services, including HIV/AIDS prevention, STI diagnosis, treatment and prevention, family planning and primary health care. Family planning, and maternal-child health clinics, for example, offer promising opportunities for reaching millions of sexually active adults with comprehensive and complementary reproductive health services. Integrating health services can also improve both cost-effectiveness and the quality of the services themselves.

Effective integration of reproductive health services is only one of the many health and development challenges posed by the HIV/AIDS epidemic. Although these challenges may seem daunting in the face of a relentlessly expanding epidemic, USAID's thorough review of prevention experience to date offers reason for cautious optimism.

Many operational questions remain, but we now have evidence that the prevention approaches we have developed and refined over the years work, and we have the experience to apply them ever more effectively. USAID's strategy, which represents the collective wisdom and vision of those on the front lines of the pandemic, offers a blueprint for using the lessons of the past decade to meet the challenges of the future.

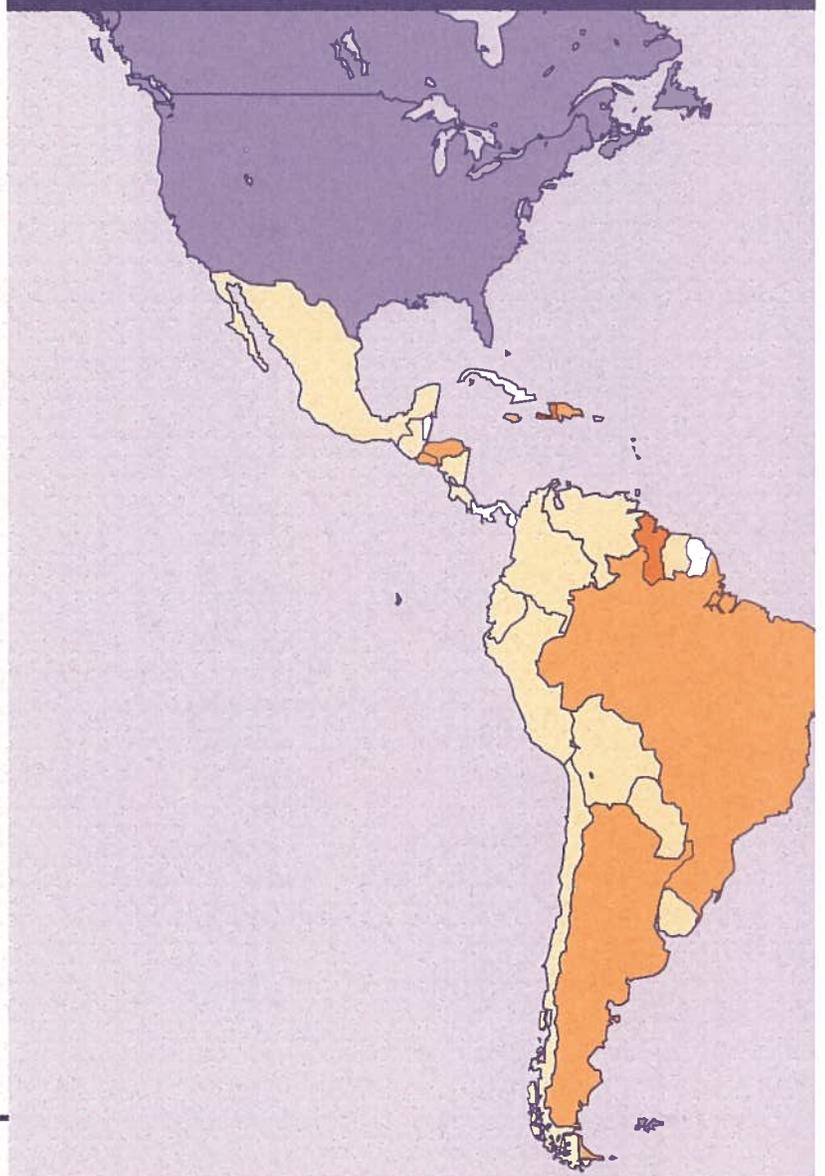
HIV in the Developing World

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 represent the best available data on HIV seroprevalence among selected 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.

The map on pages 36 and 37 shows the median HIV-1 prevalence among samples of urban individuals at high risk, including sex workers and STD clinic patients. The map on pages 38 and 39 shows the median HIV-1 prevalence among samples of women attending antenatal clinics, a population considered to be representative of the general adult population.

Continued on page 38

HIV PREVALENCE AMONG URBAN POPULATIONS AT HIGH RISK



COUNTRIES WITH LOW SEROPREVALENCE RANGES (0%-4.9%)



AFRICA	
ALGERIA	1.2
COMOROS	0.0
EGYPT	0.0
MADAGASCAR	0.3
MAURITANIA	0.9
MOROCCO	1.4
SOMALIA	2.4
TUNISIA	0.0
ASIA	
BANGLADESH	0.2
CHINA	0.3
FRENCH POLYNESIA	0.0
HONG KONG	0.0
INDONESIA	0.0
IRAN	0.0
JAPAN	0.0
LAOS	1.2
MALAYSIA	1.4
MONGOLIA	0.0
NEPAL	1.1
PAKISTAN	2.0

PHILIPPINES
SINGAPORE
SRI LANKA
VIETNAM

LAC

ARUBA	
BOLIVIA	
CHILE	
COLOMBIA	
COSTA RICA	
ECUADOR	
GRENADA	
GUATEMALA	
MARTINIQUE	
MEXICO	
NICARAGUA	
PARAGUAY	
PERU	
ST. LUCIA	
ST. VINCENT & GRENADINES	
SURINAME	
URUGUAY	
VENEZUELA	

COUNTRIES WITH MEDIUM SEROPREVALENCE RANGES (5.0%-24.9%)

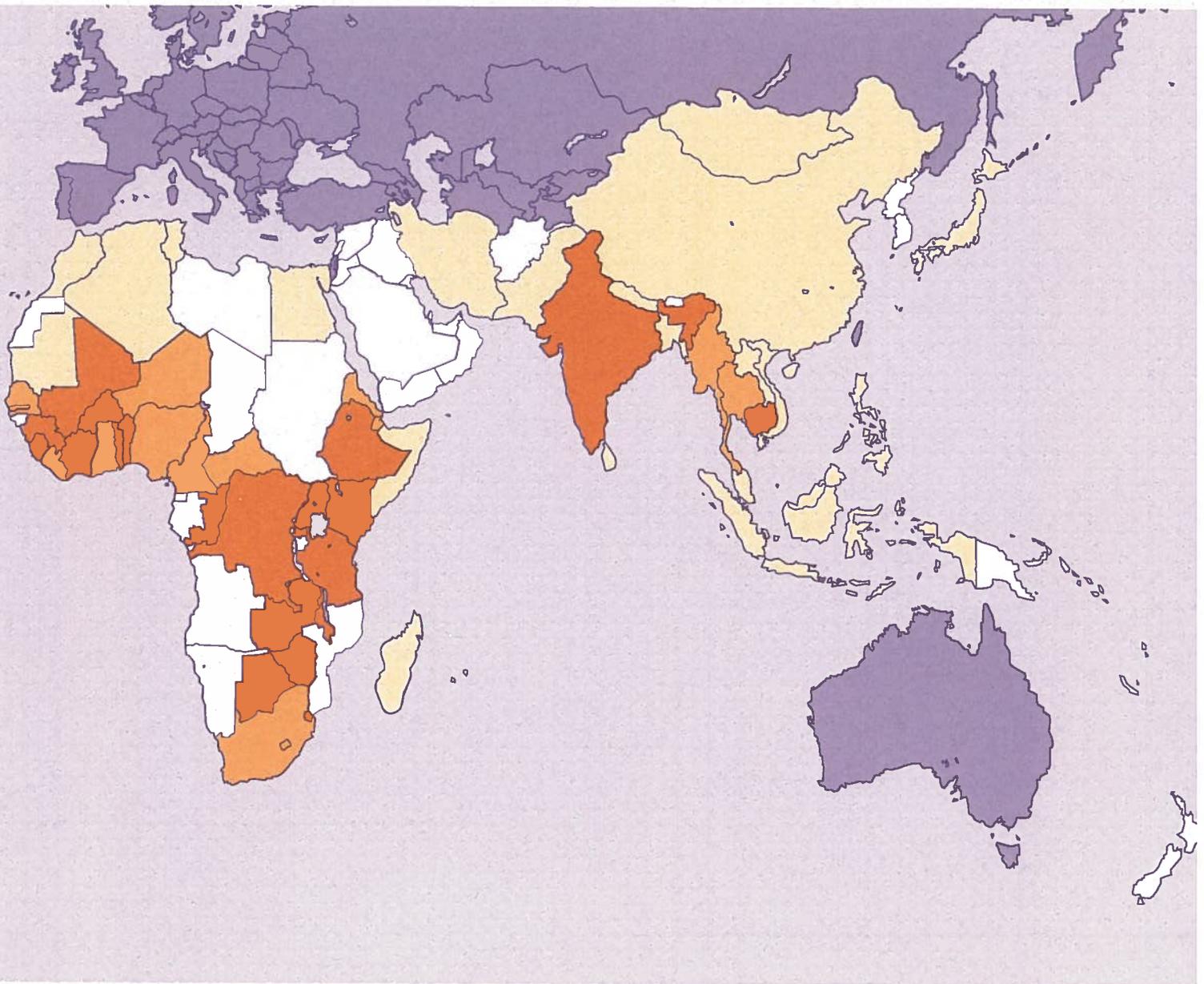


0.0	AFRICA	
1.8	CAMEROON	16.5
0.3	CENTRAL AFRICAN REPUBLIC	18.9
0.5	ERITREA	5.8
	GAMBIA	13.6
	GHANA	23.1
	LESOTHO	12.5
	LIBERIA	8.0
	NIGER	12.6
	NIGERIA	22.4
	SENEGAL	9.2
	SOUTH AFRICA	18.8
	ASIA	
	BURMA	21.0
	THAILAND	18.0
	LAC	
	ARGENTINA	7.3
	BAHAMAS	15.5
	BRAZIL	6.3
	DOMINICAN REPUBLIC	5.8
	EL SALVADOR	5.8
	HONDURAS	11.3
	JAMAICA	17.7
	TRINIDAD & TOBAGO	10.1

COUNTRIES WITH HIGH SEROPREVALENCE RANGES (25.0%+)



	AFRICA	
	BENIN	30.9
	BOTSWANA	44.9
	BURKINA FASO	60.4
	CONGO	49.2
	CÔTE D'IVOIRE	75.7
	DEM. REPUBLIC OF CONGO	32.6
	DJIBOUTI	37.7
	ETHIOPIA	54.2
	GUINEA	36.6
	KENYA	70.4
	MALAWI	61.5
	MALI	55.5
	RWANDA	33.7
	SIERRA LEONE	26.7
	SWAZILAND	27.4
	TANZANIA	55.2
	TOGO	78.9
	UGANDA	33.9
	ZAMBIA	40.0
	ZIMBABWE	78.6
	ASIA	
	CAMBODIA	40.2
	INDIA	26.1
	LAC	
	GUYANA	25.0
	HAITI	41.9



COUNTRIES WITH NO DATA AVAILABLE



AFRICA

- ANGOLA Not Available
- BURUNDI Not Available
- CAPE VERDE Not Available
- CHAD Not Available
- EQUATORIAL GUINEA Not Available
- GABON Not Available
- GUINEA-BISSAU Not Available
- LIBYA Not Available
- MAURITIUS Not Available
- MAYOTTE Not Available
- MOZAMBIQUE Not Available
- NAMIBIA Not Available
- REUNION Not Available
- ST. HELENA Not Available
- SAO TOME & PRINCIPE Not Available
- SEYCHELLES Not Available
- SUDAN Not Available
- WESTERN SAHARA Not Available

ASIA

- AFGHANISTAN Not Available
- AMERICAN SAMOA Not Available
- BAHRAIN Not Available
- BHUTAN Not Available
- BRUNEI Not Available
- COOK ISLANDS Not Available
- CYPRUS Not Available
- FIJI Not Available
- GAZA STRIP Not Available
- IRAQ Not Available
- JORDAN Not Available
- KIRIBATI Not Available
- KOREA, NORTH Not Available
- KOREA, SOUTH Not Available
- KUWAIT Not Available
- LEBANON Not Available
- MACAU Not Available
- MALDIVES Not Available
- MARSHALL ISLANDS Not Available
- MICRONESIA, FEDERATED STATES Not Available
- NAURU Not Available
- NEW CALEDONIA Not Available
- NEW ZEALAND Not Available
- NIUE Not Available
- NORTHERN MARIANA ISLANDS Not Available
- OMAN Not Available

- PALAU Not Available
- PAPUA NEW GUINEA Not Available
- QATAR Not Available
- SAMOA/ WESTERN SAMOA Not Available
- SAUDI ARABIA Not Available
- SOLOMON ISLANDS Not Available
- SYRIA Not Available
- TOKELAU Not Available
- TONGA Not Available
- TUVALU Not Available
- UNITED ARAB EMIRATES Not Available
- VANUATU Not Available
- WALLIS & FUTUNA Not Available
- WEST BANK Not Available
- WESTERN SAMOA Not Available
- YEMEN Not Available

LAC

- ANGUILLA Not Available
- ANTIGUA & BARBUDA Not Available
- BARBADOS Not Available
- BELIZE Not Available

- BERMUDA Not Available
- BRITISH VIRGIN ISLANDS Not Available
- CAYMAN ISLANDS Not Available
- CUBA Not Available
- DOMINICA Not Available
- FRENCH GUIANA Not Available
- GUADELOUPE Not Available
- MONTSERRAT Not Available
- NETHERLANDS ANTILLES Not Available
- PANAMA Not Available
- ST. KITTS & NEVIS Not Available
- TURKS & CAICOS ISLANDS Not Available

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

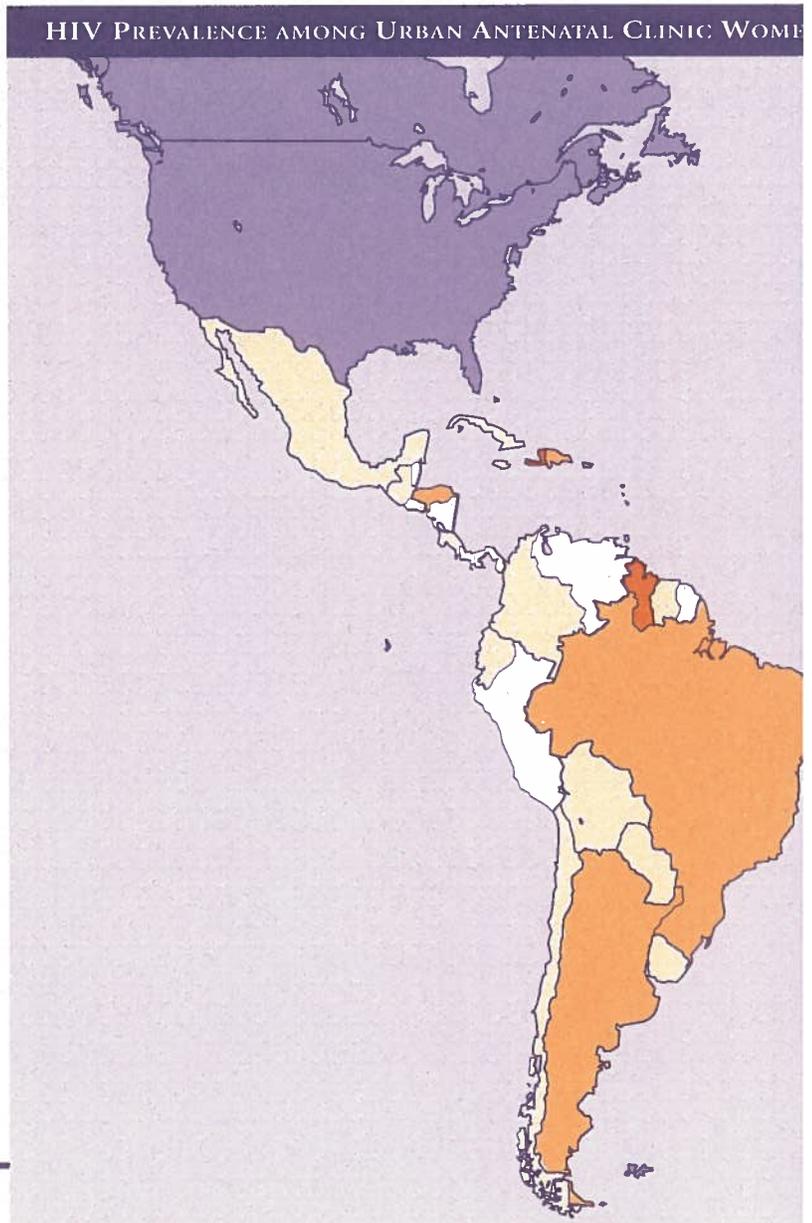
HIV in the Developing World

Continued from page 36

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.
- Better documented data were selected over poorly documented data; data without documentation were not used.

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



COUNTRIES WITH LOW SEROPREVALENCE RANGES (0%-0.9%)

AFRICA	
ANGOLA	0.9
BENIN	0.9
EGYPT	0.0
GAMBIA	0.6
GUINEA	0.7
MADAGASCAR	0.0
MAURITANIA	0.5
MOROCCO	0.2
SENEGAL	0.0
TUNISIA	0.0
ASIA	
INDIA	0.4
INDONESIA	0.0
IRAN	0.0
JAPAN	0.0
MALAYSIA	0.1
NEPAL	0.0
PAKISTAN	0.0
PAPUA NEW GUINEA	0.2

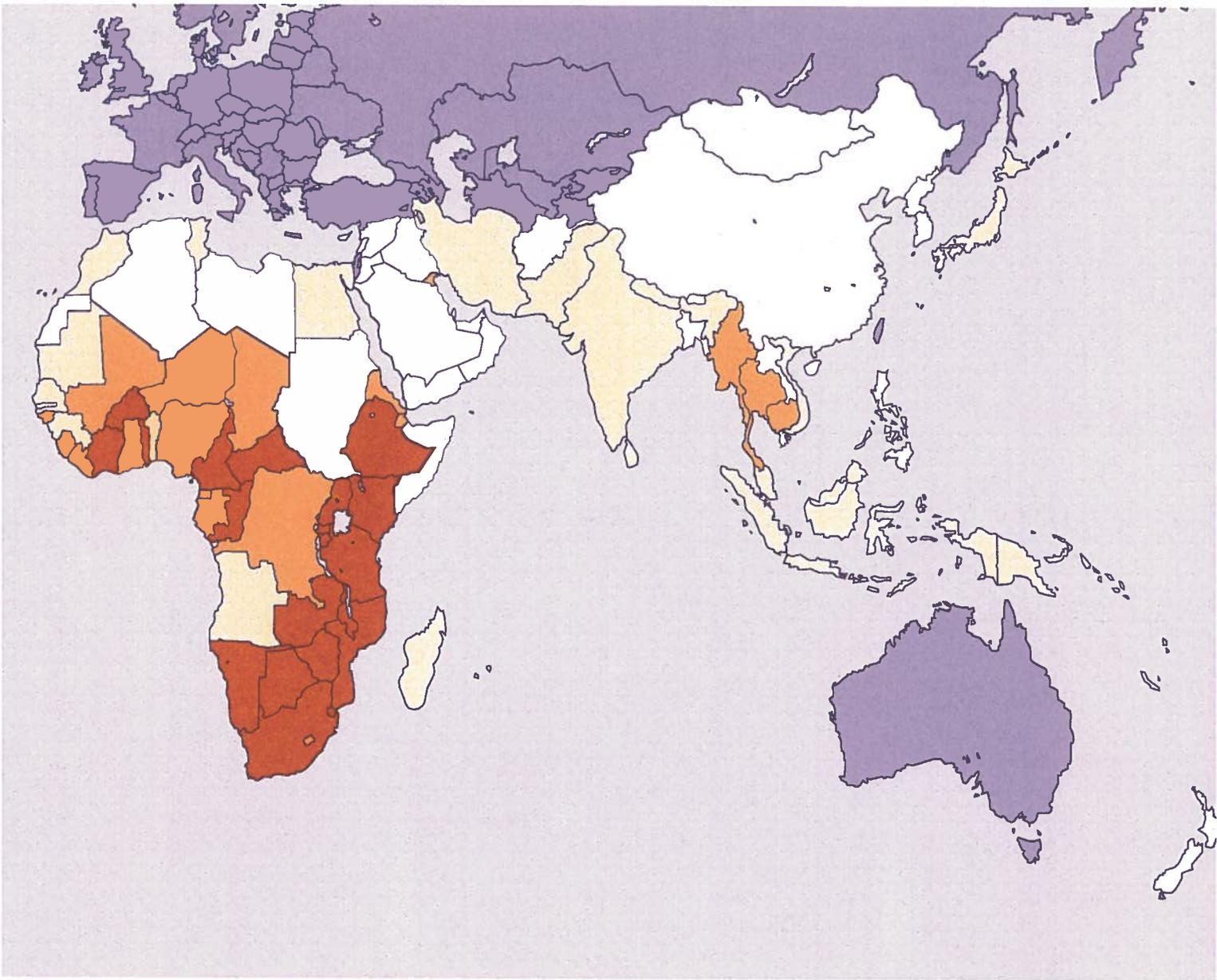
SRI LANKA	0.0
TONGA	0.0
VIETNAM	0.0
LAC	
BARBADOS	0.6
BOLIVIA	0.0
CAYMAN ISLANDS	0.0
CHILE	0.1
COLOMBIA	0.5
COSTA RICA	0.0
CUBA	0.0
ECUADOR	0.3
EL SALVADOR	0.8
GRENADA	0.0
GUATEMALA	0.0
JAMAICA	0.4
MARTINIQUE	0.9
MEXICO	0.6
PANAMA	0.3
PARAGUAY	0.0
ST. VINCENT & GRENADINES	0.2
SURINAME	0.8
TRINIDAD & TOBAGO	0.3
URUGUAY	0.0

COUNTRIES WITH MEDIUM SEROPREVALENCE RANGES (1.0%-4.9%)

AFRICA	
CHAD	4.1
DEM. OF CONGO (ZAIRE)	4.3
DJIBOUTI	4.0
ERITREA	3.0
EQUATORIAL GUINEA	1.8
GABON	4.0
GHANA	2.4
GUINEA-BISSAU	2.7
LESOTHO	4.2
LIBERIA	4.0
MALI	3.7
NIGER	1.3
NIGERIA	4.0
SIERRA LEONE	2.0
ASIA	
BURMA	1.1
CAMBODIA	1.7
THAILAND	1.8
LAC	
ARGENTINA	1.8
BAHAMAS	3.6
BRAZIL	1.5
DOMINICAN REPUBLIC	2.2
HONDURAS	2.6
ST. KITTS & NEVIS	2.0

COUNTRIES WITH HIGH SEROPREVALENCE RANGES (5.0%+)

AFRICA	
BOTSWANA	33.1
BURKINA FASO	12.0
BURUNDI	20.21
CAMEROON	6.0
CENTRAL AFRICAN REPUBLIC	10.0
CONGO	7.5
CÔTE D'IVOIRE	13.3
ETHIOPIA	18.3
KENYA	12.0
MALAWI	16.4
MOZAMBIQUE	10.6
NAMIBIA	16.7
RWANDA	10.2
SOUTH AFRICA	15.5
SWAZILAND	26.0
TANZANIA	9.6
TOGO	9.8
UGANDA	9.4
ZAMBIA	18.4
ZIMBABWE	33.6
LAC	
GUYANA	6.9
HAITI	8.4



COUNTRIES WITH NO DATA AVAILABLE



AFRICA

- ALGERIA Not Available
- CAPE VERDE Not Available
- COMOROS Not Available
- LIBYA Not Available
- MAURITIUS Not Available
- MAYOTTE Not Available
- REUNION Not Available
- ST. HELENA Not Available
- SAO TOME & PRINCIPE Not Available
- SEYCHELLES Not Available
- SOMALIA Not Available
- SUDAN Not Available
- WESTERN SAHARA Not Available

ASIA

- AFGHANISTAN Not Available
- AMERICAN SAMOA Not Available
- BAHRAIN Not Available

- BANGLADESH Not Available
- BHUTAN Not Available
- BRUNEI Not Available
- CHINA Not Available
- COOK ISLAND Not Available
- CYPRUS Not Available
- FIJI Not Available
- FRENCH POLYNESIA Not Available
- GAZA STRIP Not Available
- HONG KONG Not Available
- IRAQ Not Available
- JORDAN Not Available
- KIRIBATI Not Available
- KOREA, NORTH Not Available
- KOREA, SOUTH Not Available
- KUWAIT Not Available
- LAOS Not Available
- LEBANON Not Available
- MACAU Not Available
- MALDIVES Not Available
- MARSHALL ISLANDS Not Available
- MICRONESIA, FEDERATED STATES Not Available
- MONGOLIA Not Available
- NAURU Not Available
- NEW CALEDONIA Not Available
- NEW ZEALAND Not Available
- NIUE Not Available
- NORTHERN MARIANA ISLANDS Not Available
- OMAN Not Available

- PALAU Not Available
- PHILIPPINES Not Available
- QATAR Not Available
- SAMOA/WESTERN SAMOA Not Available
- SAUDI ARABIA Not Available
- SINGAPORE Not Available
- SOLOMON ISLANDS Not Available
- SYRIA Not Available
- TOKELAU Not Available
- TUVALU Not Available
- UNITED ARAB EMIRATES Not Available
- VANUATU Not Available
- WALLIS & FUTUNA Not Available
- WEST BANK Not Available
- WESTERN SAMOA Not Available
- YEMEN Not Available

LAC

- ANGUILLA Not Available
- ANTIGUA & BARBUDA Not Available
- ARUBA Not Available

- BELIZE Not Available
- BERMUDA Not Available
- BRITISH VIRGIN ISLANDS Not Available
- DOMINICA Not Available
- FRENCH GUIANA Not Available
- GADELOUPE Not Available
- MONTSERRAT Not Available
- NETHERLANDS ANTILLES Not Available
- NICARAGUA Not Available
- PERU Not Available
- SAINT LUCIA Not Available
- TURKS & CAICOS ISLANDS Not Available
- VENEZUELA Not Available

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

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 is beginning to experience declines in life expectancy, child survival and productivity as a result of HIV/AIDS.

Central and eastern Africa remain the hardest hit by the epidemic. These areas, which account for approximately one-sixth of the region's population, harbor between half and two-thirds of its HIV infections. In many urban areas an estimated 25 to 30 percent of those 15 to 49 years old 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 that one in every 18 adults in Kenya and about eight percent of Uganda's adult population are living with HIV.

The epidemic is also well established in West Africa, where 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 rate of 3.8 percent in adults, Nigeria is usually considered a low-prevalence country, but this classification is deceptive because of the country's large population. Over two million Nigerians are estimated to be infected with HIV.

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

REGIONAL INITIATIVES

The USAID Bureau for Africa's Strategic Objective IX calls for the adoption of cost-effective strategies to prevent and mitigate the impact of HIV/AIDS. Under this strategy, the Bureau will continue to develop activities in other sectors, including agriculture, democracy/governance and human resource development to alleviate the adverse economic and social consequences of the epidemic in the area. A seminal work is the "Private Sector AIDS Policy" tool kit, which provides businesses with information worksheets and other materials to develop a site-specific response to HIV/AIDS.

The Africa Bureau has led the way in evaluating the feasibility and appropriateness of integrating HIV/AIDS programs into programs in family planning, maternal and child health, and other development sectors. In 1995, the Bureau and its regional offices in Nairobi conducted a workshop on integration for African decision makers. The purpose of this workshop was to identify lessons learned for African programs that tested integration strategies. Presently six countries are participating in case studies on integration.

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 has also 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 STIs 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:



SEAN SPRAGUE/PANOS PICTURES

In Rwanda, a grandmother brings up her three grandchildren whose parents died from AIDS.

- effective information, education and communication (IEC) 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 STI services; and
- monitoring and evaluating program impact.

The Africa Bureau has carried out its analytic agenda for HIV/AIDS and other health and human resources issues through the six-year, U.S.\$40 million Health and Human Resources Analysis for Africa (HHRAA) Project,

which began in fiscal year 1992. The purpose of the project was 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 included a World Bank study on the economic impact of fatal adult illness due to HIV/AIDS and other causes; a study conducted by the National Research Council, *Preventing and Mitigating AIDS in Sub-Saharan Africa: Research*

and Data Priorities for the Social and Behavioral Sciences; studies on tuberculosis and HIV by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. National Institutes of Health (NIH); 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 STI 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 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.

ETHIOPIA

Situation Analysis

The first HIV infections in Ethiopia were detected in a retrospective laboratory analysis of blood samples at the Ethiopian Red Cross blood bank collected in 1984. Analysis of samples collected prior to 1984 failed to detect HIV infection. Data from 11 urban blood bank samples taken in 1994 documented a seroprevalence ranging from five to 20 percent; 6.6 percent in Addis Ababa.

The first HIV cases were detected along the country's main trading roads, with a seroprevalence rate of 17 percent among commercial sex workers. By 1991, this seroprevalence rate had reached 60 to 70 percent in commercial sex workers in some major towns. By 1993, urban sentinel surveillance data among 15- to 24-year-old pregnant women attending antenatal clinics showed a seroprevalence rate of 13.6 percent. An isolated study undertaken in 1996 in a high-risk area in Addis Ababa detected a rate of 25 percent HIV positivity among women aged 15 to 25 attending one of the clinics. A 1994 community-based study in Addis Ababa revealed that overall fewer adult males were infected than females. However, the observed difference was non-significant (OR: 0.97; 95 percent CI: 0.70-1.35).

The first AIDS cases in Ethiopia were reported in 1986. Since then, the number

of reported AIDS cases has increased rapidly. In 1992, there were about 3,000 reported cases of AIDS. This has increased over fivefold, with 20,000 reported cases of AIDS in 1995. Those in the age group 15-49 years constitute 93 percent of the reported cases. However, with the low accessibility of health services and the problems with diagnosis and reporting, this reflects only the "tip of the iceberg"; the actual number of AIDS cases could be as high as 400,000, and the number of persons infected with the HIV virus might well have reached 1.7 million in 1997.

The most common route of infection in Ethiopia is through heterosexual contact (87 percent of new HIV infections among reported AIDS cases). However, very few cases of AIDS in children have been reported, due to the difficulty of diagnosis. If the reported cases are adjusted for this underreporting (and considering the high increase of seropositivity in ANC attendants), it is estimated that about 25 percent of new infections could be accounted for in perinatal transmission.

REPORTED AIDS CASES:*

19,433 (11/95) estimated over 20,000 (1997)

DATE OF LAST REPORT: 11/95

INCREASE OVER 1994 REPORT:** 28%

TOTAL POPULATION: 56.5 million

CUMULATIVE INCIDENCE: 353 per million population

HIV-1 SEROPREVALENCE: 6.6%

(males); 6.9%(females) (among 15-49 years in Addis Ababa)

USAID Strategy

In Ethiopia, the Support to AIDS Control (STAC) project was the first health sector investment made by USAID/Ethiopia, in 1992. This project focuses on: prevention and control of STIs; behavior change targeted at youth and women at high-risk; condom promotion and social marketing; surveillance; training of personnel; providing preventive supplies and medical commodities; institutional strengthening; and the involvement of public, NGO and private institutions. The primary implementing organizations include AIDSCAP, Population Services International (PSI) and the World Health Organization (WHO). Currently, AIDSCAP programs are completed, but condom promotion and social marketing through PSI, and STI commodities and supplies through the WHO grant are ongoing. The condom social marketing program organized by PSI is heralded as one of the most successful on the continent, with over 20.7 million condoms socially marketed nationwide in 1996. The plan for 1997 is to socially market 25 million condoms, 13.3 million of which had been socially marketed by June.

In 1996, in an effort to draw the attention of policymakers, USAID supported production of an Ethiopian AIDS Impact (AIM) booklet. This was officially launched by the minister of Health and the U.S. Ambassador. In a further attempt to raise awareness of the increasing

incidence of HIV/AIDS in the country, USAID, together with the Ministry of Health, the Christian Relief and Development Association and UNAIDS, cosponsored the first national HIV/AIDS conference, in December 1996. Similarly, USAID/Ethiopia took the lead in formulating the Ethiopian Framework tree of Objectives (EFO) for HIV/AIDS through two participatory workshops.

USAID is currently in the process of finalizing a follow-on results package (RP) for HIV/AIDS prevention and control activities under its health sector project, Essential Services for Health in Ethiopia (ESHE), which was signed with the Government of the Federal Democratic Republic of Ethiopia in 1995. The EFO is the basis for the recent HIV/AIDS results package of USAID/Ethiopia. Activities will build upon achievements made under the STAC project and continue to support better management of STIs, condom social marketing, improving awareness and promoting behavior change and safer sexual practices, creating an enabling policy environment to accelerate prevention and control activities, and examining ways to improve community responsiveness. The strategies for the new RP will focus on national HIV/AIDS policies and strategies, improving capacity and utilization of service facilities, increasing community involvement in HIV/AIDS prevention and mitigation, and youth behavioral change interventions. To this end, USAID will work in close collaboration with the GFDRE, bilateral and multi-

lateral organizations, CBOs and NGOs working in the field of health development in Ethiopia.

GHANA

Situation Analysis

Ghana is at a relatively early stage of the HIV/AIDS epidemic. The high rates of STIs in the commercial sex industry and a tendency toward multiple sex partners, particularly among men, remain major factors in the continuing increase in HIV/AIDS incidence in Ghana. The infection is rapidly spreading from the groups that practice high-risk behaviors, such as commercial sex workers (CSWs), into the general population, particularly people aged 15 to 39.

REPORTED AIDS CASES:* 21,000

DATE OF LAST REPORT: 12/96

INCREASE OVER 1996 REPORT:** 153%

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** 11.3%

Population at low risk: 5%

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 STIs. Condoms are promoted and distributed by both the public and private sectors. STI treatment is supported through training in both the public and private health sectors.

USAID-Supported Country Programs 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, it also coordinated national AIDS awareness month and regional awareness campaigns and produced and distributed booklets, posters and pamphlets. The NACP sells condoms through Ministry of Health family planning service delivery points.

Public Health Laboratories

A national public health reference laboratory and three zonal public health laboratories are being constructed and equipped. Staff have been trained to provide accurate clinical and epidemiological information on the HIV epidemic and STIs.

Ghana Social Marketing Foundation (GSMF)

The GSMF distributes condoms to the private sector that are sold, at subsidized prices, in all pharmacies and chemists throughout the country. A company-based program is training AIDS counselors as well as distrib-

uting 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 nightclubs and musical concerts have been held to destigmatize condom use. Pharmacists and chemists, identified by the NACP as the primary providers of STI treatment in Ghana, are being trained to provide proper treatment.

KENYA

Situation Analysis

HIV/AIDS infection in Kenya cuts a wide swath across class and ethnic boundaries, striking down adults and newborn infants in all parts of the country. In Kenya, as elsewhere in sub-Saharan Africa, HIV/AIDS is primarily transmitted through heterosexual contact. HIV continues to spread in Kenya at an alarming rate and, within the decade, is likely to become Kenya's most serious health problem.

Adult HIV seroprevalence increased from 3.5 percent in 1990 to 8.0 percent in 1996. As of mid-1997, an estimated

1.2 million Kenyans are thought to be infected with HIV; 78,000 of them are children. By July 1997, there were 74,755 reported AIDS cases in Kenya, the highest reported number in Africa; the number of actual AIDS cases in Kenya is thought to be four times higher. Urban HIV seroprevalence, according to 1996 sentinel surveillance data, is 12.2 percent; rural prevalence is 7.1 percent. AIDS orphans number over 250,000 and could increase to 580,000 by the year 2000.

Under the worst case scenario, AIDS mortality is projected to shorten life expectancy in Kenya from 68 to under 50 years by the year 2010 (U.S. Bureau of Census 1995). AIDS treatment costs are projected to increase from 17 percent of the Government of Kenya's (GOK) health budget in 1990 to 79 percent by 2010. By 2005, the total costs of AIDS could reduce gross domestic product by 14.5 percent.

While prevalence statistics continue to be discouraging, there are encouraging signs that prevention and educational programs are having some effect, including the fact that more than 90 percent of

KEY

* 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.

Kenyan adults possess basic HIV/AIDS knowledge. Sixty-six percent of men and 50 percent of women believe they are at personal risk. Twelve percent of men are currently using condoms and 34 percent have used condoms (DHS 1993).

There has been a clear change in the policy environment in the last three years, indicating that both the public and policymakers have become engaged in the crisis, resulting in an expanded forum in which a range of HIV/AIDS issues are approached. A Sessional Paper which outlines GOK policy on HIV/AIDS was approved by Parliament in September 1997. The GOK is devoting increasing financial resources to AIDS and STI prevention activities, as evidenced by the assumption of a U.S.\$40 million credit from the World Bank for a project targeting STIs, including HIV/AIDS.

The 1994-96 National Development Plan contained a chapter addressing AIDS. Also, for the first time, the District Development Plans were required to contain AIDS Action Plans describing a strategy for multi-sectoral responses. Various government ministries have trained staff to undertake HIV/AIDS prevention education programs with their respective ministry staff at national and provincial levels.

Advocacy networks and coalitions of NGOs and religious groups have emerged or become stronger. The Kenya AIDS NGOs Consortium now

works with over 300 members to strengthen and build their capacities to more effectively undertake advocacy and policy promotion for AIDS activities at the national and local levels. Members include NGOs, churches and other local and international organizations. There has been increasing public acknowledgment by major religious institutions of the importance of HIV/AIDS prevention.

There is a widening and deepening of the discussion and debate around specific HIV/AIDS issues such as cultural practices, responsibilities of employers and youth sex education. The Kenyan print and electronic media have given a higher profile to HIV/AIDS issues, including informative and provocative newspaper columns on such issues as sex education, wife inheritance, care of those infected with AIDS and counseling.

There is a growing confidence and willingness to speak out on critical HIV/AIDS issues. A prime example is the recent challenge to Pearl Omega, a locally developed drug initially said to cure AIDS. The speed with which the specialist and HIV/AIDS prevention communities responded to the initial reports was far faster than would have been the case in years past when unsubstantiated claims for AIDS "cures" were rarely publicly challenged.

In terms of programs, integration of HIV/AIDS with family planning is official Ministry of Health policy but

improvements are still needed. HIV/AIDS counseling and syndromic management of STIs are now being practiced in both public and private sector settings. Existing guidelines on home-based care for persons with AIDS and counseling guidelines are being reviewed and revised.

Successful interventions with Kenya's private sector employers in major cities have undertaken workplace programs which include both discussions with managers about AIDS policies and programs and peer counseling. Based on projected costs of HIV/AIDS infections, many companies have indicated a willingness to pay for the interventions, which has important implications for future sustainability.

REPORTED AIDS CASES:* 74,755

DATE OF LAST REPORT: 12/95

INCREASE OVER 1995 REPORT:** 30.4%

TOTAL POPULATION: 28.71 million

CUMULATIVE INCIDENCE: 2,813.5 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS: 12.2%

USAID Strategy

USAID supports the GOK's 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 STIs.

USAID-Supported Country Programs

USAID works through a number of contractors, grantees, private voluntary organizations and various USAID cooperating agencies to implement HIV/AIDS activities in the area of policy dialogue, capacity building, behavior change communication, improved STI diagnosis, treatment and prevention, condom promotion and sales and research.

Over the next five years, under the USAID AIDS, Population and Health Integrated Assistance (APHIA) Project, USAID's approach will be to scale-up proven interventions and test promising approaches. Based on experience to date and an analysis of other donor programs and plans, USAID HIV/AIDS prevention program will:

- Accelerate the integration of HIV/AIDS prevention activities into the nationwide USAID-funded FP/MCH service delivery network, with emphasis on improving the diagnosis, treatment and prevention of STIs and risk assessment.

- Use innovative behavior change communications to target women in integrated health delivery settings, adolescents, men and women in work places and other high-risk groups to reduce the sexual transmission of HIV through changing high-risk sexual behavior.

- Continue to support a nationwide condom social marketing project; pilot sales

of "Trust" condoms by community based distributors and promotion of sales of condoms in integrated service delivery settings in both urban and rural areas.

- Maintain support for critical policy and advocacy activities which other donors are not supporting.

- Continue to offer support for practical research, evaluation and monitoring activities related to priority policy, program planning and financing issues such as evaluating the impact of condom use on HIV transmission; ascertaining the efficacy of counseling and testing in reducing HIV transmission; testing the effectiveness and affordability of methods women can control to prevent HIV/AIDS, including the female condom; evaluating the impacts of integrating STI/HIV/AIDS services into existing FP/MCH programs; and continuing to explore the interactions between HIV and contraception and between HIV and malaria.

- Actively collaborate with the GOK, UNAIDS and other donors to avoid duplication of efforts and to assure that resources, including the cost of condoms and STI drugs, will be adequate to sustain an expanded STI/AIDS control program.

MALAWI

Situation Analysis

The HIV/AIDS epidemic in Malawi is one of the most severe in the world. Thirteen percent of the adult population is estimated to be HIV-

positive, with estimated seroprevalence rates of up to one-third in some urban centers such as Blantyre and Lilongwe, and AIDS is currently the leading cause of death among the country's 15- to 49-year-old age group. HIV/AIDS awareness is almost universal (97 percent of women and 99 percent of men) among Malawians. However, incidence of HIV infection is still high, especially among adolescents and young adults, indicating a significant gap between knowledge and behavior change. Life expectancy in the country is expected to decrease by more than 13 years by the year 2003 due to the presence of the AIDS epidemic. Over the same period, at least one-quarter and up to one-half of the formal sector's educated workforce is projected to be lost due to AIDS-related complications. The impact on the economic development is predicted to be a decrease of 1.5 percent in the annual GDP due to reduction in human capital and productivity slow down.

The primary mode of HIV transmission is heterosexual contact. One contributing factor to the spread of HIV 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. Many of these men engage in brief sexual liaisons with either casual acquaintances or commercial sex workers. Their mobility facilitates the movement of the virus into all districts and villages of the country. Professional men in urban

centers also tend to have multiple partners due to their ability to afford such relationships. Youth, who comprise about 50 percent of the Malawian population, often face certain initiation rituals for entering into manhood and womanhood, and it is now recognized that some of these practices may contribute to HIV transmission.

REPORTED AIDS CASES:* 49,120

DATE OF LAST REPORT: 9/94

INCREASE OVER 1994 REPORT:** 34%

TOTAL POPULATION: 10.9 million

CUMULATIVE INCIDENCE: Not available

HIV-1 SEROPREVALENCE IN URBAN AREAS: Not available

USAID Strategy

The Mission supports HIV/AIDS prevention and family planning services through the bilateral Support to AIDS and Family Health (STAFH) Project, which it is redesigning for the next phase to better achieve the strategic objective of reducing fertility and the transmission of HIV. Currently this U.S.\$45-million project utilizes communication for behavior change, condom promotion and STI control as its three principal HIV prevention strategies.

KEY

* 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.

Project interventions are nationwide and target high-risk population groups. Where feasible, family planning and HIV prevention services are integrated. STAFH initiated a private sector task force that focuses on providing workplace interventions at all Malawian companies with more than 300 employees. Condoms are socially marketed through commercial distribution and sales channels. Government of Malawi (GOM) health service delivery systems are the primary suppliers of family planning and STI/HIV services supported by the project and are supplemented by services offered by members of the Christian Health Association of Malawi (CHAM). In addition, through a small grants program, the capacity of over 20 local NGOs to deliver HIV prevention and family planning services is being strengthened.

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 pres-

ident 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. Since that time, political commitment has been more low key. A recent assessment of the Malawi HIV/AIDS situation by a World Bank-financed team called for a substantial increase in political commitment and support. As a result, the GOM is planning to establish a multi-ministerial task force to rejuvenate and provide new leadership for AIDS policy and advocacy. The GOM is also considering the recommendations made to strengthen the AIDS Secretariat. USAID is continuing to work closely on policy formulation and implementation with the AIDS Secretariat and the National AIDS Committee.

Strengthening STI Services

The association of STIs with high levels of HIV transmission is well established. Studies have shown a sevenfold increase in the risk for HIV transmission in the presence of ulcerative and nonulcerative STI. The 1996 Malawi sentinel surveillance data indicate that the HIV prevalence rate in STI patients was 52 percent, ranging from 37 percent in Rumphu to 70 percent in Blantyre. Recognizing the importance of early diagnosis and treatment of STIs as one way of mitigating the high HIV seroconversion rate, the AIDS Secretariat, with assistance from the STAFH Project STI

advisors, has introduced syndromic management of STI services and has trained health care providers throughout the country to follow this approach using a manual developed specifically for Malawi. A recent evaluation of the effectiveness of the training has highlighted areas that need improvement, and further in-service training courses are being designed.

Promoting Condom Use

In 1994, USAID signed a three-year cooperative agreement with Population Services International (PSI) to socially market condoms and in September of that year, the brand called "Chishango," which means "shield" in Chichewa, was launched on the Malawian market. After only five months, 1.2 million Chishango condoms had been sold, surpassing the 12-month sales target of one million condoms. By the end of 1996, annual sales had reached 5.8 million. In addition to marketing through commercial establishments such as pharmacies and groceries, PSI is working closely with local NGOs and private sector companies to expand condom social marketing in workplace and community settings.

Condom distribution and use is also being implemented through community-based distribution (CBD) programs that focus on reaching villagers who live in areas where access to health and family planning services and supplies is a major obstacle. CBD activities financed under STAFH are being carried out by three U.S. PVOs and a dozen local NGOs.

AIDS Education Curriculum

USAID support for AIDS education began in 1989, when four teachers' guides and nine learners' handbooks were developed. Implementation of the curriculum did not begin until 1995, however, when one-day seminars were conducted by the Ministry of Education to orient teachers and headmasters from each of Malawi's 3,000 primary schools. Incorporated under general studies and health education at the primary level and under biology at the secondary level, AIDS is now officially recognized as a testable subject for a secondary school certificate. Results of a 1997 national survey evaluating classroom AIDS education showed that a lack of educational materials and reluctance to talk openly about sexuality were cited as the biggest obstacles to fully integrating AIDS education into the school program. More teacher training and textbooks are needed, as well as greater leadership from headmasters. Extracurricular AIDS activities among school-age students have been encouraging. Edzi Toto (No AIDS) clubs have been established in over 65 percent of upper primary and secondary schools, and many students are receiving the message about HIV prevention through speakers, group discussion, plays/drama and songs. This heightened awareness should foster a more supportive environment for future behavior change.

Increased Access to HIV/AIDS Education and Counseling

AIDS education activities supported under the STAFH project include peer education programs targeting work places and youth and mass media information and entertainment ("infotainment") developed by the Ministry of Information and Broadcasting for radio and by PSI for its two mobile video units. Pamphlets, posters and flipcharts have been developed and distributed by governmental and NGO agencies in support of their HIV/AIDS education programs. These include detailed messages on specific topics, such as the flipchart developed for STI patients. Operational research conducted to determine cultural practices has been used to develop the most appropriate messages to reduce high-risk behaviors. Specific interventions for print media personnel, such as workshops for journalists and editors, have resulted in an increase from one to four HIV/AIDS-related articles per week in the national newspapers.

Counseling is mandated for any person tested for HIV, and counselors have been trained at every hospital in Malawi, where most of the testing is carried out. The STAFH Project finances grants to four Christian Medical Association hospitals to improve counseling and testing services. In addition, the AIDS Counseling and Education Centers in Liliongwe and Blantyre (LACE and BACE), which provide HIV counseling and

testing services, are being strengthened through NGOs supported by the STAFH Project.

Mitigating the Impact of AIDS

The high HIV infection rate in Malawi results in significant increases in illness, hospitalization and orphaned children. USAID is addressing these needs by supporting home-based care activities under the STAFH Project with Save the Children (U.S.) called Community-based Options for Protection and Empowerment (COPE). The first phase of the COPE Project, carried out in Mangochi District, financed training in home-based care, income-generating activities, and support to keep orphaned children in school. The second phase of the project, which begins in 1997, will expand these activities to five additional districts.

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 STIs 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 STI patients at select sites throughout the country. A few indigenous 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:* 372

DATE OF LAST REPORT: 1996

INCREASE OVER 1993 REPORT:** 0.50%

TOTAL POPULATION: 26.1 million

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 STI management through integration of STI care and prevention into primary health care facilities. Pilot facilities in three provinces will provide complete STI care, including diagnosis, treatment, counseling and quality laboratory support for male and female clients. USAID activities will strengthen services and links among STI 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 STIs

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

Marrakech and Agadir). In each city three levels of service delivery sites are supported; comprehensive STI 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 ensure high-level capabilities in STI identification. Participating clinicians are learning an algorithmic approach to STI care, and equipment and a start-up supply of drugs is being provided. A baseline STI study is scheduled for early 1995, and a follow-up prevalence study will be conducted by the end of 1996.

MOZAMBIQUE

Situation Analysis

Since 1990, the Ministry of Health National AIDS Control Program has conducted a series of sentinel surveillance studies among STI clinic patients and pregnant women. The official estimated number of HIV infections among the

sexually active population (about eight million) is between 400,000 and 800,000. Trends from the sentinel sites show alarmingly high seroprevalence in provinces with major transportation routes within Mozambique and to neighboring countries. In Tete province, for example, 1994 data show 37.3 percent of STI patients and 18.1 percent of pregnant women were HIV-positive. These rates are approximately double the levels found in 1992. The total number of officially reported AIDS cases in the country is only 3,318, of which two-thirds occurred in the 20- to 39-year-old age group.

USAID Strategy

The recent USAID-funded assessment in Mozambique provided an analysis of the risk factors associated with transmission of HIV/AIDS and other STIs and identified programming gaps. Based on this document, the Mission has drafted a USAID strategy for HIV/AIDS/STIs programming. The strategy focuses USAID support in the following areas: STI and HIV/AIDS awareness and behavior modification through information, education and communication

KEY

* 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.

(IEC); condom social marketing; and, improved STI case management. To implement these activities USAID resources will be used to strengthen indigenous NGOs and to mobilize resources outside the public sector, possibly through HIV/AIDS workplace activities. Limited support will be given to the MOH to strengthen its capability to coordinate activities and to develop/review IEC resources designed to reach specific target groups.

USAID-Supported Country Programs

The condom social marketing program, carried out by Population Services International (PSI) and the MOH, will continue to be a USAID priority program area for HIV/AIDS prevention in Mozambique. In September 1996, the Mission signed a follow-on grant with PSI to expand this successful pilot program nationwide. Other areas of possible USAID support include: strengthening access to and quality of STI services; building IEC capacity for reaching specific target groups; strengthening NGO capacity and participation in HIV/AIDS programs. These activities are now in the design stage.

Under the Primary Health Care Support Project, USAID is the principal donor of condoms for HIV/AIDS. An estimated ten million condoms per year are distributed through the MOH, PSI and other NGO programs. This project has just been extended for two years

and will continue to provide condoms for HIV/AIDS prevention efforts.

NIGER

Situation Analysis

Niger has an estimated population of over eight million, about 16 percent of which lives in urban centers. Data from the few studies conducted in the country show HIV prevalence of less than one 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 (CSWs). As of 1993, 1,262 AIDS cases had been reported in Niger; 809 were in the capital city of Niamey.

REPORTED AIDS CASES:* 2,350

DATE OF LAST REPORT: 12/95

TOTAL POPULATION: 9 million

CUMULATIVE INCIDENCE: 26.1 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS: Not available

USAID Strategy

USAID is closing its Mission in Niger following overthrow of a democratically elected government by military coup on January 27, 1996. Most HIV/AIDS activities have been discontinued. Subject to approval of the USAID Administrator, CARE International will continue a condom social marketing program through 1998. This will be implemented in conjunction with a Bureau for Humanitarian Response-funded child survival grant, and an Official Development Assistance-funded HIV/AIDS grant.

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, STI patients and commercial sex workers through peer education, condom promotion and distribution and improved STI treatment. Project staff were trained in HIV/AIDS communication and counseling skills, DSEP laboratory technicians were trained in STI diagnostic techniques, and clinic staff were trained in STI diagnosis and treatment. Twenty-nine CSWs in eight urban communities in Niamey were trained in STI diagnosis and treatment, and 29 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 STI patients report using a condom with their last occasional partner.

(This project ended in 1995 and was not replaced because of the coup mentioned above.)

NIGERIA

Situation Analysis

The number of HIV infections in Nigeria is increasing fast. AIDS cases are now more visible and approximately two

to three percent of beds in some urban hospitals are occupied by persons with AIDS. The most current national surveillance data (1993/94) from the National AIDS and STD Control Program reported an HIV prevalence rate of 3.8 percent in the sexually active subpopulation. Presently, however, the HIV prevalence rate is estimated to be about seven percent. Between regions of the country there are notable differences, but rural to urban rates remain similar. It is also evident that the epidemic is growing rapidly among the young (56 percent of Nigeria's population is under 20 years old), especially among young females.

The political, social and economic situations in Nigeria since 1993 have resulted in a limited official response to the epidemic. As a result, the nongovernmental private sector has played a significant role in HIV/AIDS prevention efforts, though it is unable to compensate for the poor response of the public sector. AIDSCAP, supported by USAID, has been a major player in facilitating the mobilization of communities and groups to address HIV/AIDS.

REPORTED AIDS CASES:* 7,140

DATE OF LAST REPORT: 12/96

INCREASE OVER 1994:** 522%

TOTAL POPULATION: 104 million

CUMULATIVE INCIDENCE: 69 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS: (no distinct urban data reported)

Population at high risk:**** 40.6% (1996 CSW data from 4 states)

Population at low risk: 7% (1996 estimate in pregnant women)

USAID Strategy

USAID, through the AIDSCAP Project, has continued a partnership established under the joint AIDS Public Health Communication (AIDSCOM) and AIDS Technical Support (AIDSTECH) Project aimed at supporting national efforts in the prevention and control of HIV/AIDS. The cornerstone strategies are controlling STIs, 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 commercial sex workers (CSWs) and long-distance drivers (LDDs), are the focus of many interventions. Programs were initially concentrated in three states, Cross River, Lagos and Jigawa, but since 1995, an expansion into all USAID focal states was embarked upon through support to community-based organizations (CBOs) and NGOs for sensitization education and advocacy on the issues of HIV/AIDS.

The first phase of the Nigeria HIV/AIDS program concentrated largely on information, education and raising awareness. During this period, the need to address the concerns of persons living with HIV/AIDS (PLWH/A) became evident. A one-year bridging program recently developed responds to this need. The program will expand the efforts of AIDSCAP, applying lessons learned and best practices resulting from targeted

interventions, and will also act to mitigate the impact of HIV/AIDS on individuals, families and communities through care, support and advocacy initiatives.

USAID-Supported Country Programs: Behavior Change Interventions with Commercial Sex Workers and Clients

One of the largest continuing interventions carried over from the AIDSCOM and AIDSTECH projects is the Calabar Commercial Sex Worker (CSW) Project under Nka Iban Uko (Women of Courage). A second sub-project for CSWs was implemented through the National Council of Women's Societies, Jigawa State. Program strategies included peer education, condom promotion, STI referral/management, counseling, vocational/literacy skills training, material development and distribution and advocacy/policy development. Overall, the two projects trained 307 peer health educators (PHEs) and 22 outreach workers. PHEs reached 13,779 CSWs and 8,855 clients through one-on-one and group educational encounters. Over 200 CSWs were trained in vocational/literacy skills.

Approximately 154 condom outlets were established and use of condoms among CSWs increased from 77 percent (in 1990) to 98 percent, while "always" use increased from 23 to 84.5 percent by the end of project (April 1997). In addition, 91.5 percent of CSWs recognized condom use as the most important method of HIV prevention.

HIV/AIDS Prevention Among Long-Distance Drivers and Transport Workers

The Jigawa State Long-Distance Drivers (LDDs) Project, implemented by the STOPAIDS Organization, aimed to reduce risk-associated behavior among LDDs and motor park users in two towns, Hadejia and Kazaure, through peer education, information dissemination and condom promotion. The Society Against the Spread of AIDS (SASA) implemented a similar project in Cross River State for motor park and boatyard users at 20 different locations. SASA staff and transport union leaders operated two health booths in Calabar and Ikom to promote health-seeking behaviors among the target groups. Program strategies included peer education, condom promotion, STI referral, materials development and distribution, counseling and mass media outreach.

Between the SASA and STOPAIDS projects, a total of 186,152 LDDs, transport workers and motor park users were reached. One hundred fifteen condom outlets were established and 30 outreach workers were trained as PHEs

and counselors. A total of 12,713 information, education and communication (IEC) materials were produced and distributed through the health booths and outreach workers.

At the end of project, over 80 percent of LDDs were able to cite two correct methods of HIV prevention, with 91.7 percent indicating condom use, compared with 47 percent at baseline. Forty-nine percent of LDDs, compared with 23 percent at baseline, reported the use of condoms in their most recent sexual encounter.

Youth-Focused HIV/AIDS Interventions

Nigeria has a large number of university students, many of whom are sexually active and at risk of acquiring STIs or HIV. A baseline survey in the University of Calabar (1993) indicated that 15 percent of sexually active female students engaged in sex to support themselves. The Nigerian Youth AIDS Program (NYAP)-Cross River State (CRS) implemented statewide projects in 17 tertiary institutions to reduce risk-associated behaviors among college-based students through peer education, counseling, information-educational

KEY

- * 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.

cation and materials production and distribution, STI referral and management and condom promotion. The Jigawa State Youth AIDS Program (JSYAP) at Gumel conducted a similar project in Jigawa, a predominantly Muslim state, using peer educators to promote safer sex practices, ensure the prompt diagnosis and treatment of STIs, and increase condom use awareness in five post-secondary institutions. In 1995, another youth-focused project was established in eight tertiary institutions in Lagos State by NYAP-Lagos, employing staff liaisons and peer educators to reach widely dispersed campuses. In all these projects, the formation of Anti-AIDS Clubs and resource center services have been important in sustaining student interest and participation in HIV/AIDS prevention.

The three projects reached a total of 140,126 students, and trained 818 PHEs; 105,342 IEC materials were produced and distributed, and 154 condom outlets were established. HIV/AIDS education has been integrated into General Studies and Citizen's Education curricula of two higher education institutions in Calabar.

At the end of project, 90 percent of students had heard about AIDS, 80 percent understood the link between HIV and STIs, and use of condoms had increased from 25 to 47 percent among regular partners and from 13.8 to 73 percent among nonregular partners. At the

end of project, over 80 percent of students were able to indicate two correct methods of HIV prevention, with 81.9 percent citing condom use.

HIV/STI Prevention in the Workplace: Dockworkers Project

In 1995, a workplace program was established in two ports in Lagos—the Apapa Wharf and Tin Can Island Port. This project was implemented by the Society for Environmental Management and Planning (SEMP) to educate low literate, daily wage, casual dockworkers. The project aim was to mobilize and motivate a hard-to-reach group to reduce their HIV/AIDS/STI-associated risks. Intervention strategies included peer education, condom promotion, materials development and distribution, and STI referral and treatment.

The project trained 90 peer educators and 30 condom retailers, and established 36 condom outlets. A total of 11,284 workers were reached through 5,232 one-on-one educational sessions. More than 15,000 IEC materials were produced and distributed. At the end of project (April 1997), 80 percent of dockworkers were able to cite two correct methods of HIV prevention, with 92 percent citing condom use.

AIDSCAP Women's Initiative (AWI)

In 1995, working with four local NGOs—the Federation of Moslem Women Association of Nigeria (FOMWAN/Jigawa), Women In Nigeria (WIN/Lagos), WIN/CRS, WIN/Katsina and Association

for Development Options (ADON/Ibadan)—AIDSCAP/Nigeria initiated the AIDSCAP Women's Initiative. The objectives of the Initiative were to promote mother-daughter sexuality communication/dialogue and parent-child sexuality communication/dialogue, and to train women to be a credible source of HIV/AIDS/STI information and education at the community level. Through this program 10,000 women and men and 300 girls were reached.

Rapid Response Fund (RRF)

The Rapid Response Fund's (RRF) purpose was to support innovative efforts by small community groups, to provide a mechanism for bridging program gaps, and to support activities which promoted networking and exchange and developed the capacity of NGOs and communities. The program supported 22 youth-focused activities, eight village-level initiatives, five training workshops for health care providers, three care and support training workshops, three workplace-focused activities and two church-based activities.

The RRF-funded activities reached a total of 8,7282 men and women between 1994 and 1997.

In total, 1000 youth PHEs, 100 CSW PHEs, 909 community-based outreach workers, 200 health care workers and 2,076 workplace and church-based PHEs were trained, and a total of 157,655 IEC materials were produced and distributed through the RRF program.

RWANDA

Situation Analysis

In April 1994, extremist elements of the ruling regime launched a genocide, targeting Tutsis and the Hutu political opposition, to maintain power. Up to one million people were killed and over two million Rwandans were displaced in a three-month period. After the military victory of the Rwandan Patriot Front (RPF) in July 1994, an estimated 800,000 "old caseload"—the refugees of 1959 and their children—returned to Rwanda. In late 1996, an estimated 1.3 million "new caseload"—Rwandans who fled the country in 1994—came home in a sudden and massive return.

There are now 7.6 million people living in Rwanda. The situation is characterized by demographic shifts, massive resettlement and rehabilitation needs, a huge loss of human resources and a society struggling to overcome the polarizing effects of years of ethnocentric rule which culminated in genocide.

The new Government of Rwanda (GOR) has identified HIV/AIDS as a growing epidemic and priority health and development problem for Rwanda. Pre- and post-war surveillance data indicate high HIV infection rates throughout the country. Data gathered from ten sentinel surveillance sites in 1996 indicate that HIV prevalence rates remain high in urban Kigali (33 percent) and appear to be increasing in rural and semi-rural areas (3.6 percent to 9.9 percent). The National AIDS Program estimates that

the overall infection rate in the under 20-year-old age group is 9.7 percent.

REPORTED AIDS CASES:* Not available

INCREASE OVER 1993 REPORT:** Not available

TOTAL POPULATION: 7.6 million

CUMULATIVE INCIDENCE:*** Not available

HIV-1 SEROPREVALENCE IN URBAN AREAS:****

Population at high risk:**** 33.7%

Population at low risk: 10.2%

USAID Strategy

In late 1994, USAID provided significant support to Rwanda's National AIDS Control Program (PNLS) through the AIDSCAP Project. AIDSCAP/Rwanda was the first health development activity to be re-established in the post-crisis period and played a critical role in rebuilding the National AIDS Control Program and creating capacity within the Rwandan health system to combat STIs, including HIV. AIDSCAP was instrumental in launching a nationwide condom social marketing project; providing IEC material and media supports; establishing a peer education pilot program; and supporting education through the military and local associations.

To better adapt USAID assistance to needs in the transition period and move Rwanda towards long-term stability and development, USAID is supporting GOR

Ministry of Health (MOH) commitments to decentralized and integrated basic health care. Future HIV/AIDS programming aims to integrate and improve the planning, management and implementation of STI/HIV services at the health district level.

USAID-Supported Country Programs Decentralized STI and HIV/AIDS Prevention Program

This activity aims to integrate and improve the delivery of STI/HIV services in four pilot regions. Through improved clinical skills and practices, provider and client information dissemination, improved information and IEC implementation, and improved management practices at the regional and district levels, quality STI services will be integrated into and strengthen the overall quality of the existing primary health care system in rural areas.

Ministry of Health Financial and Administrative Accounting and Transparency

Weak financial accounting and administrative systems impede the MOH and its National AIDS Program from efficiently managing and decentralizing its resources. Strong financial and administrative accounting and systems are needed for the GOR/MOH to assume ownership and provide leadership in the health sector. USAID will work with a recognized international accounting firm to build a solid financial and administrative capacity within the MOH at the central and

regional levels and to improve education and communication interventions at the community level.

HIV/AIDS Peer Education Prevention Program

USAID is supporting the second phase of a peer education pilot project in the Gitarama Prefecture. CARE International, the implementation partner, will refine peer education methodologies and activities initiated in phase I to build a local capacity to sustain peer education networks and create linkages between the education components of the formal health delivery system.

Rwandan Health Communication Center

The creation of Rwandan capacity to design and produce quality health education materials is key to the fight against AIDS and other communicable and preventable infections. Effective education and communications are critical tools in preventing and reducing infection transmission, particularly STIs. In collaboration with the World Bank, USAID, through its implementing partner Population Services International (PSI), will contribute technical assistance in

the design and management of communications campaigns in addition to production skills in audio, video and print media. The Communications Center is designed to operate as a non-profit, private-sector organization and will be responsible for achieving a high degree of cost-recovery over time.

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 1.5 percent. HIV sentinel surveillance data collected since 1989 in Dakar, Kaolack and Ziguinchor, and since 1993 in Thies and Mbour continue to document low levels of HIV-1 and HIV-2 (i.e., below 1 percent) in pregnant women. Infection levels among people seeking treatment for other STIs range from 1.5 to 3.0 percent. The highest rates of HIV infection—an average of 21

KEY

* 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.

percent—are found among commercial sex workers (CSWs). In late 1991/early 1992, the distribution of HIV infection was the following: 70 percent HIV-2 and 30 percent HIV-1. However, three years later, the distribution had changed to 51 percent HIV-2 and 49 percent HIV-1.

REPORTED AIDS CASES:* 2,168

DATE OF LAST REPORT: 6/97

INCREASE OVER 1994 REPORT:** 50%

TOTAL POPULATION: 8.8 million

CUMULATIVE INCIDENCE: 246.3 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** 10 to 21%

Population at low risk: 0.30 to 1.42%

USAID Strategy

Since 1985, USAID/Senegal has supported AIDS prevention and control efforts in Senegal, primarily through its Family Health and Population Project. In June 1992 USAID/Senegal, through AIDSCAP, developed a U.S.\$10 million, six-year project to provide comprehensive assistance to the national AIDS control 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 STIs. Through AIDSCAP, USAID is also acting as a catalyst to assist governmental and non-

governmental agencies, communities and individuals in setting up a national HIV prevention program.

USAID-Supported Country Programs AIDS Control Program

The USAID-funded Senegal country program supports the national AIDS control and prevention program in the regions of Dakar, Thies, Kaolack and Ziguinchor. AIDSCAP has developed diverse subprojects with agencies of the Ministry of Health, Ministry of Communication, and national and international NGOs, incorporating strategies of behavior change communication, strengthening case management of STIs, promotion and distribution of condoms, policy support, behavioral and operations research, and evaluation. AIDSCAP has also provided strategic planning and sentinel surveillance support to national and regional AIDS control programs.

A total of 31 subprojects (including 15 small Rapid Response Fund grants) have been initiated, focusing on in- and out-of-school youth, men in the workplace, registered CSWs, and men and women working in the informal sector.

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 of HIV/AIDS and encourage behavior

change to reduce HIV transmission. Training manuals in different local languages have been developed and related training has been conducted for 280 peer educators who will reach youth and sexually active men and women at the regional and district levels, adolescents, men and women in the informal sector, and market women and their daughters.

Policy Dialogue

There were three major ground-breaking efforts in HIV/AIDS policy in Senegal. The first two were separate two-day colloquiums organized for Muslim religious leaders (March 1995) and Christian leaders (January 1996) to provide basic information on HIV/AIDS and to assist them in defining their roles and responsibilities in the fight against the epidemic. Several recommendations and interventions were made by the religious leaders themselves to intensify information, education and communication activities for the community. They also called for a partnership between Christian and Muslim leaders. The third major event was a two-day conference for more than 50 parliamentarians that took place in the National Assembly (July 1996) to sensitize these leaders and decision makers to the AIDS epidemic.

Sentinel Surveillance

Senegal is fortunate to already have in place many of the systems that can help provide a comprehensive

picture of the epidemic and the impact of prevention activities. HIV sentinel surveillance has been conducted in Senegal since 1988, and behavioral surveillance was introduced in early 1997. Baseline data have also been established for assessing the quality of providers' skills. The following have been included in the sentinel surveillance: high-risk groups (registered CSWs, male STI patients), low-risk groups (pregnant women, blood donors) and intermediate-risk groups (TB patients, hospital patients). The behavioral surveillance survey has provided measures of behavioral indicators in key target groups: in- and out-of-school youth, men in workplaces, CSWs, clients of CSWs, and men and women in informal sector.

STI Control

An ethnographic study of local perceptions, attitudes and behaviors regarding STIs and STI treatment-seeking behavior was carried out. This study provided essential information on local STI terminology as well as on the attitudes of health workers and prevailing perceptions of health services in the community. The results of the study led to the development of training modules, pocket guides and wall posters, and the provision of essential equipment and supplies for STI prevention and case management. By early 1997, 1,167 health workers and 12 laboratory technicians from six regions had been trained in STI case management following the national treatment algorithms. In addition,

clinical and laboratory equipment was supplied to select public health facilities.

Simultaneously, due to the higher volume of women than men being treated in the public sector for STIs, operations research was conducted to validate treatment algorithms for women with vaginal discharge or lower abdominal pain. As a separate activity, a baseline survey was conducted in 1997 using an adapted version of the WHO protocol for assessing STI case management to determine the proportion of STI patients being diagnosed and treated according to the national guidelines. Significant improvements were noted in most indicators of STI case management.

Condom Promotion

Since 1985, USAID has provided the national AIDS control program with more than ten million condoms for distribution to CSWs, STI patients, youths and adults through clinics and during events such as World AIDS Day, and the Women against AIDS and Youth Against AIDS national weeks.

Although SOMARC began condom social marketing efforts in Senegal in 1995, the selling of condoms was allowed by the Ministry of Health (MOH) only through pharmacies and other medical outlets, which limited the integration of condom social marketing and behavior change interventions. Negotiations are still ongoing within the Ministry of Health on moving condom sales into

nontraditional outlets. SOMARC is also negotiating with the national pharmacy to get its condom brand into the Bamako Initiative circuit.

Because an uninterrupted supply of condoms for STI/HIV/AIDS prevention is a key component of successful behavior change and STI prevention activities, USAID will continue to make condoms available to high-risk groups through the national AIDS control program under the current AIDSCAP program until condom social marketing through nontraditional outlets is fully operational.

SOUTH AFRICA

Situation 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. Prior to the development of HIV antibody tests, about 100 blood transfusion-related infections are known to have occurred between 1982 and 1985. HIV testing of stored sera from a community survey in rural KwaZulu/Natal and blood donor data showed a very low prevalence of HIV in the general population in 1985. HIV-1 is the dominant strain in South Africa, with HIV-2 remaining rare.

Although the current HIV, AIDS and STI data are patchy and incomplete, the annual, national antenatal HIV seroprevalence surveys provide a good indication of the temporal trends of the HIV epidemic in South Africa. The

results of the national antenatal surveys have been used to estimate the number of South Africans infected with HIV. It was estimated that at the end of 1995 almost one million (986,113) women ages 15 to 49 were HIV-positive. A further 719,862 males were estimated to be HIV-positive at that time. Based on this and previous antenatal surveys, it is estimated that 99,655 babies were born to HIV-infected women. In total, based on these assumptions, it was estimated that almost 1.8 million South Africans were HIV-positive at the end of 1995. The most recent antenatal seroprevalence survey (1996) estimates this figure to be 2.4 million infected adults and 156,000 infected children born since 1990.

While the HIV epidemic is more advanced in some provinces, such as KwaZulu-Natal, Mpumalanga and Gauteng, it is well established in all provinces. Currently, 12,583 AIDS cases have been reported through December 1996 and there are approximately 1,200 new HIV infections daily. Within seven years, the prevalence of HIV infection rose more than fourteenfold, from 0.76 percent in 1990 to 14.07 percent in 1996.

The epidemic is progressing rapidly through the country, and the rate of new infections is estimated to be doubling every 11 to 13 months. HIV risk is highest among women and particularly young people between the ages of 15 and 30. The high background prevalence of STIs (it is estimated that approximately four million episodes of STIs occur each year in South Africa), the migrant labor system and oscillatory migration and the social status of women appear to be critical risk factors in the rapid transmission of HIV in South Africa.

REPORTED AIDS CASES:* 12,583

DATE OF LAST REPORT: 12/96

INCREASE OVER 1994 REPORT:** 300%

TOTAL POPULATION: 38 million

CUMULATIVE INCIDENCE: Not available

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:****

2 to 20%

Population at low risk:

0 to 5%

USAID Strategy

The Mission's HIV/AIDS strategy has been to support educational efforts in three areas: prevention of sexually

KEY

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*** 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.

transmitted HIV/AIDS; 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 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 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 sub-regions 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

Six NGOs provide peer-led HIV/AIDS prevention education to youth in urban, rural and informal settlement areas. The education activities include discussions on sexuality, STIs, 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).

The AIDS Control and Prevention (AIDSCAP) Project

Since 1991, AIDSCAP has provided technical assistance to USAID-funded NGOs in South Africa and recipients of the small grants program. In addition to providing assistance in the areas of program design and implementation, AIDSCAP has conducted three major HIV-prevention programs: Project CHAMPS, a home-based care and support program for HIV-infected mothers and their children; an HIV/AIDS and STI training program for traditional healers; and the provision of periodic presumptive treatment for STIs in a mining community. AIDSCAP established a network of resource centers which distributed educational materials and assisted local organizations in the preparation and design of educational materials. The small grants program provided funding to NGOs and community-based organizations (CBOs) to conduct comprehensive, integrated HIV-prevention activities and establish coalitions to strengthen HIV prevention programs in South Africa.

Policy Development

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 STIs, 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

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.

Operations Research

The Institute for Urban Primary Research, based at Alexandra Health Center, has conducted operations research on primary health care strategies for improving partner notification for STIs. The Institute plans to implement a clinic-based pilot intervention to standardize clinician-patient interaction during existing STI consultations at Alexandra Health Center and standardize the content of notification letters and information packs. Additionally, in collaboration with other South African partners, the Institute will conduct a national survey of current notification practices. The findings from both the pilot intervention and the survey will facilitate the development of policies for partner notification.

Media Campaign

At the request of the Department of Health, the Media Group, Inc. (New York) was commissioned in August 1995 to develop and produce a series of television and radio spots, ranging in length from 30 seconds to one minute. In collaboration with Health Systems Trust (HST), funds from a grant produced 45 spots portraying either persons currently infected with the virus or public figures endorsing the messages. The purpose of the series was to promote HIV/AIDS awareness and

present a "face" to the HIV/AIDS epidemic in South Africa. HST sponsored a four-day capacity-building workshop for NGOs in KwaZulu-Natal to teach methods of developing AIDS media specifically targeted to behavioral change related to HIV infection.

Home-based Care and Support

The South African Red Cross provides home-based support and counseling to HIV-infected individuals and to persons living with AIDS and their families in the rural areas of the East Cape Province. In addition, the Red Cross conducts peer-led HIV/AIDS prevention education presentations for the general public and engages a team of volunteer community-based home-care givers to provide information on HIV/AIDS prevention, the syndromic diagnosis of STIs and referrals to the appropriate clinics for treatment.

STI Management

AIDSCAP piloted a periodic presumptive treatment project in a mining community. The objective of the project was to reduce the prevalence of curable STIs through provision of STI treatment services, including periodic presumptive treatment and prevention education, to a core group of high-risk women.

A mobile clinic was set up to provide STI services to women at high risk who previously had poor access to STI care. Women were encouraged to attend the clinic on a monthly basis for exami-

nation and counseling, and were treated presumptively for bacterial STIs with a stat one-gram dose of azithromycin. Impact of the intervention on community STI prevalence was assessed through surveillance at the mine hospital, and through comparison of baseline and post-intervention gonorrhea and chlamydia prevalence using urine LCR in a population-based sample of miners.

Community mapping was done to identify priority areas for outreach. Several outreach strategies were employed to encourage women at high risk to use the services. A questionnaire was administered to determine previous history of STIs and levels of prevention behavior.

TANZANIA

Situation Analysis

Tanzania's HIV/AIDS epidemic is severe and considered to have moved from groups practicing high-risk behaviors to the general population in most areas of the country. Heterosexual contact is the primary means of transmission. Estimated HIV seroprevalence from blood donors is 6.8 percent for males and 8.2 for females. Antenatal clinics in different regions

within the country indicate prevalence among pregnant women ranges from 5.5 to 32.5 percent. Sentinel surveillance shows that three regions—Mbeya, Kagera and Iringa—are reporting prevalence rates of 15 to 20 percent, with the majority of other regions not far behind. The National AIDS Control Program (NACP) projects that there will be one million AIDS cases and three 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 one million orphans by the end of the decade. The U.S. Census Bureau's 1996 projections for Tanzania indicate that by 2010, the infant mortality rate will increase by 40 percent, the child mortality rate will rise by more than 25 percent and life expectancy at birth could decline from 55 to 35 years, due to HIV/AIDS.

REPORTED AIDS CASES:* 88,667

DATE OF LAST REPORT: 12/96

INCREASE OVER 1993 REPORT:**
110%

TOTAL POPULATION: 28.4 million

KEY

* AIDS cases reported to the World Health Organization.

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*** 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.

CUMULATIVE INCIDENCE: 3,122.0 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 U.S.\$24.3 million contract funded by USAID and implemented through the AIDSCAP Project. Initiated in 1993, the project will terminate in September 2000. During the 1997/98 period, USAID will be defining the design of its next five-year strategy for HIV/AIDS activities which will support the Mission's strategic objective to increase the use of family planning/maternal child health and HIV/AIDS preventive measures.

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 unique, as it uses an NGO cluster "networking" strategy to stimulate behavior change and alleviate the impact of AIDS on individuals, communities and families. The project presently works with over 180 NGOs through nine NGO clusters, operating in nine out of 21 regions in Tanzania.

While the NGOs form the primary activities of TAP, the project has also been instru-

mental in increasing the number of private sector health care providers who are trained in syndromic management as one strategy to reduce the prevalence of STIs. Additionally, TAP focuses on increasing condom use through a national condom social marketing program also supported by NGO cluster information, education and communication (IEC) and peer education efforts. USAID was previously the sole source of public sector condoms in Tanzania, but has since shifted its condom supply to the private sector. The United Nations Population Fund (UNFPA) assumed responsibility for public sector condom supply in 1995.

USAID-Supported Country Programs Condom Social Marketing

Under TAP, condom social marketing and distribution systems were established throughout the country. By the project's third year, condom sales of 28 million (as of December 1996) have far exceeded a projected target of 11 million. Population Services International (PSI), which implements the condom social marketing program, uses a local feminine products manufacturer to package condoms locally and relies on over 30 regional distributors to supply small shops and stalls. The sales campaign is supported by a television, radio and print media campaign which was launched during the World Cup matches broadcast in Tanzania.

NGO Capacity Building

Implemented through AIDSCAP, NGO capacity is being developed to provide HIV/AIDS prevention and control services, administer funds and promote cost sharing of activities within the community. The NGO cluster approach enables NGOs within a given region to coordinate geographic and technical coverage, collaborate in addressing training needs and plan for new services. Presently, NGO clusters in nine regional capitals of Tanzania are focusing on decentralizing HIV/AIDS prevention activities to the district level. Through trainer of trainer workshops in peer education, income generating activities and IEC during the first two years of the project, project activities have developed regional capacity to train and implement activities to support behavior change at the regional level.

Worksite Prevention Programs

AIDSCAP has also developed a worksite component to engage private sector businesses in HIV/AIDS prevention activities in the work place. AIDSCAP collaborates extensively with the African Medical Research and Education Foundation (AMREF) in the design and implementation of these activities.

STI Syndromic Management Training

To increase access to quality STI services within Tanzania, AIDSCAP has played a significant role in training private sector providers in the syndromic approach to STI diagnosis and control. Three private and semi-private public health institutions now provide STI syndromic management training for private and some public facilities.

Support to National AIDS Control Program (NACP)

TAP also includes funding to the National AIDS Control Program (NACP). As NACP has gone through significant staff changes USAID is supporting the program to improve its management and build capacity to move to a policy/donor coordination role rather than program implementation. The main focus of this support assists NACP in team-building workshops, AIDS Impact Modeling (AIM) to mobilize policy and community leaders, and development of NACP's third midterm plan.

UGANDA

Situation Analysis

AIDS has now become a central fact of social, economic, and political life in Uganda. The catastrophic impact of the virus jeopardizes the many positive strides in development which Uganda has recently achieved. In a population of about 20 million, an estimated 1.5 million citizens are infected with HIV. In addition to a substantial effect on adult

mortality, it is clear that AIDS has had a substantial impact on infant and child mortality. According to research, the risk of infant death for mothers who are HIV infected is 4.7 times greater than for mothers who are not infected. Based on this research, it has been projected that in urban sites in Uganda where up to 15 percent of mothers are HIV infected, deaths of the infants born to these mothers may account for up to 45 percent of all infant mortality.

In the midst of this catastrophe, encouraging trends are emerging. Recent Ministry of Health reports based on HIV sentinel surveillance in urban antenatal clinics suggest that since 1993, there has been a decline in HIV prevalence in pregnant women, the first hopeful trend in Uganda's decade-long experience with AIDS. Based on continued routine testing beginning in 1989 of pregnant women attending antenatal clinics in a number of locations in the country, there is increasing evidence that HIV prevalence is declining, especially among young women. The decline is particularly pronounced among pregnant women ages 15 to 19, but is also observed in women ages 20 to 24. For example, in one site in Kampala, 15- to 19-year-old women had an HIV prevalence rate of 26 percent in 1992 but this has declined to nine percent in 1996.

These trends are consistent with a 50 percent reduction in incidence, or new cases of HIV infection, in young

women these ages. At the same time, behavioral surveys strongly indicate that young people are waiting longer before their first sexual activity, a reduction in casual sexual partners, an increase in general condom use, and, especially, increased condom use with casual sexual partners. Taking all these findings together, demographers and epidemiologists now assert that the documented contraction in the HIV epidemic in Uganda is "most likely causally linked" to changes in high-risk behavior. Beginning in 1988, USAID funded projects have emphasized increased knowledge of risk factors, reduction in high-risk behaviors, and condom promotion and distribution.

REPORTED AIDS CASES:* 51,344

DATE OF LAST REPORT: 1996 data, report is dated 1997

INCREASE OVER 1994 REPORT:** 11%

TOTAL POPULATION: 20 million

CUMULATIVE INCIDENCE:

HIV-1 SEROPREVALENCE IN URBAN AREAS: 8 to 15%
(Note: these are the 1996 rates in prenatal clinics in urban areas.)

USAID Strategy

USAID's strategy in Uganda in the last two years has emphasized voluntary HIV testing and counseling, condom promotion, STI control and integration of supportive care and prevention counseling for people living with HIV/AIDS. In addition, USAID supports the training of rural health care

workers to enable them to provide integrated HIV/AIDS, family planning, and STI detection and treatment. Previous USAID AIDS education projects worked with community and religious groups; these and other efforts have clearly been successful, as close to 100 percent of persons interviewed in the 1995 Demographic and Health Survey were aware of AIDS.

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 1996, over 320,000 Ugandans had received HIV testing and counseling through the AIDS Information Center (AIC). In spite of encouraging trends in younger women who come to prenatal clinics, among women who come to AIC for testing, 38 percent between the ages of 25 and 29 are already infected with HIV. Provision of test results, accompanied by counseling, enables these women to make

informed decisions about childbearing, so they can avoid infecting future children. Provision of integrated AIDS prevention and family planning services thus has the potential to reduce infant and child mortality associated with the AIDS epidemic.

Data from AIC has also indicated that 18 percent of currently married couples requesting testing are discordant; one partner is already infected though the other is not. Provision of test results is essential for these couples so they can prevent transmission of HIV to the uninfected partner. AIC is studying ways to provide intensified services to these couples to help maintain family stability and health in spite of these disturbing results.

In response to client demand for STI testing and treatment, in 1995 and 1996 AIC successfully pilot-tested the addition of STI counseling, syphilis screening and treatment of HIV-positive people into the ongoing HIV counseling and testing services. In 1997, AIC began to receive support from the STD/AIDS Control Programme under a World Bank-

KEY

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*** 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.

financed health project, thereby making it possible to offer these services to all AIC clients on a routine basis.

In 1995 and 1996, AIC, in collaboration with the U.S. Centers for Disease Control and Prevention, tested rapid HIV tests which give same-day results. These trials found that rapid tests can be used, even in field sites, without compromising the quality of counseling or the accuracy of HIV testing, and are more cost effective, as all clients learn their sero-status. This approach was implemented in all AIC-supported sites in early 1997, and is a model which can readily be adapted in other developing countries. AIC is now working with other health care agencies in Uganda to extend the availability of this service throughout the country.

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 grass-roots 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 one of the leading AIDS service organizations. By the

end of 1996, TASO had eight centers throughout the country and had served over 38,000 clients. Recently, TASO has also integrated family planning and the detection and treatment of other sexually transmitted infections into its services. 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. TASO also encourages persons living with AIDS to "go public" to reduce the stigma associated with AIDS.

Training of Health Care Workers in Reproductive Health

USAID, through Pathfinder, the University of North Carolina, and the African Medical and Research Foundation (AMREF), has been training both urban and rural health care workers, including nurses, midwives, medical assistants, medical doctors and laboratory workers, to enable them to provide integrated reproductive health services, including antenatal and post-natal care, family planning, HIV/AIDS counseling and testing and STI diagnosis and treatment. Pre- and post-training tests have revealed substantial increases in knowledge and skills as a result of this training, and subsequent supervision, during which actual service delivery is observed, indicates that a considerable majority of trainees are now performing to higher standards. Through AMREF, USAID has supported the development of the STD Control Unit of the

Ministry of Health and the STI laboratory, which is providing important information upon which rational STI treatment recommendations are made.

WEST AND CENTRAL AFRICA (FHA-WCA)

USAID-Supported Country Programs

The Family Health and AIDS in West and Central Africa Project, also called Santé Familiale et Prévention du SIDA (SFPS), is a five-year project funded by USAID's Regional Economic Development and Support Office for West and Central Africa (REDSO-WCA). The purpose of FHA-WCA is to increase the availability and use of quality family planning, reproductive health, STI/HIV/AIDS, and maternal and child health services in concert with other donors and host country efforts in targeted areas of the region.

The FHA-WCA project is a unique and innovative model for USAID to contribute to family health improvement and AIDS prevention in the region. While the project is a regional one, special emphasis, especially in the area of service delivery, will be placed on the following countries where USAID does not have Missions: Burkina Faso, Cameroon, Côte d'Ivoire, Togo and Benin. The FHA-WCA project is committed to expanding social marketing activities and integrating STI/HIV/AIDS prevention and care into family planning

services by providing information, products and services to the sexually active. The objective of its HIV/AIDS prevention component is increased condom use by an average of 2.5 percent per year in project-targeted areas.

Increased Knowledge of HIV/AIDS Prevention

FHA-WCA efforts to increase knowledge of HIV/AIDS and prevention include support of a television series and a radio program about HIV/AIDS, an integrated IEC kit that includes materials for HIV/AIDS prevention, and NGO capacity building in materials development. SIDA dans la Cité (SDLC2), developed by Population Services International (PSI) /Côte d'Ivoire and partially funded by FHA-WCA, is an educational soap opera that addresses issues concerning HIV transmission and prevention, discrimination, and coping with AIDS. It has been very successful in Côte d'Ivoire and is slated for broadcast in several neighboring countries. The radio broadcast Yamba-Songo is diffused by Radio Afrique No. 1 at the regional level and through local stations at the national level in Togo, Cameroon, Côte d'Ivoire and Burkina Faso.

Through the PSAMAO Migrant Initiative, launched in Côte d'Ivoire and Burkina Faso during fiscal year (FY) 1997, AIDSCAP will help upgrade the skills of local NGO staff in Côte d'Ivoire and Burkina Faso and produce materials in support

of their implementation of behavior change intervention for migrant populations.

Following baseline data collection on attitudes and practices about STI and HIV/AIDS among transport workers, prostitutes and migrant workers, a social marketing campaign targeting those at-risk populations is being developed. The campaign includes media advertising (TV, radio and billboards), education and counseling services for transport workers, and increased condom availability through sales by drivers and merchants in and around the trucking stations.

The FHA-WCA Project is also supporting a Cameroonian research institute to study adolescent reproductive health in Cameroon and develop an intervention to increase access to services and information for adolescents.

The Demographic Health Surveys (DHS) in Burkina Faso (1993) and Côte d'Ivoire (1994) found that having sexual relations with a single partner was the most frequently cited means of HIV prevention (56 percent), followed by use of condoms (32 percent). In both Burkina Faso and Côte d'Ivoire, men were twice as likely as women to mention the use of condoms in infection prevention. Increases in the level of knowledge of STI and HIV/AIDS transmission and prevention will be measured in the DHS surveys that will be conducted in 1997 and 1998.

Condoms

Baseline data compiled from the DHS reports estimate that approximately 11 percent of men in Burkina Faso and Côte d'Ivoire used condoms consistently in the two months preceding the survey. Increases in the use of condoms will be measured in the DHS surveys that will be conducted in 1997 and 1998.

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. With both retail outlets and community-based distribution networks, Benin, Burkina Faso and Cameroon combined had over 26,000 sales outlets for condoms at the end of the second quarter of FY 1997. This included more than 3,400 new sales points established in the past six months, an increase of 15 percent in the number of sales points

In the first six months of FY 1997, there was a 31 percent increase in the number of condoms distributed through social marketing channels compared to the previous six months. This included the sale of condoms in Benin, where FHA-WCA has been providing condoms to assist in the "bridging" of social marketing activities for FY 1997. In all, 21,574,219 condoms were sold in the first two quarters of FY 1997 compared to 16,487,334 in the last two quarters of FY 1996.

FHA-WCA is supporting a study that examines the acceptability of condoms in northern Cameroon. This study will provide pertinent

information for tailoring interventions to better reach the Muslim populations in the region.

Provision of Integrated Counseling

An integrated counseling curriculum is being developed to train service providers to offer counseling on a broad range of subjects in family planning, STI/HIV/AIDS and reproductive health. The curriculum will be available in August 1997, and training of trainers will be carried out in early FY 1998.

Capacity Building

FHA-WCA sponsored ten participants from West and Central Africa to attend HIV/AIDS epidemiological courses organized by RETRO-CI (a project of the Centers for Disease Control and Prevention and the Ivorian Ministry of Health on HIV/AIDS research in Côte d'Ivoire).

AIDSCAP has undertaken capacity-building activities in counseling and testing, gender and AIDS, and IEC materials development. It also sponsored journalists from the

target areas to attend two workshops organized in Abidjan, Côte d'Ivoire.

AIDSCAP provided technical assistance to ESPOIR-CI, an NGO working on HIV/AIDS voluntary testing and counseling in Côte d'Ivoire, to undertake a needs assessment for HIV/AIDS testing and counseling activities in the region. ESPOIR-CI capacity will be strengthened under the FHA-WCA project to become a resource training center for counseling and testing in the region. A workshop in Burkina Faso on the subject of gender and AIDS was attended by high-level managers of HIV/AIDS national prevention programs and women NGOs such as the Society for Women Against AIDS in Africa from Burkina Faso, Cameroon, Côte d'Ivoire and Benin. And national AIDS control program coordinators from Côte d'Ivoire and Burkina Faso, along with representatives of NGOs, attended a workshop for the production of IEC materials for STI/HIV/AIDS prevention for truck drivers, commercial sex workers and migrants.

KEY

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ZAMBIA

Situation Analysis

The rates for STIs and HIV/AIDS infections in Zambia continue to rise rapidly. The 1997 seroprevalence data from antenatal clinics show the HIV prevalence across the country to range from 12 to 32 percent. Recent analysis estimates that the HIV prevalence among the adult population in Zambia to be 20 percent, or about one million people. These rates rank among the highest in the world.

In Zambia, as in the rest of Africa, the highest mode of HIV/AIDS transmission is through heterosexual intercourse. The peak for females is in the 20- to 29-year-old age group, while for males, it is in the 30- to 39-year-old age group. The number of reported female cases exceed those of males from ages 14 to 29, but after that the male cases predominate. The HIV/AIDS epidemic differs between rural and urban areas. In urban areas, HIV prevalence is expected to reach its estimated peak of 33 percent in 1998, while the estimated peak for rural areas is expected to be reached by 2004. The number of AIDS orphans is expected to rise from about 70,000 in 1993 to between 600,000 and one million in the year 2000; infant and child mortality rates are expected to increase to 129 and 269 respectively by 2005; life expectancy is expected to fall from 51 in 1990 to 42.6 by 2002; and the

rate of population growth is expected to decline from 3.5 to about 2.6 percent.

The epidemic continues to seriously threaten Zambia's prospects for economic development as it depletes the country's most educated, energetic, productive and youthful population. This is in spite of the fact that knowledge of AIDS is almost universal.

REPORTED AIDS CASES: * 44,942

DATE OF LAST REPORT: 9/95

INCREASE OVER 1995 REPORT: ** 66%

TOTAL POPULATION: 9.6 million

CUMULATIVE INCIDENCE: 68.00 per 100,000

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** 50 to 70%

Population at low risk: 13 to 25%

USAID Strategy

USAID/Zambia's Results Package for Population, Health and Nutrition (PHN) for 1998 to 2002, Zambia Integrated Health Package (ZIHP), supports the ambitious Zambian vision for health reform which began following the democratic transition in 1991. The health reform program was stimulated by extreme deterioration of health services and the consequent decline of the health status of Zambians. The Government of the Republic of Zambia (GRZ) is committed to providing equitable access to cost-effective quality health care as close to the family as possible. The Ministry of Health vision is to: 1) create environments

conducive to health; 2) disseminate knowledge on the art of being well; and 3) ensure equitable access to an essential package of integrated health care services. Within the context of health reform, there is a reorientation from highly centralized vertical programs to decentralized integrated programs.

USAID/Zambia has developed ZIHP to map out its support for implementation of health reform for the period 1998 to 2002. The development hypothesis of ZIHP is that an integrated, decentralized health care system is the most cost effective and technically sound framework for enabling individuals to improve their own health, expanding access to services at the community level and through the private sector, and improving the quality of health services. The guiding principles of ZIHP focus on integrating USAID support into the Zambian health reforms, support for the integrated delivery of PHN interventions, partnerships and "Zambianization" (including the potential endowment of an appropriate organization) of program activities.

USAID's HIV/AIDS activities are designed to support the GRZ National HIV/AIDS Plan of Action (NHAPA), which calls for a national multisectoral response and all Ministries to address the HIV/AIDS pandemic. The Ministry of Health is still leading the national effort.

USAID-Supported Country Programs Multisectoral HIV/AIDS District Initiatives

USAID supports, through Project Concern International/Zambia, activities to strengthen district-level multisectoral HIV/AIDS programming in five districts (Lusaka, Ndola, Kitwe, Livingstone and Nohelenge) through promoting a multisectoral response. Focus has been on the establishment of functional multisectoral HIV/AIDS Task Forces at the district level. These task forces have facilitated the development of multisectoral partnership plans for HIV/AIDS programming in the district, based on identified program gaps and on the comparative advantage of the participating groups. Through these HIV/AIDS Task Forces, District Health Management Teams have begun to mobilize a concerted effort in HIV/AIDS programming among the Ministries of Education, Community Development and Social Welfare, local government authorities, the military, police, local court justices, churches, and major NGOs in the development and implementation of HIV/AIDS programs. The HIV/AIDS Task Forces are being funded to complement these activities; however, Task Force member groups are also contributing funds and in-kind towards activities.

The following five intervention/programming areas are being emphasized by the HIV/AIDS Task Forces and

through all partnerships with NGOs/CBOs and other networks: health education/IEC; STI syndromic management; access to condoms (male and female); voluntary counseling and testing; and community care and support services (home care, counseling, orphans).

Condom Social Marketing

USAID funding supports a social marketing program implemented by the Society for Family Health (SFH), a local NGO trust in partnership with Population Services International (PSI) and the Pharmaceutical Society of Zambia (PSZ). Since the launch of "Maximum" brand condoms in December 1992, more than 30 million condoms have been sold nationally. Sales now average more than 550,000 per month, which is one of the highest in Africa on a per capita basis. Maximum is distributed through a variety of traditional outlets (pharmacies, drug stores, private clinics, stores), nontraditional outlets (bars, hotels, kiosks, night clubs, petrol stations, barber-shops) and through workplaces and NGO-sponsored outreach programs. In 1997, a new initiative to utilize government-sponsored community health workers (CHWs) is increasing distribution to rural communities. Educational brochures, point-of-purchase materials, and mass media are used to encourage safe sex practices

and create demand for condom use. In October 1997, SFH, in partnership with the Ministry of Health and the UK Department of International Development, launched the "Care" brand female condom, one of the first social marketing initiatives in Africa to promote this new method. The SFH has a mobile video unit (MVU) that travels to all provinces and conducts more than 90 shows each year in peri-urban and rural communities. The MVU shows a variety of videos to promote protective behaviors such as delaying sexual activity, fidelity and safe sex.

Youth Initiatives: The Key to the Future

USAID, through the SFH, Johns Hopkins University/Population Communication Services (JHU/PCS), Project Concern International, CARE International, and SFH/PSI is accelerating efforts to address adolescents/youth as a key target group. Peer-educator-promoters (PEPs) work in four provincial capitals performing short dramas, conducting condom use demonstrations and answering questions on STI/HIV, safe sex, and avoiding unwanted pregnancies. A youth radio show called "Club NTG" (New Teen Generation) airs weekly on three stations to a national audience, and NTG clubs that follow the weekly program have been formed in schools around the country.

USAID, in collaboration with the GRZ and other collaborating partners, is devel-

oping a framework for expanding adolescent participation and action to prevent the future spread of HIV. These activities are supported by PCI/Z, PSI, JHU and the FOCUS Project. A national inventory of adolescent activities is being conducted. An evaluation of adolescent strategies, including training health providers, the use of participatory methodologies, and the formation of peer education groups, will be evaluated and will serve as a basis for best practices. JHU/PCS supports a newspaper, *Trendsetters*, and radio programs written by youth for youth addressing sensitive reproductive health issues. *Trendsetters* recently won the 1997 Global Media Award from the Population Institute for best team reporting effort.

Policy Environment to Expand the National Response

USAID has been supporting, through PCI/Z, the development of a national voluntary counseling and testing policy. USAID has also been supporting the development of the HIV/AIDS sections of the following national policies, strategies and guide-

lines: Integrated Health Education/IEC; Integrated Technical Guidelines and Planning Guidelines; National Integrated Public Health Practitioner Training Policy and Curriculum.

The Futures Group and PCI/Z, USAID has been supporting the development of an AIDS Impact Model (AIM) for Zambia, which will be disseminated in early 1998 to multisectoral partners. AIM is a microcomputer projection model designed to develop a set of clear and consistent messages on the status and significance of the epidemic, increase leadership support for HIV/AIDS policies and programs, and provide inputs for action-oriented strategic planning at national, regional and district levels.

Church Mobilization

Church umbrella groups were mobilized at the national level to develop church-specific responses to the HIV/AIDS epidemic, and to develop plans for action for their churches. To complement this effort, the first district-level Interfaith Network was established in the Lusaka district, which brings together various

KEY

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Christian denominations, Islamic and Bahai communities to work together towards a concerted effort in HIV/AIDS prevention and care.

Innovation Fund: Small Grants to NGOs/CBOs

PCI/Z has been administering a small grants fund to encourage innovation in HIV/AIDS programming among smaller NGOs and CBOs. Activities funded under this program are intended to complement activities proposed under the District Task Force plans. To date, 33 small grants, the majority of which are under U.S.\$10,000 each, totaling U.S.\$136,000 have been awarded to NGOs and CBOs for activities in the areas of HIV/AIDS-related research, training, materials development, community response and equipment provision.

STI Syndromic Management

USAID, through FHI/AIDSCAP funds and PCI/Z technical assistance, helped the University Teaching Hospital Board develop and implement an STI syndromic management training course. Seventy-six health personnel were trained, including 28 district heads and 48 front-line health practitioners (22 clinical officers and 26 nurses/midwives). Under this subproject, a national training curriculum, color slides and wall charts were produced, and a color atlas is in the process of being

developed. The UTH Board plans to extend this course to nurses and midwives across the country.

Mobilization of Traditional Healers (THS)

As a follow-on to the former USAID-funded Morehouse School of Medicine Zambia HIV/AIDS Prevention Project, USAID, through the PCI/Z project, has continued to work with a team comprising leadership of the Traditional Health Practitioners Association of Zambia (THPAZ), Ministry of Health Traditional Medicine Unit, University of Zambia, and the Chongwe District Health Center to: redesign/improve teaching materials from the former project; develop a flipbook to help THs conduct peer and community education; redesign the training and follow-up program strategy, which is expected to be implemented in the new PCI/Z project district in partnership with the District Multisectoral HIV/AIDS Task Forces and THPAZ national and district representative; and help THPAZ develop an acceptable small grant proposal for the national mobilization of THs.

Community-based Support of Orphaned/Vulnerable Children

USAID/Zambia in cooperation with the USAID/Displaced Children and Orphans' Fund (DCOF) recently initiated a new set of activities to improve the quality of life of orphaned/vulnerable children in Zambia. The major elements of this program are: policy review and support for the

development of law and regulations governing child welfare; strengthening the Ministry of Community Development and Social Services to support, coordinate and supervise the work of NGOs/CBOs, networks and institutions to improve the delivery of key PHN interventions; and grants to NGOs/CBOs that are providing "best practices" support for the care of orphaned/vulnerable children.

ZIMBABWE

Situation Analysis

HIV seroprevalence in Zimbabwe is currently estimated at one million people, with about 22 percent of the adult (sexually active) population infected. Distribution of the infection shows the highest risk of infection to be in the 5-year-old and younger age group, through mother-to-child transmission, and in the 15- to 50-year-old age group, mainly through heterosexual contact. The epidemic has the greatest impact on the working population age group, with higher infection rates in urban centers, growth points and in people with STIs. The spread of HIV is facilitated by the high mobility of the population, conditions of increasing poverty and rising unemployment. As the epidemic matures, the main impact of HIV-related illness, death and the consequent social and economic problems, will be increasingly severe by the late 1990s.

REPORTED AIDS CASES:* 57,518

DATE OF LAST REPORT: 6/96

INCREASE OVER JUNE 1995

REPORT:** 27.6%

TOTAL POPULATION: 11.1 million

CUMULATIVE INCIDENCE: 22%

HIV-1 SEROPREVALENCE IN URBAN AREAS:***

Population at high risk:****
78.6%

Population at low risk: 33.6%

USAID Strategy

Over the past ten years, USAID has provided approximately U.S.\$16 million in support of AIDS prevention and control efforts in Zimbabwe. In 1993, through the Zimbabwe AIDS Prevention and Control Project (ZAPAC), funding was made available for the National AIDS Coordination Program (NACP), UNICEF and the AIDSCAP Project.

USAID-Supported Country Programs AIDSCAP

Several workplace interventions have been initiated through peer education. Beyond USAID's assistance, the projects themselves have provided financial, material and level of effort support from many subprojects. Activities target farm workers and their families, truckers, their assistants and lodging personnel, railway workers and their families, sugar estate workers and their families, the air force and national army and their families and children at the schools on military bases. A gender project aimed at school girls and their female peers,

mothers and aunts to foster self-empowerment is being implemented in six secondary schools. In addition, there is media involvement in both print, radio and television. All programs include a vast condom distribution program.

UNICEF

USAID supports a program aimed at students in tertiary education institutions. It is designed to develop knowledge, skills and attitudes that promote low-risk behavior and communication skills and teaching methods on STI/HIV/AIDS, contributing to the reduction in

the spread of HIV/AIDS. This complements UNICEF's programs in primary and secondary schools.

NACP

As the AIDS epidemic spreads, it gives rise to diverse responses in different sectors. These responses directly or indirectly infringe on the rights and freedoms of people infected or affected by HIV/AIDS. In light of this, the NACP has recognized the need for a national policy on HIV/AIDS to ensure the development of effective, ethical, clear and consistent responses to the epidemic to safeguard the rights of people living with HIV/AIDS. USAID

is supporting this initiative. The policy encompasses a wide range of concerns in the broad areas of health care, home care, counseling, research, information and legal and human rights in general. It will be discussed, debated and refined during 1997.

Contraceptive Social Marketing

A joint initiative by USAID and British Overseas Development Agency (ODA) to distribute male and female condoms has just begun.

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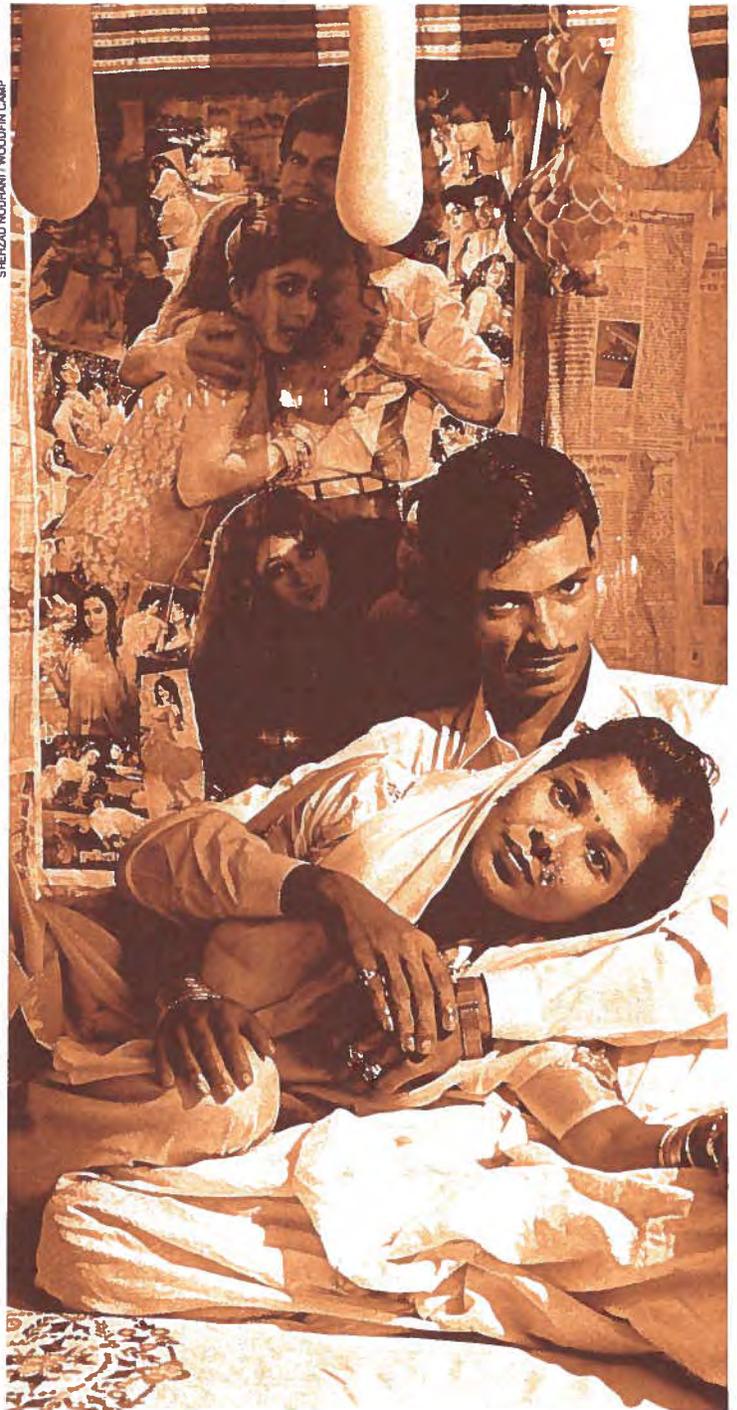
Asia and the Near East

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

Cross-border movement through India, Nepal, Burma and Thailand by migrant laborers, traders, transport workers and tourists plays an important role in the spread of the virus in the region and has led to some of the highest infection rates in the world. Recent HIV surveillance in Cambodia suggests that the country is experiencing the most severe and widespread epidemic in Asia.

The Asian epidemic is considered to be most severe in Cambodia, Thailand, India and Burma. While Thailand has made considerable progress in reducing new infections, the approximately 900,000 HIV-infected individuals as of 1996 will continue to strain health care systems for years to come. In other countries, the epidemic continues unabated. After just a few short years, Cambodia is now experiencing an epidemic expected to surpass the severity of neighboring Thailand—and with fewer resources and institutional strengths. In 1996, surveillance in Cambodia indicated that 41 percent of sex workers were infected, six percent of police and military, and almost two percent of women seeking care at antenatal clinics. With its large population, India is already estimated to have about two million HIV-infected individuals, and an epidemic difficult to characterize because of considerable geographic variation.

In many Asian countries, few HIV infections and AIDS cases have been detected or reported. Sentinel surveillance systems have yet to be set up to track infection



SHEHZAD NODIRANI / WOODFIN CAMP

In Bangladesh, a CSW poses with a man who wants to marry her. She wants to make sure he has enough money so she won't have to return to commercial sex work if he deserts her.

rates in many areas. For example, several states of India, with populations the size of several African countries, do not yet have systems in place to detect an epidemic before it starts.

In Indonesia and the Philippines, infection rates remain relatively low. However, epidemiologists warn that the risk behaviors in these countries could spark an epidemic at any moment; both have well-established commercial sex industries, and condom use with sex workers and their clients remains inconsistent.

Similarly, Nepal is currently reporting few HIV infections. However, its traffic and trade with neighboring India, where rates are high, signal that the country must prepare for higher epidemic levels. Furthermore, hundreds of thousands of sex workers in India come from Nepal, and many return when they find out they are HIV infected.

Even less is known about the epidemic in the Middle East and Northern Africa. Fewer than 2,000 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 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. The greatest prevention challenge in all Asian countries, except Thailand, is the absence of visible AIDS cases, which continues to allow government and individuals to deny the presence of the epidemic. As these epidemics mature, more individuals with HIV will become known and force a response which should have occurred sooner.

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;
- innovative pilot projects that address regional HIV/AIDS issues; and
- the upgrading of surveillance activities so that HIV trends can be detected.

The ANE Bureau 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 policymakers to Thailand to learn about the impact of the epidemic and the government response.

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 in Arab states and research on cross-border movement within the Near East.

BANGLADESH**Situation Analysis**

Bangladesh is in the early stages of the HIV/AIDS epidemic, with a reported HIV prevalence rate of about 0.05 percent in sexually active adults. The first AIDS case was diagnosed in Bangladesh 1989. By the end of 1996, ten AIDS cases and 79 HIV-positive people had been identified in the country. Many factors suggest that HIV could spread rapidly in the near future. These include high rates of STIs (some studies show rates of up to 50 to 60 percent among sex workers) and hepatitis B; significant numbers of commercial sex workers (over 100,000); widespread high-risk behaviors (pre- and extra-marital sex, and low condom usage); a large international and national migrant labor force; an essentially unscreened blood supply derived mostly from professional blood donors, approximately 20 percent of whom test positive for hepatitis B and syphilis; and rising injecting drug use. The present HIV situation could, therefore, evolve rapidly into an impending and escalating epidemic. According to World Health Organization estimates, the roughly 20,000 current cases of HIV will increase to 150,000 by the year 2000. Knowledge about HIV/AIDS among the population remains low; the 1996-97 Bangladesh Demographic and

Health Survey revealed that only 33 percent of married males and 19 percent of married females had even heard of AIDS.

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 a number of NGOs initiated significant HIV/AIDS activities in the areas of training, information, education and communication; however, some of the larger NGOs working nationwide still hesitate to address the issue. In 1996, the United Nations Development Program supported interventions through the Bangladesh AIDS Prevention and Control Program.

The Joint United Nations Programme on HIV/AIDS became operational in 1996 to work with the BDG, NGOs, the private sector and donors to support the national response to HIV/AIDS. A task force was convened to initiate the process of policy formulation. The national HIV/AIDS policy document was reviewed and examined by a multisectoral consensus workshop in October 1996. A special committee, chaired by the prime minister, approved the National HIV/AIDS Policy in May 1997, which led to setting up an STD/AIDS Directorate. The fifth HIV/AIDS Prevention Project (HAPP) proposes restructuring some components of the Health and Family Welfare wings towards unified service delivery.

REPORTED AIDS CASES:*10

DATE OF LAST REPORT: 7/97

INCREASE OVER 1994 REPORT:**
150%

TOTAL POPULATION: 123 million

CUMULATIVE INCIDENCE:
.081 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS:***

Population at high risk:****
0.2%

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 STI services available to these groups. First, USAID will assist the Mission-funded social marketing company to launch a program targeting commercial sex workers and their clients in 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 populations at risk. USAID will also assist local NGOs and other organizations to upgrade STI treatment services and engage in policy dialogue with the national AIDS committee and other HIV/AIDS-prevention implementing agencies.

USAID-Supported Country Programs

In 1994, preparations were completed to conduct an AIDSCAP-sponsored workshop on developing and implementing curricula for HIV/STI prevention and education for employees of NGOs. The workshop took place in December 1994, and a total of 28 people from 17 NGOs participated. In December 1996, the Association for Voluntary and Safe Contraception and AIDSCAP conducted a trainer-of-trainers course on STI and reproductive tract infection syndromic case management.

CAMBODIA**Situation Analysis**

With one of the worst epidemics (per capita) in the region, and also one of the poorest countries in Asia, Cambodia is heavily dependent on outside assistance to fight the spread of HIV. This external assistance has been put to good use by an extremely dedicated national AIDS program unit and by international private voluntary organizations that help fill the gap in government services. The results are now starting to appear, with HIV increases apparently slowing in a number of sen-

tinel populations, as measured by the 1997 round of surveillance. Behavioral surveillance confirms that condom use in risk situations has increased to the high levels that Thailand has achieved. Cambodia must greatly improve and expand its reproductive health service infrastructure in the provinces in order to sustain program impact and prevent resurgent and secondary epidemics in the coming years.

REPORTED AIDS CASES:* 300
(through December 1996)

DATE OF LAST REPORT: 1995

INCREASE OVER 1995 REPORT:**
30-fold

TOTAL POPULATION: 10 million

CUMULATIVE INCIDENCE: 100,000

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk: 40%

Population at low risk: 3%

USAID Strategy

USAID funding supports targeted and integrated national prevention efforts. Perhaps the most important U.S. government contribution to date has been support for the condom social marketing project of Population Services International, which makes quality condoms available at very affordable prices in all areas of the country. HIV serological and risk behavioral surveillance, also supported by USAID through the AIDSCAP Asia Regional Office, is demonstrating that (1) condom use in high-risk situations has reached very

high levels and (2) sentinel populations with higher protective behaviors also have lower HIV prevalence. Currently, the social marketing of "Number One" brand condoms grosses nearly one million pieces sold per month. USAID also supports integrated family planning, STI and HIV prevention through a grant to Family Planning International Assistance.

The National AIDS Program (NAP) has conducted surveillance of STIs, HIV and risk behavior in many parts of the country, with the assistance of AIDSCAP. An STI prevalence study conducted by the University of Washington through AIDSCAP helped identify the patterns of STIs in Cambodia and exposed considerable drug resistance, leading to the establishment of new treatment protocols.

Finally, USAID support through FHI has created a capability within the NAP to conduct behavioral surveillance on high-risk, low-risk and bridge populations to help evaluate program impact and warn of trends in emerging patterns of risk as the society adapts to the threat of HIV/AIDS. The military conflict in mid-1997 has led to a temporary ban on U.S. development assistance to Cambodia (except for humanitarian purposes). It is expected that assistance will resume in 1997 and that increased support to Cambodia's national AIDS control program will sustain the progress made in recent years.

INDIA

Situation Analysis

The HIV/AIDS epidemic in India continues to grow rapidly. Among the at-risk populations, alarming increases in incidence have been confirmed during the last two years. Over 50 percent of commercial sex workers in Mumbai are estimated to be infected, as are over 65 percent of intravenous drug users in Manipur. While knowledge of methods of transmission among risk groups is high, condom use remains low. A recent survey in Tamil Nadu, for example, shows that only 44 percent of truck drivers who reported engaging in high-risk sex used condoms. Available data indicate that transmission of HIV in India has been largely through heterosexual contact except in Manipur, where needle use by drug abusers has been the main route of infection.

Unfortunately, lack of systematic surveillance makes it difficult to estimate HIV prevalence, and the absence of such data restricts the ability to influence the opinion of the public and of policy-makers. HIV infections

reported by the Government of India (GOI), on the basis of very limited surveillance, are low (45,866 HIV and 2,639 AIDS cases in August 1996). Not surprisingly, most Indians, including medical professionals, do not believe HIV/AIDS to be a threat.

UNAIDS estimates that there are currently about three million people in India infected with HIV. If the epidemic follows the African pattern, within the next decade AIDS will become the leading cause of death among people between the ages of 15 and 39, and it will become the second leading cause of child mortality. Judging from the trend of transmission now apparent, it is estimated that by the year 2000, about five million Indians will be infected by HIV and the number of AIDS cases will exceed one million. With India's large pool of manpower, the epidemic may not significantly affect economic activity, but would certainly increase the economic burdens of low- and middle-income families when breadwinners are lost. Large and growing numbers of sick people will place unprece-

KEY

* 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.

dented demands on the already overburdened health system.

The GOI's national program started in 1993. Government commitment to aggressive action against HIV/AIDS has not, however, led to effective program implementation countrywide. While the areas of Tamil Nadu, Maharashtra and Manipur and, to a limited extent, Goa, Pondicherry, Delhi and Punjab have shown effective implementation of programs, little has been done in other regions. Much remains to be done in the important areas of research, surveillance, and sensitization and training of medical professionals.

The U.S.\$60 million World Bank loan which funds the National AIDS Control Program ends in 1997. The Bank plans to provide a twelve-month extension, and has invited the GOI to prepare a fresh loan application. The Bank hopes that the Government of India's new proposal will address the issue of how to overcome ineffective implementation at the state level.

USAID-Supported Country Programs

USAID has worked on HIV/AIDS in India since 1991. Early activities aimed at helping the GOI establish a testing and surveillance system to obtain better data to help galvanize a national response. USAID is presently engaged in four sets of HIV/AIDS activities in India.

AIDS Prevention and Control Project (APAC)

USAID has committed U.S.\$10 million to the ten-year, bilateral AIDS Prevention and Control Project (APAC), which focuses on prevention of HIV in the south Indian state of Tamil Nadu. APAC's purpose is to reduce the sexual transmission of HIV through a comprehensive program of activities and interventions demonstrated to have the greatest impact on the spread of HIV: prevention and control of STIs, a proven approach for reducing sexual transmission of HIV infection; promotion of condom use and expanding the distribution system for condoms; and promotion of behavior change among those individuals and groups who are at the highest risk. USAID's worldwide AIDSCAP Project provides technical assistance to APAC.

There has been significant progress in project activities over the last year. A major study to gather baseline data on key indicators, including knowledge of HIV prevention methods, condom use and care-seeking behavior for STIs, was completed in December 1996. The study shows that while there is a high degree of knowledge about methods of preventing the transmission of HIV, the adoption of safe behaviors lags behind. Condom use by populations engaging in high-risk behavior is low. Eighteen NGOs in Tamil Nadu have been funded to work with high-risk groups on HIV/AIDS prevention. Over

800 volunteers, peer educators and NGO heads were trained to work on community-based interventions. APAC-supported NGOs have identified and reached persons at risk with behavior change, condom use and STI treatment messages. PSI India has been funded to systematically reach and brief journalists and media persons and to stimulate them to improve the quality and quantity of reporting on and coverage of the HIV/AIDS issue.

A comprehensive research study on the availability and quality of condoms at retail outlets in Tamil Nadu has been completed and shows that condoms are widely and conveniently available, and that there have been dramatic improvements in their quality. APAC has entered into a collaborative arrangement with a major private sector producer and marketer of condoms to extend the distribution network and increase the number of nontraditional outlets so that condom availability to high-risk groups can be further improved.

A study of knowledge and practices related to STI diagnosis and management of 100 doctors (known to treat a large number of STI cases in the city of Madras) was completed. The findings of the study were used to develop a training module for physicians in diagnosis and management of STIs. The module was tested in two training programs, attended by a total of 23 male and 27 female physicians. Three well known

teaching and training institutions in Tamil Nadu have been selected to conduct regular training programs for physicians, using this module. Training of physicians commenced in February 1997.

National Quality Control Laboratory

USAID is assisting the GOI to establish a national quality control laboratory which will ensure the quality of diagnostics and blood products used in India. This will contribute greatly to the important issue of blood safety in India.

PACT/CRH Project

USAID's bilateral PACT/CRH Project works with commercial sector organizations such as pharmaceutical companies and condom manufacturers to accelerate and expand the commercial availability of high quality technologies such as STI and HIV diagnostics, and of condoms and other barrier protection methods against STIs and HIV.

HIV Education

With funds from the Asia Near East (ANE) Bureau, the Center for Development and Population Activities (CEDPA) supports an NGO in Bihar to work on HIV education with rural families in Bihar, and a New Delhi NGO to work with street children.

The ANE Bureau also funds an important AIDSCAP cross-border activity: HIV transmission routes are often the same routes and highways that transport drugs, commodities and migrant people. Stemming the transmission of

the virus requires cross-border initiatives and multi-nation cooperation. The AIDSCAP activity includes a trucker education and STI control program along the Indo-Nepal highway that crosses into Nepal from Raxaul on the Indian side. Recently, there have also been attempts to engage the authorities in Bangladesh in this activity.

USAID's current program of activities in HIV/AIDS was drawn up as far back as 1992, and since the AIDS situation in India has evolved considerably in the intervening years, USAID has undertaken a situational review to determine whether there are new opportunities for involvement in HIV/AIDS prevention in the country, and if present activities need redefining. Management decisions based on this review will be taken during the course of this year.

INDONESIA

Situation Analysis

Indonesia, an archipelago of 13,000 islands, is still in the early stages of the AIDS epidemic. HIV/AIDS prevalence is still relatively low, with 501 reported cases (384 HIV, 119 AIDS) in 19 provinces by the end of December 1996. Most people with HIV were discovered through limited blood testing of groups engaging in high-risk behaviors, screening of donated blood, voluntary

confidential testing, testing for overseas work visas, or as a result of testing symptomatic patients in hospitals. The World Health Organization estimates that between 60,000 to 100,000 Indonesians may currently be infected. 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 started to address HIV/AIDS as a national priority. A presidential decree issued in May 1994 established a new multi-sectoral National AIDS Commission (NAC). A National AIDS Strategy and a five-year plan of action have been developed to guide GOI and donor-funded HIV/AIDS prevention activities. Several important policies have been approved by the NAC, including assurance of care and rights of AIDS patients, national guidelines for information, education and communication (IEC), and use of syndromic approach guidelines to STI management.

REPORTED AIDS CASES:* 119

DATE OF LAST REPORT: 12/96

INCREASE OVER 1994 REPORT:** 100%

TOTAL POPULATION: 200 million

CUMULATIVE INCIDENCE: 0.25 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS: Not available

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 programs to prevent further transmission of HIV/AIDS, through the GOI, NGOs and the private sector. 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, IEC, improved STI management and social marketing of condoms. Major activities include facilitation of policy development, policy study tours, epidemic modeling, IEC training and strategy development, NGO institutional development, condom marketing and implementation of outreach activities targeting those at highest risk.

USAID-Supported Country Programs HIV/AIDS Prevention Project (HAPP)

Building upon earlier activities, USAID/Jakarta assisted the GOI in launching its National AIDS Prevention Program by designing and

supporting a five-year, U.S.\$20 million bilateral HIV/AIDS Prevention Project (HAPP). The GOI will be contributing an additional U.S.\$6,667,000 to the project, which will be implemented by the Ministry of Health, within the overall coordination of the National AIDS Prevention Committee.

A comprehensive set of HAPP activities is being carried out in three project sites—North Jakarta, Surabaya and Manado—focusing on four mutually supportive technical components: policy support and dissemination; IEC for behavior change; improved management of STI services; and condom social marketing.

Technical assistance has been provided to the GOI to assist in developing national IEC guidelines and national guidelines for STI diagnosis and treatment using a syndromic approach. Baseline data collection of achievement indicators has been completed by the University of Indonesia and the Indonesian Epidemiologist Network. STI training modules incorporating national STI guidelines and research on condom pro-

KEY

* 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.

motion, pricing and promotional interventions for increasing condom use among the high-risk groups have been developed. Development of a radio drama scripts targeting adolescents is underway as are other IEC activities. In addition, basic reproductive tract infection and STI prevention messages for women at risk have been developed and reviewed.

AIDS Prevention and NGO Strengthening

Since 1993, USAID has provided over U.S.\$1.3 million to PATH to implement HIV/AIDS prevention and NGO strengthening activities in seven locations in Indonesia—Jakarta, West Java, Yogyakarta, Bali, South Sulawesi, North Sulawesi and Irian Jaya. PATH works collaboratively with local NGOs to implement HIV/AIDS prevention activities targeted to commercial sex workers (CSWs), young persons at immediate risk, STI clinics, medical and paramedical staff, young factory workers and blue collar workers. Increasingly, PATH is focusing support on Irian Jaya, which has the highest HIV infection prevalence rate of all provinces.

From 1993 to 1996, USAID supported the U.S.\$3.1 million Enabling Private Organizations to Combat HIV (EPOCH) Project, which provided institutional development and technical assistance to 11 NGOs to strengthen their programmatic, administrative and financial capabilities to implement STI/HIV pre-

vention programs in Jakarta, Surabaya and Bali. Three of these NGOs have become self-financing. Major EPOCH project components included behavior change communication material development, peer outreach, condom promotion, counseling, training and STI prevention and referral.

AIDS Control and Prevention (AIDSCAP) Project

USAID has provided approximately U.S.\$1.4 million over the past three years to the AIDSCAP Project. This funding supports the Ministry of Health's Center for Health Education in developing an IEC strategic planning program and educational materials. AIDSCAP has also supported innovative NGO programs focusing on high-risk behavior change and development of IEC modules.

AIDSCAP is also working with the GOI to foster closer relationships between government and NGOs. In collaboration with PATH, AIDSCAP assisted the GOI in conducting a rapid assessment for HIV risk in five cities—Medan, Semarang, Manado, Balikpapan and Ambon—which supported choosing Manado as the third HAPP demonstration site. In addition, AIDSCAP has provided a small grant to PACT to implement an outreach intervention targeting street children aged 12 to 20 in Jakarta.

Finally, in recognition of the fact that AIDS does not respect national borders, AIDSCAP is supporting prevention activities among mobile populations that are vulnerable to contracting

HIV. These activities are being carried out in Irian Jaya, Sumatra and Sulawesi, where the potential for cross-border HIV transmission is high.

Donor Coordination

Quarterly donor meetings led by the Joint United Nations Programme on HIV/AIDS provide a regular opportunity for discussion of key issues, progress of the epidemic and donor activities. Donor working groups for STI prevention and IEC directly contributed to the development of national guidelines for using the syndromic approach to the diagnosis and treatment of STIs and to development and acceptance of national guidelines for IEC in HIV/AIDS prevention.

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 in the country. 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 through heterosexual contact. The male-to-female ratios of HIV and AIDS infection 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 Center for AIDS and STI 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 collaboration with the non-governmental sector nationwide.

REPORTED AIDS CASES:* 32

TOTAL POPULATION: 20 million

CUMULATIVE INCIDENCE: 1.6 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS:**

Population at high risk: 1.1%

Population at low risk: 0%

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 AIDSCAP Project, USAID's three-year, U.S.\$1.9 million program aims to increase the access of target populations at highest risk—commercial sex workers (CSWs) and their clients—to improved STI prevention and treatment services, extend condom distribution to target populations, develop targeted communication interventions to reduce high-risk behaviors and increase awareness of HIV/AIDS/STI issues among policymakers.

USAID-Supported Country Programs STI Case Management Training and Education

To improve access to effective STI services, the Nepal Medical Association developed a management training curriculum and trained general practitioners in the private sector in STI case management using the syndromic approach to STI diagnosis and treatment. The training complements Nepal's national STI case management guidelines.

STI/HIV/AIDS Prevention Education

The Nepal Chemists and Druggists Association is developing a training curriculum; in mid-1995 it will begin training chemists and alternative health providers to strengthen their role as prevention educators and condom promoters in the prevention and control of STI/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 goods stores. A media campaign to raise public awareness of HIV/AIDS and the importance of condoms in HIV and STI 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 NGOs, 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, in 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.

A Baseline Survey of CSWs and Their Clients on Land Transportation Routes

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 STI service infrastructure. Recommendations from the survey include focusing HIV prevention interventions on specific target groups, using low- and nonliterate messages, distributing condoms near points of use and encouraging STI treatment.

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

THE PHILIPPINES

Situation Analysis

The Philippines remains in the early stages of the HIV/AIDS epidemic. As of January 1997, 871 cases of HIV/AIDS infection had been reported to the National HIV/AIDS Registry. HIV seroprevalence data among high-risk groups show that infection rates are, on average, still below one percent. The prevalence of high-risk behavior and high STI rates, however, signal a potentially devastating epidemic. The

Government of the Philippines has addressed HIV/AIDS as a national priority by implementing a National AIDS/STI Prevention and Control Program.

REPORTED AIDS CASES:* 871

DATE OF LAST REPORT: 01/97

INCREASE OVER 1995 REPORTS:** 22%

TOTAL POPULATION IN 1997: 71 million

CUMULATIVE INCIDENCE: 12.2 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk: 0.1 to 1.3%

Population at low risk:**** <0.1%

USAID Strategy

Recognizing the need to support focused efforts on HIV/AIDS prevention, USAID authorized the AIDS Surveillance and Education Project (ASEP) in July 1992. Given the relatively low prevalence rate of HIV infection in the Philippines, USAID acknowledges that early and effective targeting of HIV prevention interventions to high-risk groups is critical because interventions diminish in cost-effectiveness as the infection moves out of the

KEY

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*** 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.

high-risk groups to other segments of the population. USAID continues to support the efforts of PVOs and NGOs skilled in reaching people who practice high-risk behaviors, improve STI case management through provision of training on the syndromic approach, and strengthen blood safety programs. The Mission also focuses on mobilizing the national sentinel surveillance system to track the transmission of the infection among targeted population groups most frequently practicing high-risk behavior, and monitoring behavioral change in these groups.

USAID-Supported Country Programs

National HIV Sentinel Serologic Surveillance

Through a grant agreement with the World Health Organization, ASEP is supporting the Philippine Department of Health (DOH) National HIV Sentinel Surveillance (HSS) and Behavioral Surveillance Survey (BSS) systems. The HSS is currently established in ten strategically located sites throughout the country and is providing systematic early warning data on increases in HIV infection rates among the groups considered at high risk. Behavioral surveillance surveys are monitoring risk behavior prevalence. The sentinel groups for HSS and BSS include registered and free-lance female commercial sex workers (CSWs), male CSWs,

male STI patients, men who have sex with men and intravenous drug users.

HIV/AIDS Communication and Behavior Change Programs

Through a cooperative agreement with the Program for Appropriate Technology in Health (PATH), the education component of ASEP is strengthening the DOH to develop and oversee implementation of a primary prevention AIDS information, education and communication (IEC) strategy. Operational plans for carrying out strategic activities have been developed and target groups and geographic areas for HIV education have been selected.

Educational Outreach Services to High-risk Groups

PATH has given subgrants to more than 20 NGOs working in STI/HIV/AIDS prevention. NGO HIV/AIDS IEC outreach intervention activities are encouraging behavior change among individuals within the targeted risk groups in the major cities of the Philippines, which are also the sites of HIV surveillance activities.

STI Care and Management

PATH is developing STI intervention pilot projects and is testing different approaches to STI syndromic case management in selected major cities with high STI prevalence.

National Safe Voluntary Blood Bank System

The New Tropical Medicine Foundation, Inc. (NTMF), through a suba-

greement with PATH, has developed the strategic plan for the National Voluntary Blood Donation Program. This activity is providing the framework and direction for the integrated national response to ensuring the safety of the country's blood supply.

National STI Control Plan

The AIDSCAP Project is providing assistance to the DOH's STI/HIV/AIDS Unit to develop a national STI control plan.

SRI LANKA

Situation Analysis

Sri Lanka is classified as a low-prevalence country for HIV/AIDS. However, the potential for an explosive epidemic exists in Sri Lanka because it has many of the risk factors associated with high prevalence countries in the region, including high levels of cross-border migration and the return of refugees from high-prevalence neighboring countries; increasing 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 STIs. The Government of Sri Lanka has developed a medium-term plan to address HIV/AIDS that focuses on diagnosis, testing and treatment at poorly equipped government facilities. In addition, the government is

also focusing on home- and community-based care and support systems. The plan recognizes the importance of nongovernmental institutions supplementing the government's efforts in controlling the epidemic through education, prevention and treatment.

REPORTED AIDS CASES:* 226

DATE OF LAST REPORT: 11/94

INCREASE OVER 1994 REPORT:** 450%

TOTAL POPULATION: 18 million

CUMULATIVE INCIDENCE:*** 13.2 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS:***

Population at high risk:**** 0.3%

Population at low risk: 0%

USAID Strategy

While HIV/AIDS is not a primary strategic focus of USAID's program portfolio, USAID provides support to two local private voluntary organizations for programs that create awareness of HIV/AIDS among vulnerable groups. USAID plans to continue to support HIV/AIDS education programs primarily through the International HIV/AIDS Alliance (IA) and its linking organization, Alliance Lanka, addressing HIV/AIDS issues. Financing of future programs will be provided by the Asia Near East Bureau.

USAID-Supported Country Programs PVO Grants

USAID has awarded a grant to the Sri Lanka Association for Voluntary and Safe

Contraception (SLAVSC), which focuses on women living in poverty who are experiencing many different problems associated with social marginality. The objective of the grant is to empower women and youth, from age 16 to 30, to raise HIV/AIDS/STI awareness and facilitate safe sex practices. The activities under this grant propose intervention schemes to assist these women through social, economic and psychological empowerment, and provide them with knowledge of HIV/AIDS and other STIs. SLAVSC will continue with the training programs for voluntary health workers and counselors in HIV/AIDS and other STIs, and use the centers for counseling high-risk groups in selected districts.

USAID has given a grant to the Community Front for Prevention of AIDS (CFPA) to establish an outreach health education program targeting high-risk groups with HIV/AIDS information and education. The main objective of this activity is to sustain behavioral changes among high-risk groups, especially women and youth, and offer skills training for alternative employment. CFPA will

establish vocational training centers for counseling services and peer educator programs.

THAILAND

Situation Analysis

The HIV epidemic peaked nationally among young Thai males, at four percent in 1993, and among antenatal clinic clients, at 2.3 percent two years later in 1995. The national case load of HIV will continue to increase for some time, however, as secondary transmission will outnumber deaths from AIDS. The premature decline of HIV incidence in Thailand is generally attributed to the aggressive effort of the Ministry of Public Health, which has implemented a national prevention program since approximately 1990. The strongest evidence of intervention impact is the well-documented decline in STIs, which plummeted 75 percent from over 400,000 cases annually in the late 1980s to fewer than 100,000 cases by 1993. The key factors cited to explain this success include openly admitting the scale of the epidemic early on, switching from a "pull" to a "push" policy on free condom distribution, and strong policy backing at the central and provincial level for comprehensive prevention programming which involved

multiple sectors of society. Although many aspects of the Thai HIV epidemic and response may be unique to that country, other programs in Asia are benefiting from the numerous lessons learned.

REPORTED AIDS CASES:* 65,792

DATE OF LAST REPORT: 1995

INCREASE OVER 1995 REPORT:** 300%

TOTAL POPULATION: 61 million

CUMULATIVE INCIDENCE: 850,000 to 1,000,000

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** 20%

Population at low risk: 2%

USAID Strategy

USAID closed its bilateral Mission in September 1995 and concluded all U.S. Government (USG) development assistance to Thailand one year later, in view of Thailand's advanced development status. The last

USAID-sponsored HIV prevention programs to be absorbed by local institutions in Thailand include the U.S.-Thai Development Partnership Fund, the Thai Women of Tomorrow project and the centrally funded Bangkok Fights AIDS comprehensive prevention program. USAID continues to engage Thai institutions and consultants in helping to build capacity for other prevention programs in the region in the area of behavioral and HIV surveillance, communication materials development, behavior change program design, STI program management, counseling and people with AIDS support group networks. On behalf of USAID, the AIDSCAP Project has prepared a number of documents which consolidate lessons learned from over ten years of USG support to the Thai HIV prevention effort.

KEY

* 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.

Latin America and the Caribbean

The Pan American Health Organization (PAHO) believes that official reports underestimate the extent of the HIV/AIDS epidemic in Latin America and the Caribbean (LAC), and estimates the true number of HIV infections in the region to be between 1.6 million and two million, while as of December 1996, 211,670 cases of AIDS had been reported.

There are striking differences in the levels of HIV/AIDS throughout LAC. HIV seroprevalence rates range from less than one half of a percent in Ecuador to up to ten percent in certain urban parts of Haiti. Brazil, with the largest population and one of the best reporting systems in the region, has reported 110,872 AIDS cases, the second largest number in the world, and it is estimated that between 560,000 and 850,000 Brazilians are infected with HIV. The male-to-female ratio has shifted from 28:1 in 1985 to 3:1 in 1996, a clear indication of the increasing importance of heterosexual transmission.

Despite its relatively low HIV prevalence, Jamaica has the potential for a severe HIV/AIDS epidemic, with high rates of sexually transmitted infection (STI), large numbers of migrant workers and significant tourist and commercial sex industries. The latter two are also present in another Caribbean country, the Dominican Republic, where the seroprevalence rate in a population of pregnant women in Puerto Plata, an important tourist center, has risen from 2.9 percent in 1994 to 7.9 percent in 1996.

Since 1992 the LAC Bureau has focused its efforts in HIV/AIDS prevention in five HIV/AIDS emphasis countries—Brazil, Haiti, the Dominican Republic, Jamaica and Honduras. USAID Field Missions in Bolivia, Peru and Nicaragua have also implemented country-specific prevention activities, and USAID's Central American Regional office is currently carrying out a sub-regional HIV/AIDS prevention program which addresses HIV/AIDS issues throughout Central America across national borders.



Performances by Jamaica's ASHE Caribbean Arts Ensemble helped youth and their parents discuss HIV/AIDS.

REGIONAL INITIATIVES

Recognizing the increasing importance of cross-border HIV transmission in different parts of the region, the LAC Bureau has sought new ways to complement its support of national HIV/AIDS programs. The first regional HIV/AIDS initiative in the region, the AIDS Communication and Technical Services Project (ACTS) worked to improve the capacity of national AIDS programs in the Caribbean to develop and implement programs to promote sexual behavior change. Subsequently, the Regional Development Office for the Caribbean supported the development of an automated HIV/AIDS and STI surveillance and tracking system for the Eastern Caribbean until the Mission was closed in 1995.

The LAC Bureau, in collaboration with the Global Bureau and USAID's Central American Regional Office in Guatemala, supported the development of a Central American regional AIDS prevention program, which began in 1996. This program recognizes the striking demographic, sociocultural, political, economic and epidemiologic similarities among the countries of Central America. Its goal is to slow the spread of HIV/AIDS through: 1) assisting local nongovernmental organizations working in HIV/AIDS prevention; 2) improving awareness among policymakers of the political and economic implications of HIV/AIDS; and 3) promoting safer sexual practices through the social marketing of condoms.

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 currently, the majority of HIV infections are resulting from heterosexual transmission.

Fifty-six percent of Bolivia's HIV and AIDS cases have occurred in the department of Santa Cruz, which lies on the border with Brazil. Since 1994, HIV cases have been reported in smaller numbers in each of the other eight departments of Bolivia. Although the total number of HIV infections reported to date remains low, studies indicate that STI prevalence in Bolivia is extremely high, suggesting that the country is vulnerable to a widespread HIV/AIDS outbreak.

REPORTED AIDS CASES:* 234

DATE OF LAST REPORT: 11/96

INCREASE OVER 1994 REPORT:** 27%

TOTAL POPULATION: 7.5 million

CUMULATIVE INCIDENCE: 31.2 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS: 0.62%

USAID Strategy

Through the STI and HIV/AIDS Control and Prevention Project, USAID/Bolivia has helped the National Secretariat of Health to develop an STI/HIV/AIDS control strategy for Bolivia based on a three-pronged approach recommended by the WHO and the AIDSCAP

Project. This approach consists of strengthening health service capacity for diagnosis and treatment of STIs; promoting preventive messages targeting behavior modification through information-education-communication-counseling (IECC); and promoting and marketing of condoms for general preventive and commercial sex use. The Bolivian model is based on diagnosing and treating STIs in high-risk populations (i.e., commercial sex workers and homosexual men) to delay the spread of HIV/AIDS into the general population. From the beginning, the Centers for Disease Control and Prevention (CDC) in Atlanta has provided technical assistance.

With support from USAID, the Government of Bolivia (GOB) has successfully implemented this STI/HIV/AIDS model in the four major population centers of the country through the establishment of model STI clinics in each area. STI prevalence among commercial sex workers in La Paz brothels was cut in half (from nearly 60 to 30 percent) in two years, and condom use among CSWs significantly increased. Similar success in behavior change has also been accomplished among homosexual men.

Although USAID has retained its focus on high-risk populations, recent activities have been developed to integrate STI diagnosis and treatment into reproductive health programs through the training of health personnel in STI case management. Recent education activities are also aimed increasingly at the

general population, especially adolescents. Considerable emphasis is now being placed on achieving financial sustainability for the GOB's STI clinics.

USAID-Supported Country Programs Health Sector Training

Interdisciplinary teams (physicians, biochemists, psychologists) provide STI diagnosis and treatment training courses throughout the country. Courses offered include syndromic and laboratory diagnosis of STIs, treatment modalities and the psychological management and support of patients. Participants are also trained in HIV and STI prevention counseling and condom promotion and use. Training participants include health and health services-related personnel from both the public and private sectors.

Public Sector STI Model Clinics

With technical support from the CDC, USAID conducted extensive STI prevalence research and updated treatment protocols as a foundation for establishing four model public sector STI clinics to offer improved STI diagnosis, treatment and counseling services for registered CSWs. Increasingly,

these clinics have responded to the demand from the general population for these services. In 1996, USAID initiated the creation of rotating funds for laboratory reagents and pharmaceuticals for STI treatment in these fee-for-service clinics, improving their capacity to reach financial sustainability.

Men Who Have Sex with Men (MSM)

USAID supports the HIV/AIDS prevention efforts of UNELDYS (Unidos en la Lucha por la Dignidad y la Salud), a gay organization based in the city of Santa Cruz. The organization offers one-on-one and small group STI/HIV education and promotes condom use and safe-sex practices through the outreach activities of community educators. Sexual health counseling, anonymous HIV testing with pre- and post-test counseling, and a referral system for STI treatment are also offered through this intervention. Since 1994, this intervention has been successfully replicated in La Paz through the local gay organization, Grupo Libertad-Movimiento Gay La Paz (MGLP), and in Cochabamba with the organization Movimiento Dignidad.

KEY

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**** 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.

Commercial Sex Workers (CSWs)

Teams of psychologists, health personnel and trained community educators and volunteers work in the STI clinics of La Paz, El Alto, Cochabamba and Santa Cruz are helping registered CSWs to provide pre- and post-HIV-test counseling and general sexual health counseling and education, with an emphasis on risk assessment, condom use and negotiation techniques. Condoms are available at subsidized prices in the clinics. In 1996, this intervention reached over 4,000 registered CSWs.

Teams of community health educators work in the cities of La Paz, El Alto, Santa Cruz and Cochabamba to educate CSWs on STI and HIV/AIDS at their work sites. The intervention targets groups of CSWs working in the streets, parks and clandestine brothels who do not attend STI services because of their low income status and lack of information and education. As a result, they have high prevalence rates of STIs. The education modules used with these groups emphasize condom use, negotiation skills, health risk assessment and referrals to STI services.

Interventions targeting CSWs are supported by additional educational programs for owners and administrators of brothels. These programs aim to educate brothel owners and administrators on

HIV/AIDS and to encourage this group to support CSWs in promoting and negotiating condom use in their establishments. Materials promoting condom use, such as posters, matchbooks and tablecloths, are distributed as part of the educational programs for use and display in the brothels.

Sexual Health Education in Jails

In 1996, 59 inmates of the San Pedro jail in La Paz were trained as peer educators for the jail population of 1,600. A condom sales system within the jail supports the peer education program, and physicians serving the jail population have received STI diagnosis and treatment training.

AIDS “Hotlines”

Since 1993, USAID has supported an STI/HIV/AIDS telephone “hotline” in the city of Santa Cruz (population 800,000) offering basic STI/HIV/AIDS information, emotional support and a referral system for STI services. The hotline is staffed by a team of psychologists and trained community educators and volunteers who respond to approximately 2,500 phone calls annually. The counseling services are anonymous and free. All referral services have received STI diagnosis, treatment and counseling training, are regularly monitored for quality of service and client satisfaction, and offer affordable services. In 1996, this intervention was extended successfully to the city of Cochabamba. In the first four months of operation, the Cochabamba hotline responded to 810 calls.

Social Marketing of Condoms

Since 1993, USAID has assisted the National Secretariat of Health in institutionalizing condom distribution in Bolivia. Condoms are currently distributed through the National Secretariat of Health’s distribution system to the public sector STI and family planning clinics and sold at subsidized prices. USAID has also supported social marketing of condoms in the private sector. In 1996, a newly implemented and extremely successful social marketing program sold over 2.5 million condoms in the private sector. Forty percent were sold through the non-traditional (outside of pharmacies) sector.

BRAZIL

Situation Analysis

Brazil has the second highest number of reported AIDS cases in the world. First documented in homosexual and bisexual men, there is currently an increase of new AIDS cases from heterosexual transmission of HIV. Today, the male/female infection ratio is 3:1, and in São Paulo, AIDS is now the leading cause of death among reproductive-aged women, reflecting a shift in the epidemic to heterosexual transmission, with its negative consequences increasingly apparent in the adolescent and female populations. The epidemic shows signs of stabilizing among certain population subgroups,

and in some regions is visibly declining. These changes lead to the conclusion that the HIV/AIDS epidemic in Brazil increasingly affects the poorest, most marginalized and vulnerable populations. Researchers in Brazil have described the importance of the pauperization of the epidemic affecting a population which traditionally has suffered from other infectious diseases, malnutrition, precarious sanitary conditions and generally poor quality of basic health care services.

REPORTED AIDS CASES:* 94,997

DATE OF LAST REPORT: 12/95

INCREASE OVER 1995 REPORT:** 62%

TOTAL POPULATION: 155.8 million

CUMULATIVE INCIDENCE: 68 per 100,000

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** 9 to 98%

Population at low risk: 0 to 1.9%

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 AIDSCAP Project has developed a comprehensive set of interventions and program assistance in behavior change communication (BCC), condom social marketing and reduction of STIs. Three support strategies—behavioral research, policy development and evaluation—enhance the effectiveness of the primary components.

The six-year program consists of 14 projects covering all major components and focusing on the following target populations: commercial sex workers (CSWs); STI patients; men who have sex with men (MWM); men in the workplace (MWP); and adolescents.

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 multi-faceted 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 STIs and using condoms.

Interventions for MWM

Outreach activities target MWM through peer education, information dissemination, condom distribution, referrals for STI treatment, safe-sex workshops and expressionist theater. More than 3,800 MWM were reached directly through both safer sex workshops and counseling sessions. Outreach workers also distributed approximately 121,000 information, education and communication (IEC) materials and 87,000 condoms in gay cruising areas and meeting points in Rio de Janeiro and São Paulo.

Interventions for Men in the Workplace

Project activities are being implemented at the Santos harbor, the largest in Latin America, by the Center for AIDS Prevention Studies (CAPS/University of California) in collaboration with the Health Secretariat. The intervention is reaching 15,000 harbor workers through behavior change communication, condom promotion, STI diagnosis and treatment. A team of seven health agents visits the harbor daily to promote activities. With CAPS, AIDSCAP is also conducting a cohort study among the workers, including HIV seroprevalence, behavioral research and prevention intervention.

Interventions for People With STIs

The majority of people with STIs in Brazil seek treatment from the informal sector. Public sector health services are poor, and STI drugs and condoms are often not available. Project activities focus on improving health-seeking behavior among STI patients in target geographic regions and expanding access to and improving the quality of HIV/AIDS/STI service management, diagnosis and treatment. A total of 13,000 STI patients were diagnosed and treated at Santos' 22 polyclinics. In Rio de Janeiro, 4,000 STI patients were treated and 23 clinics received constant technical assistance.

Condom Social Marketing

In support of AIDSCAP project activities, DKT do Brasil provides low-price

condoms to target populations, retail pharmacies and nontraditional outlets in project areas. DKT imports and sells a high-quality, low-cost condom with the objective of increasing condom sales and promoting competition among available condom brands. Major successes include the sale of 26,887,248 "Prudence" condoms, representing a 46 percent increase over 1995 sales levels. According to research data, the total market growth for 1996 was close to 20 percent, bringing the total up to 175 million units. The price of "Prudence" is one-fourth that of the other local brands, and its sales reached 14 percent of the national condom market. DKT implemented a number of special promotional campaigns during the 1996 and 1997 Carnival seasons in key beach regions, sponsoring blocks, balls, parades, roving bars and placards in public buses. A considerable number of more than 40 NGO collaborative activities contributed heavily to the sales gains.

AIDS and Women

In response to the rapid increase in HIV infections in

women, USAID/Brazil has included in its strategy interventions promoting HIV/AIDS prevention among women not formerly considered at high risk of infection. Pilot activities aiming to integrate STI/AIDS prevention into USAID Family Planning-funded projects are being implemented. BEMFAM, the International Planned Parenthood Federation affiliate, has implemented a comprehensive AIDS prevention program in its clinics in public sector service sites and schools. The program includes staff training, counseling, STI prevention, diagnosis, treatment and referral, and condom promotion.

Small Grants Program

The Rapid Response Funds mechanism enabled the Brazil country office to fund 36 small-scale activities that complemented the overall country program, focusing on women and adolescents.

Activities included theater presentation, creation of an interactive prevention maze, publication of IEC material, and evaluation of one of the BEMFAM women's projects.

KEY

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Private Sector

The AIDSCAP country office collaborates monthly with *Cláudia* magazine (circulation 700,000) in the development of HIV/AIDS prevention messages for women. The local NGO implementing the AIDSCAP project was chosen to manage an international AIDS prevention T-shirt campaign, "Wear for a Cure," that will fund other AIDS prevention projects in the near future.

THE DOMINICAN REPUBLIC

Situation Analysis

The HIV/AIDS epidemic has become well established in the Dominican Republic over the past ten years. UNAIDS now estimates that over 85 percent of the HIV infections in the Caribbean region are in Haiti and the Dominican Republic (UNAIDS 1996).

Although available data on the epidemic are somewhat limited, there is a growing base of information and scientific studies that do provide adequate data to develop a reasonable profile of the natural history of the HIV and AIDS epidemic in the Dominican Republic. These data come from official reports of HIV infection and AIDS, blood donor records, HIV sentinel surveillance and other scientific studies.

It is estimated that the HIV seroprevalence rate for sexually active Dominicans is now 2.5 percent. Recent projections estimate this may rise to 4.3 percent by the end of

the decade. As of January 1997, the total number of reported AIDS cases was 3,631. Throughout the country, HIV has moved steadily from original core groups with high-risk behavior (CSWs and MWMs) into the general population. The main mode of transmission among the total number of AIDS cases reported continues to be sexual (75.3 percent) and mainly heterosexual (66 percent).

A number of contributing factors move the epidemic in the DR: an ever-growing commercial sex industry (male and female); a thriving tourism industry; poverty and social inequity; migration, especially Haitian inflow; women's socially conditioned lack of power; and alcohol abuse.

The socioeconomic and political environment in the Dominican Republic in which HIV is immersed has recently been evolving. Political changes are illustrated by the recent change in government (August 1996), which consolidates a growing democratic process within the country, and brings hope for greater attention to prevention of HIV. For example, the new government has expressed an interest in increasing social welfare in the areas of health and education. Thus, it is anticipated that there will be policy which could affect the AIDS projects supported to date.

The emergence of the new government also poses new challenges in terms of negotiating further collaboration between governmental orga-

nizations, NGOs, international donors and the private sector.

REPORTED AIDS CASES:* 3,631

DATE OF LAST REPORT: 1/95

INCREASE OVER 1994 REPORT:** 40%

TOTAL POPULATION: 8,089,000

CUMULATIVE INCIDENCE: 370 per million (6/96)

HIV-1 SEROPREVALENCE IN URBAN AREAS: (6/96)

Population at high risk:**** 4.9%

Population at low risk: 1.7%

USAID Strategy

USAID invests in the private sector through NGOs and other organizations with access to the communities where HIV is most easily transmitted. As the infection spreads into the population at large, more attention is being directed toward secondary groups, including lower-income men and women and the clients of CSWs. Most efforts to date have targeted groups such as adolescents from marginal, underserved urban and periurban settings, those working in the tourism industry, and industrial park employees.

USAID has furthered new initiatives to respond to the country's growing HIV/AIDS epidemic. Special attention is given to raising awareness of STIs/HIV/AIDS to generate and sustain further prevention interventions. New programs aimed at mobilizing the private sector and opinion leaders in support of AIDS prevention have been ini-

tiated. These programs respond to research findings on the impact of HIV/AIDS in different sectors such as the industrial and tourism sectors.

Interaction with STI training and services organizations has been pursued to improve quality and timeliness of STI care. National STI norms are being developed in collaboration with the NACP. These will be based on the algorithmic approach to STI diagnosis and treatment previously validated in the country.

Support to improving condom accessibility is also a main part of the strategy; a project to increase availability of condoms nationwide is being implemented through a private sector pharmaceutical company.

USAID also collaborates with the Ministry of Health in maintaining a Sentinel Surveillance Program.

USAID-Supported Country Programs

The USAID country program has three main strategic objectives: (1) to raise awareness of STIs and HIV/AIDS to generate and sustain prevention interventions, (2) to expand access of the general population to STI/HIV/AIDS prevention, and (3) to build the capacity of local institutions to carry out HIV/AIDS/STI prevention.

The program has been coordinated by the AIDSCAP Project and implemented through local NGOs, government organizations, private organizations and universities. To fulfill this

program, target audience interventions are complemented with program support interventions.

Workplace Interventions

Implemented by the *Comite de Vigilancia contra el SIDA (COVICOSIDA)*, this project targets hotel employees (HEs) and managers from 13 hotels in the *Playa Dorada Resort, Puerto Plata*. The project systematically targets employees working in the food and beverage departments, entertainment and casinos. Strategies were designed to reach HEs in and out of the workplace, through short theater skits at bus stops, discussions (*charlas*) during breaks, Employee of the Month parties and one-on-one interactions.

In 1995 to 1996, the project reached 7,949 people during educational activities and 8,932 educational materials were distributed.

An intervention targeting workers and managers from 58 industries established in the industrial parks of *Haina, Herrera and Nigua* in *Santo Domingo* has been implemented by the *Centro de Orientación y Investigación Integral (COIN)* since 1991. During 1995 to 1996, a network of peer educators reached approximately 67,500 industrial zone workers inside the industries with HIV/AIDS messages. They distributed 122,690 condoms in posts located inside the participating industries and 31,235 educational materials. A strategy to integrate gate-

keepers including industry managers and labor union leaders into the project was also implemented.

During 1997 educational activities within the workplace will continue through the network of health messengers (HMs). However, major efforts will be concentrated on developing a marketing strategy that will make this program sustainable. This strategy will include charging a "fee for service" to install prevention programs for the private sector. Target audiences and gatekeepers will be involved in designing the strategy.

Young Adults

From 1994 to 1996, the *Coordinadora de Animación Socio-Cultural (CASCO)* and the *Instituto Dominicano de Desarrollo Integral (IDDI)* implemented the *Acuario Project*. This was an HIV/AIDS educational intervention project targeting 13- to 24-year-olds in four marginal suberved areas in *Santo Domingo: Villa Mella and Guaricano, La Zurza and Herrera*.

These young people were reached in their own environment (school, home and extra-curricular activities). Interventions incorporated skill building, risk assessment and other behavior change promoting techniques.

The project also targeted the environment, promoting parental/teacher involvement and support for STI and HIV/AIDS youth programs. Teachers were trained in adolescent sexuality and STI/HIV/AIDS in order to convey appropriate messages

to their students. CBOs also participated actively in all HIV/AIDS prevention community events.

The project developed several innovative educational materials for youth and was also able to initiate gender-specific interventions.

From 1995 to 1996, a total of 3,269 people were trained and 76,780 educated through this project. Likewise, over 100,000 condoms (United Nations Population Fund donated) and 47,120 materials were distributed. Although the *Acuario Project* ended, *CASCO/IDDI* will continue conducting STI/HIV/AIDS activities with youth.

Commercial Sex Workers (CSWs)

The *Avancemos* project targets CSWs, their clients and brothel/bar owners. This project is implemented by *COIN* in *Santo Domingo, La Romana, Santiago and San Cristobal*. It is also implemented by *COVICOSIDA* in *Puerto Plata*.

CSWs are reached through a network of HMs who deliver educational messages through interpersonal communication in brothels and bars. Clients of CSWs, male brothel/bar owners and staff are reached through theater

presentations, educational sessions and workshops conducted by educators. Project educators and the network of HMs also promote health-seeking behaviors and STI services, stress the importance of early diagnosis and treatment of STIs, and distribute condoms and educational materials during their interventions.

From 1995 to 1996 1,172 people were trained and approximately 67,824 reached with educational messages through the *COIN* project. The HM network distributed 528,400 condoms and 60,378 educational materials to the target audience.

During this same period *COVICOSIDA* trained 563 target audience members and reached 19,553 people with educational messages in *Puerto Plata*. They also distributed 137,911 condoms and 31,232 educational materials during project activities.

In 1997, both *COIN* and *COVICOSIDA* will be involved in the development and implementation of a marketing strategy to make these projects sustainable. The strategy will include charging a "fee for service" to business owners. Target audience and gatekeepers will be involved in designing the strategy.

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Men Who Have Sex With Men (MWMs)

ASA has been implementing STI/HIV/AIDS prevention interventions among the MWM community since 1991. MWMs are targeted in the cities of Santo Domingo and Puerto Plata. A network comprised of HM leaders and volunteers conducts outreach, home visits and mini-workshops with this target audience.

During 1995 to 1996, the project reached 26,116 men who have sex with men (MWM) through outreach. During these activities 247,799 condoms and 17,740 educational materials were distributed. These data are a compilation from October 1994 to September 1995.

Through these interventions, ASA has contributed to slowing the spread of HIV/AIDS among MWM. According to epidemiological data released in 1993 by the national AIDS control program (PROCETS), the HIV seroprevalence rate among this group was estimated at 15 percent. A study conducted in 1994 indicated that this rate was about 11 percent.

The project has been successful in raising awareness among the MWM community and educating them about HIV/AIDS. However, a study revealed that more work had to be done to address basic issues that underlie risk taking, such as low self-esteem and anonymity. Thus, during 1997 ASA will develop and implement a new educational

strategy which has proven successful in other countries. It consists of improving MWM's self-esteem and identity through support groups. A methodological manual based on this strategy will be developed by ASA.

Behavior Change Communication (BCC)

USAID has played a very active role in providing support to local counterparts in developing and implementing new BCC strategies.

In coordination with the National AIDS Control Program (NACP), support was provided to governmental and nongovernmental organizations working with adolescents in developing a national AIDS prevention strategy/campaign for adolescents. This was the direct result of priorities established within the National IEC strategy for AIDS prevention also developed with USAID support. USAID played a leading technical role not only in the development of the strategy but in the production and launching of the campaign itself.

Through the AIDSCAP Project, ample support and collaboration have been obtained from the private sector mass media. More than 5 million dollars in free air time has been leveraged.

The campaign has obtained great recognition in and out of the country. Recently it won first place as the best educational effort for adolescents in the Second Seminar on Communication and Sexual/Reproductive Health of Adolescents in Latin America and the Caribbean.

AIDS Hotline

In 1996, USAID supported the inclusion of STI and HIV/AIDS information services into an existing national hotline operated by the NGO INDESUI. USAID provided technical assistance, equipment and training.

Support and guidance was also provided to INDESUI in establishing an interinstitutional collaboration agreement with PUCAMAIMA University. This university designed and installed the computerized information program and has pledged to provide continuous computer training to hotline volunteers.

This hotline provides callers from any site in the country with updated information on HIV/STI/AIDS and AIDS services providers. The hotline service complements the youth mass media campaign, since all campaign materials advertise the hotline telephone number.

Condoms

In 1995, USAID defined a strategy to ensure condom availability/accessibility for successful AIDS prevention. Based on this strategy, a joint partnership was negotiated and developed between NGOs and the private sector to increase condom distribution nationwide. This was accomplished with AIDSCAP and John Snow Incorporated's overview and logistics system coordination.

The partnership with the private sector is a unique, first-time endeavor to ensure access to good quality, low-

priced condoms to the entire population through a self-sustainable project. It also complies with USAID/DR's strategy of leveraging the private sector's support for AIDS prevention efforts. USAID/DR was instrumental in fostering this partnership and providing the technical support to initiate this venture. Condoms being distributed were donated by USAID and are being marketed under the brand name "Pantera."

Overcoming barriers to condom sales through non-traditional outlets has been a continuous and difficult process. Great efforts have been made to strengthen the CBD program for the Pantera Condom. A promotional plan and promotional materials were produced and delivered to the NGOs, and technical assistance and training in sales and marketing have also been provided.

STIs

During 1995 a training program was implemented to increase access to and improve the quality of STI services nationwide. The program involved the algorithmic approach to STI treatment. It targeted clinicians, lab technicians and health promoters serving the target audiences reached by the NGOs supported by USAID. This training program was implemented by a local university (INTEC) in conjunction with the STI department of the Dermatologic Institute (DETS).

The overall goal and objectives of the training program were completed in a timely and effective manner. 513

promoters, 325 clinicians and 16 bioanalysts were trained nationwide. Its success is attributed to a number of factors: high level of professionalism among instructors, technical and financial support from USAID/DR, and efficiency and commitment from the implementing agencies.

The program has received widespread recognition during presentations at regional and international conferences in Chile and Vancouver. This interest has been sparked because of its effectiveness and innovation. It was a comprehensive program, combining human sexuality, syndromic management, "four C's" (counseling for risk assessment, condom use, contact tracing, compliance with treatment), and training of trainers, all in one. It was also the first STI syndromic management course designed in Spanish. It had full participation from course attendees in the development and validation of the instruction manuals.

USAID has also contributed to the development of an STI referral services guide. The guide contains a list of clinicians and nonclinicians who participated in the CETS/INTEC STI Algorithm training program. It also includes other noted health professionals working with AIDS. The guide will be distributed nationwide and will be added to the AIDS hotline referral section of the computer database.

GUATEMALA

Situation Analysis

AIDS was first reported in Guatemala in 1984. Through June 1997, 1959 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. Current HIV seroprevalence data is insufficient to characterize the epidemic, however, a major multisectoral effort is underway to establish a national sentinel surveillance system.

Sexual transmission of HIV is thought to account for approximately 90 percent of all HIV/AIDS cases reported to date. There is insufficient behavioral data to distinguish between the heterosexual, homosexual and bisexual components of this transmission. Transmission through blood products has accounted for 3.5 percent and mother-to-infant transmission for 2.6 percent. The male-female ratio is narrowing and is now reported to be 3:1. Most of the AIDS cases are in people aged 20 to 39.

HIV/AIDS prevention projects are being implemented by the public and private sectors, NGOs, international PVOs and donor organizations in Guatemala. Guatemala has formed a Multisectoral Network of Agencies working in HIV/AIDS Prevention, which has been effective in coordinating the activities of disparate groups.

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 included 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 continues to provide condoms to the sexually active populations and most vulnerable groups through its implementing agencies: the Ministry of Health's (MOH's) Reproductive Health Unit, the MOH's National AIDS Control Program, the Social Security System, Asociación Pro-Bienestar de la Familia (APROFAM), and Importadora de Productos Farmacéuticos, S.A. (IPROFASA). The Mission is currently sponsoring the reproduction and dissemination of *El Peligro Oculto* (The Hidden Danger), a book on the impact of AIDS on women in the region. The Mission also actively participates in the UNAIDS Expanded Country Team Group promoting intersec-

toral collaboration in AIDS programming, policy dialogue, information dissemination and public awareness.

HAITI

Situation Analysis

Haiti has long been the poorest country and the one with the worst health status indicators, including the highest HIV seroprevalence rate, in the Western Hemisphere. Continuing economic and social instability and high-risk sexual practices have led to particularly high HIV rates among certain Haitian populations. Although during the pandemic's early years more men were infected than women, the ratio has long since equalized. Seroprevalence among pregnant women recently tested as high as 16 percent in one sentinel surveillance site, and more than 50 percent of commercial sex workers (CSWs) tested in Haiti are infected with HIV. Although AIDS awareness in Haiti is high, adoption of low-risk behaviors is slow.

REPORTED AIDS CASES:* 4,967

DATE OF LAST REPORT: 1993

INCREASE OVER 1993:** Not available

KEY

* 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.

TOTAL POPULATION: 7.8 million

CUMULATIVE INCIDENCE: Not available

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** 21.4 to 50+%

Population at low risk: 4% to 13%

USAID Strategy

For years USAID/Haiti was confined to working exclusively with NGOs, and it focused most of its resources on vertical sectors, including STI/HIV/AIDS. In 1995, however, after the return of constitutional government, the Mission developed an integrated health program, the Health Systems 2004 Project, to increase the efficiency and effectiveness of its assistance to NGOs and to provide assistance to the public health sector. Presently this project supports STI/HIV/AIDS activities through provision of a package of basic health services to approximately 2.5 million persons at the community health level and of condoms through national distribution channels and condom social marketing, as well as specialized training in HIV/AIDS counseling and STI treatment for selected personnel. USAID/Haiti also supplied major assistance to the Ministry of Health and Population in the development of its Strategic Five-Year Plan for STI/HIV/AIDS. Several NGOs previously supported under the Mission's AIDSCAP program have received funding from the

Dutch government, United Nations Population Fund and the World Bank to continue their work.

USAID-Supported Country Programs 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 HIV infection rates of eight percent among adults in Port-au-Prince and 33 percent among STI patients. Through its HS 2004 Project, 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 for coordinating counseling activities with other health service agencies has been established.

Condom Social Marketing

With assistance from USAID through its HS 2004 Project, Population Services International (PSI) implements a highly successful 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 its introduction in 1992; more than 32 million condoms have been sold. PSI also recently implemented a pilot project to introduce female condoms and sold over 12,000 in less than a year.

JAMAICA

Situation Analysis

Sexual transmission remains the most prevalent mode of HIV infection in Jamaica. To date, the number of AIDS cases in Jamaica has been relatively low for the Caribbean, but HIV seroprevalence is increasing. The high incidence of other STIs, certain types of drug use, and the limited resources of the public health care system could 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 HIV/AIDS/STI. It is commonly acknowledged in Jamaica that only one in ten HIV/AIDS cases is officially detected and reported. Part of the problem is that HIV-infected persons are not commonly identified, but merely a small percentage who actually have AIDS.

REPORTED AIDS CASES:* 2,060 (50 percent of the cases occurred in the past two years).

DATE OF LAST REPORT: 12/96

INCREASE OVER 1994 REPORT:** over 100%

TOTAL POPULATION: 2.5 million

CUMULATIVE INCIDENCE:*** 824 per million

HIV-1 SEROPREVALENCE IN URBAN AREAS:

Population at high risk:**** Homosexuals 356.6/1,000

Commercial sex workers 125.8/1,000

STI clinic attendees 59/1,000

Antenatal clinic attendees 5/1,000

Population at low risk:

Food handlers 12/1,000

Blood donors 08/1,000

USAID Strategy

USAID's strategy to control STIs and HIV/AIDS encompasses educational activities, applied operations research and improved STI diagnosis and treatment at the Ministry of Health (MOH) facilities. The original AIDS/STD Project was expected to end in August 1997. However, AIDSCAP Project bought into the original project, providing assistance to the MOH Epidemiology Unit through grants to the unit and to NGOs for various STI/HIV/AIDS activities between 1993 to 1996. On September 29, 1996, the USAID Mission in Jamaica formally extended the AIDS/STD Project through August 31, 2001.

The initial USAID project focused on training contact investigators (CIs) and employing them for two years prior to their employment by the Government of Jamaica. The impact of the 25 CIs trained to date is clearly seen, as the annual total cases of reported infectious syphilis fall.

The AIDSCAP Subagreements targeted different facets of the program. The main areas involved behavior change communication (BCC) and strengthened STI case management, which includes partner notification and contact tracing. Under the project extension, work will continue in these two

areas and will increase in a third area—condom promotion and access.

The BCC component requires the integration and coordination of the STI/HIV/AIDS program with other social agencies and community projects. Its implementation involves a series of comprehensive activities aimed at reducing transmission of STI/HIV/AIDS and promoting healthy lifestyles. Communication with target audiences will continue to take place through several different formal and informal channels. These channels include: print material, mass media, public relations, cultural events, the Face-to-Face Program, social networks, special events and targeted interventions.

BCC Strategy

The communications team within the Epidemiology Unit was responsible for the development of the behavior change communication strategy, as well as overseeing the development and distribution of materials with consistent messages within all subprojects. The team also coordinates mass media campaigns and production of small media and the training of National AIDS Committee (NAC) member organizations.

Project achievements include the production and distribution of at least 414,746 materials distributed to target groups; a 30-minute community drama video; a 30-minute video on targeted community intervention;

three STI radio public service announcements (PSAs); two television PSAs by popular DJs and local artists on condom use; and, a 30-second HELPLINE promotional jingle. In addition, 25 percent of the NAC members were trained in BCC skills, two interviews were conducted with HIV-positive persons on local radio, and two HIV/STI musical radio shows were conducted with 20,000 young people in Western Jamaica.

Jamaica AIDS Support (JAS)

Jamaica AIDS Support (JAS), an NGO, worked 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 combined the use of educational outreach activities, informal presentations and in-depth, long-term interpersonal sessions for groups of MWM. JAS' innovative approaches include "parties" featuring safer sex skits, discussions, information booths and educational materials. MWM have been reached through counseling networks in Kingston and the tourist resorts of Ocho Rios and Montego Bay. JAS also targeted the general public with outreach activities that include education workshops for police, church members and youths. JAS also targeted persons with AIDS (PWA), facilitating home and hospice care.

AIDS in the Workplace

The AIDS in the Workplace Program of the Epidemiology Unit worked with private organizations to develop sustainable, self-

funded workplace HIV/AIDS education programs and nondiscriminatory policies to protect HIV-infected employees. Major companies (1,000 or more employees) were targeted to develop workplace programs. In-house coordinators were trained to provide workers with regular HIV/AIDS and STI information and education. At the end of the program more than 54 chief executive officers and 118 in-house coordinators had been trained, and 3,943 employees had been educated.

Targeted Community Intervention

This project targeted five marginal communities in the Kingston metropolitan area, with group education on STIs, HIV and AIDS; sessions on personal risk assessment; correct condom use; condom negotiating skills; 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 were used to draw an audience for the educational messages and behavioral interventions. Anonymous, aggregate results of HIV/STI testing were later

shared with the community through drama and individual counseling. The project output included 12,551 persons educated, 8,322 pieces of material distributed and 34 condom outlets established.

Public Relations HIV/AIDS Risk Reduction Project

Working through trained youth opinion leaders, this project educated young adults about HIV/AIDS. It also created awareness among national opinion leaders by increasing their knowledge of the national vulnerability and possible consequences of an STI/HIV/AIDS epidemic in Jamaica. To support the efforts of the National HIV/STD Control Program, achievements included placement of 421 newspaper articles, 64 radio and TV programs, and distribution of information packets to journalists. The campaign was also instrumental in attaining extensive media coverage for World AIDS Day.

Association for the Control of Sexually Transmitted Diseases (ACOSTRAD)

This project strengthened ACOSTRAD's capacity to carry out comprehensive STI/HIV/AIDS prevention outreach, targeting marginalized groups, commercial sex workers (CSWs) and STI

KEY

* 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.

clinic attendees in Kingston. Over 20 community members were trained to conduct outreach work with marginalized groups, motivating them to seek treatment for STIs and adopt safer sex practices. CSWs were trained as peer educators encouraging CSWs and bar and club owners to attend a weekly drop-in center where AIDS prevention activities and exercises were conducted. STI clinic attendees were reached through 17 trained peer counselors, who conducted group education sessions in clinic waiting areas. STI patients received free condoms and were encouraged to purchase additional supplies at locally identified vendors. The project successfully reached over 74,000 women and 47,000 men. In addition, over 600,000 condoms and over 166,828 educational materials from a national program were distributed and subsequently 60,000 new materials were distributed.

Face-to-Face Program

The Face-to-Face Programs of the Epidemiology Unit targeted adolescents, sexually active adults, young adults with multiple sex partners and persons with STIs. Face-to-Face identified key young adults in study, work and leisure organizations to participate as community and peer educators. The Face-to-Face team members included classroom teachers, health workers, workplace peer educators, and youth and com-

munity group leaders. These persons were trained by Face-to-Face to reach their peers with sustained STI and HIV/AIDS prevention programs. This island-wide network of trained team members held small, informal interactive "rap" sessions with groups of young adults in their communities, focusing on STI/HIV/AIDS information, personal risk perception and skills building.

Counseling and Social Welfare

The Counseling and Social Welfare Program of the Epidemiology Unit increased the effectiveness and utilization of support services provided by both governmental and nongovernmental agencies for people with HIV/AIDS. Forty social service agencies became part of the referral network; by the end of the project, over 1,072 volunteers and health care personnel were trained in counseling and support services, and 6,525 pamphlets on living with HIV/AIDS were distributed to social welfare agencies and health care workers as part of the regional network. The Counseling and Social Welfare Program was also responsible for the STD/AIDS Helpline, which continues to function with support from the USAID project extension.

Island-wide HIV/STD Prevention Program in Jamaica

This project, implemented by the American National Red Cross in conjunction with the Jamaica Red Cross, provided a national training system to

support peer educators for youths across the island. Fifty-three instructor trainers and 477 peer educators were trained. Under this project, the peer educators educated thousands of young people about HIV and STI prevention, promoting the correct use of condoms and referring participants to appropriate centers for HIV/STI testing, counseling and treatment. To reinforce the messages of the peer educators, the project broadcast a radio drama to over 60,000 listeners on STI/HIV prevention issues faced by young people and adults. During the project, an instructor training manual was developed and over 50 copies were distributed. Additionally, 500 peer educators' manuals, 5,000 activity kit booklets and 500 sets of posters were developed and distributed.

NICARAGUA

Situation Analysis

The first HIV and AIDS cases in Nicaragua were diagnosed in 1987. Each year, the number of HIV infections has increased in each of the country's 17 departments, though the majority of reported HIV infections—53 percent—are in Managua, the country's capital. 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.

According to PAHO/WHO data, for every case of AIDS diagnosed, it is estimated that there are four cases of AIDS and 21 persons infected with HIV.

The Ministry of Health estimates that the prevalence of HIV infection is anywhere between 260 and 790 per 100,000 inhabitants, and that Nicaragua is expected to have more than 24,600 persons infected with HIV by the year 2000.

Currently, the breakdown of AIDS cases by geographic zone in Nicaragua is: Pacific zone, 77 percent; North and Central zone, 17 percent; and, Atlantic zone, 5.7 percent.

The ratio of male-to-female infection is approximately 7:1, and the largest number of infections is among those ages 15 to 35. Among women, most HIV infections occur within the 15- to 24-year-old age group. Sexual transmission is the primary means of HIV infection, accounting for almost 93 percent of HIV transmission. Within this mode, heterosexual transmission accounts for over 53 percent of all cases, and homosexual and bisexual transmission account for 39 percent. Transmission through injection drug use accounts for almost six percent of all cases. Since December 1995, one out of three infants reported as "probably infected" has died. It is expected that there will be an increase in the number of women and children infected with HIV.

The Syphilis and HIV/AIDS Seroprevalence Study revealed that condom use varies among high-risk groups. Female sex workers who reported using condoms consistently had clientele that paid more per service, more often examined their clients before sex, engaged in less sex during menstruation, engaged in less anal sex, and had a client with an STI less often. Among men who have sex with men, men identifying themselves as heterosexual or bisexual tended to use condoms less often with women, male receptive and regular partners, and/or when giving or receiving money for sex. They used the condom more often with the last insertive partner.

A qualitative study carried out by the NGO Fundación Nimehautzin, *Sexo Inseguro*, revealed that the level of knowledge about HIV/AIDS varied among female sex workers: In general, they demonstrated a great awareness of AIDS and how it

is transmitted, while they expressed confusion about the nature of HIV and its mode of transmission.

REPORTED AIDS CASES: 164

DATE OF LAST REPORT: 9/97

TOTAL POPULATION: 4,409,465

HIV SEROPREVALENCE IN URBAN AREAS:

Commercial sex workers:
0.7%

Men who have sex with men:
2%

USAID Strategy

USAID's response has been multifaceted, consisting of the following activities:

- Providing condoms to the HIV/AIDS Prevention and Control Program of the Ministry of Health
- Providing condoms to NGOs through the International Planned Parenthood affiliate, Profamilia
- Providing technical assistance to NGOs in the area of institutional strengthening (strategic planning, management and adolescent coun-

seling workshops) through the Development Training Project

- Implementing a nationwide information, education and communication campaign through a subagreement with Johns Hopkins University
- Providing technical assistance in the areas of institutional training, advocacy and social marketing through the Regional Project (PASCA).

USAID has also assisted in obtaining resources to support an assessment of HIV/AIDS in Nicaragua. Findings from a socioeconomic study, *Informe Final Sobre Impacto del VIH-SIDA en Nicaragua en el Año 2000*, and a recently completed

behavioral research study, *Prevalence of HIV and Syphilis among Female Sex Workers and Men who have Sex with Men in Nicaragua*, are being used to develop a behavioral change and communication strategy. The findings of the two studies, along with a behavioral study financed by AIDSCAP, *Sexo Inseguro*, will update policymakers on the current and impending HIV/AIDS situation in Nicaragua and provide a framework with 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.

KEY

- * 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 Newly Independent States (NIS) and Eastern Europe

The incidence of HIV/AIDS in the former Soviet Union and Eastern Europe is relatively low compared to other regions. Previously, the closed borders and tight control on social freedoms maintained by the Communist governments of the region during the Soviet era helped keep the epidemic at bay through most of the 1980s. The first case of HIV in the Soviet Union was not documented until 1987, in a sailor returning from Africa, and in Russia and Ukraine the number of reported infections did not exceed 100 annually per country until the mid-1990s. However, the fall of communism in the region brought with it more open borders and less restrictions on society, and the rates of HIV incidence in the NIS climbed steadily until 1996, when rates began to soar dramatically. In 1996, 1,535 cases of new HIV infections were reported in Russia, more than the cumulative number of HIV infections reported from 1987 to 1995.

The causes of HIV infection appear to vary between Eastern Europe and the NIS. In the early years of the epidemic, male-to-male sex was the primary mode of transmission in both. Up to December 1994, in 53 percent of the HIV/AIDS cases reported among adult males in Russia, the primary mode of transmission was male-to-male sex in. Male-to-male sex is still the primary mode of transmission in most of Eastern Europe, including the Baltic states.

In the NIS, the primary mode of transmission appears to have shifted recently. Beginning in 1996, the rate of infection among injecting drug users (IDUs) skyrocketed, and IDUs now account for almost half of the known HIV infections in Russia. In 1996, the year that HIV rates increased most dramatically (reported cases of infection increased more than eightfold that year over reported cases for 1995), 62 percent of the new cases were IDUs. In the first five months of 1997, the overall rate of infection increased 22 percent, and the number of IDUs infected nearly doubled over the previous year. Last year in Ukraine, more than 3,000 drug users were reported to be infected with HIV.

The epicenter of the epidemic among IDUs in the NIS appears to be the Black Sea area, which is also a gateway for illegal drugs into the region. Ukraine recently reported an increase of infected IDUs in cities bordering

the Black Sea. In Russia, the city of Sochi is a conduit into the country for liquid opium produced in Turkey and Bulgaria. For the first four months of 1997, Krasnodar Kray, located on the shores of the Black Sea, ranked second in Russia among regions for prevalence of HIV-I infection.

Although the number of HIV-infected individuals in the region is currently substantially less than in Africa or Asia, social circumstances make HIV/AIDS an emerging threat in the NIS. The region is plagued by failing economies, high unemployment, and crumbling, antiquated, Soviet-style health care systems. The governments do not have the revenue needed to continue the state-subsidized health care that was in place under the Soviet Union, nor do they have the funds to restructure and modernize the system. High rates of unemployment and a backlog of wage arrears in many industrial sectors results in the inability of citizens to afford health care, especially the prohibitively high costs of HIV/AIDS treatment. Lack of access and availability of condoms, the previous use of fear campaigns in dealing with HIV/AIDS, the persistence of the Soviet mentality that the State should or will continue to provide free health care to citizens, and the continuation of the Soviet myth that HIV/AIDS and its primary modes of transmission are "Western" social problems that do not occur in the NIS, are all social factors that also create difficulty in mitigating the epidemic.

The NIS and Eastern Europe are still in the early stages of the epidemic, but already demonstrate alarming signs of following the same path as Asia. HIV rates among IDUs are increasing at explosive rates, with no end in sight. The next group to be affected will likely be the commercial sex worker population, which has boomed in recent years due to high unemployment and a stagnating economy. From there the disease will likely spread to all parts of the population and all parts of the region. The NIS region has an opportunity to slow the epidemic before it reaches the proportions of other regions. However, without intervention, circumstances point to the likelihood that Eastern Europe and the NIS region will follow the rest of the world in succumbing to the pandemic.

USAID FY 1995 HIV/AIDS OBLIGATIONS BY COUNTRY

Country	DEVELOPMENT ASSISTANCE		DEVELOPMENT FUND FOR AFRICA		ECONOMIC SUPPORT FUNDS	SPECIAL ASSISTANCE INITIATIVE	NEW INDEP STATES	POP ACCOUNT	FY 95 COUNTRY TOTAL
	Mission Core Funds	FS Funds	Mission Core Funds	FS Funds	Mission Core Funds	Mission Core Funds	Mission Core Funds		TOTAL FUNDS
AFRICA REGION									
Africa Regional	30,000	263,000	1,426,000	--	--	--	--	--	1,719,000
Benin	--	--	--	--	--	--	--	19,882	19,882
Burkina Faso	--	--	--	--	--	--	--	348,527	348,527
Burundi	--	--	--	--	--	--	--	90,030	90,030
Botswana	--	--	1,324,000	--	--	--	--	--	1,324,000
Cameroon	--	--	--	--	--	--	--	582,120	582,120
Central African Rep.	--	--	453,000	--	--	--	--	311,819	764,819
Chad	--	--	--	--	--	--	--	17,839	17,839
Congo	--	--	--	--	--	--	--	3,655	3,655
Côte d'Ivoire	--	--	--	--	--	--	--	696,602	696,602
Ethiopia	--	750,000	6,396,000	--	--	--	--	1,626,336	8,772,336
Gambia	--	--	--	--	--	--	--	16,154	16,154
Ghana	--	--	695,000	--	--	--	--	1,055,571	1,750,571
Guinea	--	97,000	--	--	--	--	--	152,580	249,580
Guinea-Bissau	--	--	--	--	--	--	--	6,375	6,375
Kenya	--	--	119,000	750,000	--	--	--	3,918,183	4,787,183
Lesotho	--	--	--	--	--	--	--	19,361	19,361
Madagascar	--	--	--	--	--	--	--	188,219	188,219
Malawi	--	--	2,645,000	--	--	--	--	1,314,359	3,959,359
Mali	--	--	1,273,000	--	--	--	--	397,631	1,670,631
Mauritania	--	--	--	--	--	--	--	16,338	16,338
Mozambique	--	--	1,525,000	--	--	--	--	290,860	1,815,860
Niger	--	100,000	--	--	--	--	--	245,910	345,910
Nigeria	--	--	174,000	200,000	--	--	--	6,111,109	6,485,109
REDSO/EA	--	198,000	--	--	--	--	--	--	198,000
REDSO/WA	--	--	4,058,000	--	--	--	--	--	4,058,000
Sahel Regional	--	--	65,000	--	--	--	--	--	65,000
Senegal	--	88,000	433,000	750,000	--	--	--	352,028	1,623,028
Sierre Leone	--	--	--	--	--	--	--	42,119	42,119
Somalia	--	--	--	--	--	--	--	41,333	41,333
South Africa	--	--	4,128,000	--	--	--	--	--	4,128,000
Swaziland	--	--	105,000	--	--	--	--	--	105,000
Tanzania	--	450,000	1,925,000	300,000	--	--	--	737,474	3,412,474
Togo	--	--	--	--	--	--	--	451,299	451,299
Uganda	--	--	918,000	--	--	--	--	1,263,248	2,181,248
Zaire	--	--	--	--	--	--	--	11,922	11,922
Zambia	--	--	1,851,000	--	--	--	--	939,461	2,790,461
Zimbabwe	--	--	974,000	--	--	--	--	--	974,000
Africa Regional Total	30,000	1,946,000	30,487,000	2,000,000	--	--	--	21,268,344	55,731,344

Note: The grand total includes 1995 Population Account funding for contraceptive procurement of \$31,197,882.

Source: USAID Activity Code/Special Interest System 10/16/96 and USAID Worldwide Database.

USAID FY 1995 HIV/AIDS OBLIGATIONS BY COUNTRY

Country	DEVELOPMENT ASSISTANCE		DEVELOPMENT FUND FOR AFRICA		ECONOMIC SUPPORT FUNDS	SPECIAL ASSISTANCE INITIATIVE	NEW INDEP STATES	POP ACCOUNT	FY 95 COUNTRY TOTAL
	Mission Core Funds	FS Funds	Mission Core Funds	FS Funds	Mission Core Funds	Mission Core Funds	Mission Core Funds		TOTAL FUNDS
ANE REGION									
ANE Regional	—	1,060,000	—	—	—	—	—	—	1,060,000
Bangladesh	—	—	—	—	—	—	—	452,523	452,523
Cambodia	—	—	—	—	2,018,000	—	—	31,074	2,049,074
Egypt	—	—	—	—	—	—	—	197,453	197,453
Fiji	—	—	—	—	—	—	—	3,155	3,155
India	255,000	300,000	—	—	—	—	—	—	555,000
Indonesia	3,542,000	300,000	—	—	—	—	—	—	3,842,000
Jordan	—	—	—	—	—	—	—	6,561	6,561
Morocco	—	—	—	—	—	—	—	276,769	276,769
Nepal	10,000	100,000	—	—	—	—	—	1,771,560	1,881,560
Oman	—	—	—	—	—	—	—	24,448	24,448
Philippines	2,540,000	300,000	—	—	—	—	—	727,268	3,567,268
Sri Lanka	—	—	—	—	—	—	—	66,280	66,280
West Bank/Gaza	—	—	—	—	—	—	—	1,777	1,777
ANE Regional Total	6,347,000	2,060,000	—	—	2,018,000	—	—	3,558,868	13,983,868
ENI/NIS REGION									
Russia	—	—	—	—	—	—	—	171,764	171,764
Turkey	—	—	—	—	—	—	—	1,262,235	1,262,235
ENI/NIS Regional Total	—	—	—	—	—	—	—	1,433,999	1,433,999
LAC REGION									
Antigua	—	—	—	—	—	—	—	1,412	1,412
Aruba	—	—	—	—	—	—	—	4,000	4,000
Bahamas	—	—	—	—	—	—	—	650	650
Barbados	—	—	—	—	—	—	—	1,681	1,681
Belize	—	—	—	—	—	—	—	2,352	2,352
Bolivia	842,000	—	—	—	—	—	—	203,940	1,045,940
Brazil	—	1,000,000	—	—	—	—	—	608,680	1,608,680
Chile	—	—	—	—	—	—	—	13,257	13,257
Colombia	—	—	—	—	—	—	—	50,699	50,699
Curacao	—	—	—	—	—	—	—	2,956	2,956
Dominica	—	—	—	—	—	—	—	3,312	3,312
Dominican Republic	1,062,000	750,000	—	—	—	—	—	464,899	2,276,899
Ecuador	—	—	—	—	—	—	—	213,161	213,161
El Salvador	—	—	—	—	—	—	—	332,981	332,981

Note: The grand total includes 1995 Population Account funding for contraceptive procurement of \$31,197,882.

Source: USAID Activity Code/Special Interest System 10/16/96 and USAID Worldwide Database.

**USAID FY 1995
HIV/AIDS OBLIGATIONS BY COUNTRY**

Country	DEVELOPMENT ASSISTANCE		DEVELOPMENT FUND FOR AFRICA		ECONOMIC SUPPORT FUNDS	SPECIAL ASSISTANCE INITIATIVE	NEW INDEP STATES	POP ACCOUNT	FY 95 COUNTRY TOTAL
	Mission Core Funds	FS Funds	Mission Core Funds	FS Funds	Mission Core Funds	Mission Core Funds	Mission Core Funds		TOTAL FUNDS
Guatemala	—	—	—	—	—	—	—	335,731	335,731
Guyana	—	—	—	—	—	—	—	39,373	39,373
Haiti	2,515,000	1,000,000	—	—	384,000	—	—	150,086	4,049,086
Honduras	150,000	600,000	—	—	—	—	—	417,147	1,167,147
Jamaica	965,000	875,000	—	—	—	—	—	86,885	1,926,885
Mexico	—	100,000	—	—	—	—	—	565,961	665,961
Montserrat	—	—	—	—	—	—	—	348	348
Nicaragua	113,000	25,600	—	—	—	—	—	418,815	557,415
Panama	—	—	—	—	—	—	—	28,385	28,385
Peru	—	—	—	—	—	—	—	638,426	638,426
ROCAP	2,000,000	—	—	—	—	—	—	—	2,000,000
Suriname	—	—	—	—	—	—	—	74,593	74,593
Trinidad & Tobago	—	—	—	—	—	—	—	46,633	46,633
LAC Regional Total	7,647,000	4,350,600	—	—	384,000	—	—	4,706,363	17,087,963

WORLDWIDE

Interregional	—	—	—	—	—	—	—	329,705	329,705
PHNC	51,841,000	—	8,247,000	—	—	154,000	364,000	99,400	60,705,400
PPC	287,000	—	—	—	—	—	—	—	287,000
BHR	897,000	—	—	—	—	—	—	—	897,000
WIDC	1,261,000	—	13,000	—	—	39,000	39,000	—	1,352,000
AA/STC	73,000	—	1,000	—	70,000	—	—	—	144,000
Worldwide Total	54,359,000	—	8,261,000	—	70,000	193,000	403,000	429,105	63,715,105
GRAND TOTAL	68,383,000	8,356,600	38,748,000	2,000,000	2,472,000	193,000	403,000	31,297,279	151,852,879

Note: The grand total includes 1995 Population Account funding for contraceptive procurement of \$31,197,882.

Source: USAID Activity Code/Special Interest System 10/16/96 and USAID Worldwide Database.

USAID FY 1996 HIV/AIDS OBLIGATIONS BY COUNTRY

Country	DEVELOPMENT ASSISTANCE		DEVELOPMENT FUND FOR AFRICA		ECONOMIC SUPPORT FUNDS	SPECIAL ASSISTANCE INITIATIVE	NEW INDEP STATES	POP ACCOUNT	FY 96 COUNTRY TOTAL
	Mission Core Funds	FS Funds	Mission Core Funds	FS Funds	Mission Core Funds	Mission Core Funds	Mission Core Funds		TOTAL FUNDS
AFRICA REGION									
Africa Regional	1,995,000	550,000	-	-	-	-	-	-	2,545,000
Benin	772,000	-	-	-	-	-	-	231,014	1,003,014
Cameroon	-	-	-	-	-	-	-	764,771	764,771
Central African Rep.	-	-	120,000	-	-	-	-	102,565	222,565
Chad	-	-	-	-	-	-	-	3,193	3,193
Côte d'Ivoire	-	-	-	-	-	-	-	744,686	744,686
Eritrea	288,000	-	-	-	-	-	-	140,062	428,062
Ethiopia	2,813,000	-	-	-	-	-	-	1,100,793	3,913,793
Ghana	1,645,000	-	-	-	-	-	-	623,667	2,268,667
Guinea	1,504,000	-	-	-	-	-	-	179,060	1,683,060
Guinea-Bissau	-	-	-	-	-	-	-	10,117	10,117
Kenya	1,206,000	1,501,000	-	-	-	-	-	-	2,707,000
Lesotho	-	-	-	-	-	-	-	19,164	19,164
Madagascar	-	-	-	-	-	-	-	220,534	220,534
Malawi	5,687,000	-	-	-	-	-	-	412,852	6,099,852
Mali	-	-	2,028,000	-	-	-	-	333,317	2,361,317
Mauritania	-	-	-	-	-	-	-	17,288	17,288
Mozambique	2,251,000	500,000	-	-	-	-	-	259,549	3,010,549
Niger	136,000	100,000	-	-	-	-	-	123,799	359,799
Nigeria	90,000	910,000	-	-	-	-	-	1,187,014	2,187,014
Rwanda	-	-	1,994,000	-	-	-	-	259,455	2,253,455
REDSO/EA	138,000	-	-	-	-	-	-	138,000	-
REDSO/WA	2,030,000	670,000	-	-	-	-	-	-	2,700,000
Sahel Regional	-	-	61,000	-	-	-	-	61,000	-
Senegal	-	725,000	-	-	-	-	-	456,871	1,181,871
Sierra Leone	-	-	-	-	-	-	-	5,794	5,794
South Africa	4,028,000	-	-	-	-	-	-	-	4,028,000
Southern Africa Region	-	-	250,000	-	-	-	-	-	250,000
Tanzania	441,000	3,820,618	-	-	-	-	-	613,838	4,875,456
Togo	-	-	-	-	-	-	-	186,362	186,362
Uganda	4,943,000	-	-	-	-	-	-	701,069	5,644,069
Zambia	1,988,000	-	-	-	-	-	-	280,645	2,268,645
Zimbabwe	2,990,000	440,000	-	-	-	-	-	-	3,430,000
Africa Regional Total	34,945,000	9,216,618	4,453,000	-	-	-	-	8,977,479	57,592,097

ANE REGION

ANE Regional	4,500,000	-	-	-	-	-	-	-	4,500,000
Algeria	-	-	-	-	-	-	-	104,592	104,592
Bangladesh	-	-	-	-	-	-	-	1,327,361	1,327,361
Cambodia	-	-	-	-	1,025,000	-	-	44,878	1,069,878

Note: The grand total includes 1996 Population Account funding for contraceptive procurement of \$19,701,021.

Source: USAID Activity Code/Special Interest System 10/16/96 and USAID Worldwide Database and G/PHN/HN.

**USAID FY 1996
HIV/AIDS OBLIGATIONS BY COUNTRY**

Country	DEVELOPMENT ASSISTANCE		DEVELOPMENT FUND FOR AFRICA		ECONOMIC SUPPORT FUNDS	SPECIAL ASSISTANCE INITIATIVE	NEW INDEP STATES	POP ACCOUNT	FY 96 COUNTRY TOTAL
	Mission Core Funds	FS Funds	Mission Core Funds	FS Funds	Mission Core Funds	Mission Core Funds	Mission Core Funds		TOTAL FUNDS
Egypt	-	-	-	-	-	-	-	242,001	242,001
India	1,466,000	300,000	-	-	-	-	-	-	1,766,000
Indonesia	732,000	300,000	-	-	-	-	-	2,913	1,034,913
Jordan	-	-	-	-	-	-	-	24,788	24,788
Morocco	-	-	-	-	-	-	-	640,335	640,335
Nepal	-	699,990	-	-	-	-	-	1,729,961	2,429,951
Oman	-	-	-	-	-	-	-	7,981	7,981
Philippines	104,000	150,000	-	-	-	-	-	274,719	528,719
Solomon Islands	-	-	-	-	-	-	-	975	975
Sri Lanka	-	-	-	-	-	-	-	74,019	74,019
Tonga	-	-	-	-	-	-	-	644	644
Tunisia	-	-	-	-	-	-	-	2,466	2,466
Vanuatu	-	-	-	-	-	-	-	550	550
West Bank/Gaza	-	-	-	-	-	-	-	31,710	31,710
Western Samoa	-	-	-	-	-	-	-	490	490
ANE Regional Total	6,802,000	1,449,990	-	-	1,025,000	-	-	4,510,383	13,787,373

ENI/NIS REGIONAL

Czech Republic	-	-	-	-	-	-	-	1,137	1,137
Russia	-	-	-	-	-	-	-	18,231	18,231
Turkey	-	-	-	-	-	-	-	1,324,482	1,324,482
ENI/NIS Regional Total	-	-	-	-	-	-	-	1,343,850	1,324,482

LAC REGION

Aruba	-	-	-	-	-	-	-	4,354	4,354
Bahamas	-	-	-	-	-	-	-	1,069	1,069
Belize	-	-	-	-	-	-	-	1,426	1,426
Bolivia	726,000	-	-	-	-	-	-	305,661	1,031,661
Brazil	2,456,000	2,305,946	-	-	-	-	-	1,435,731	6,197,677
Colombia	-	-	-	-	-	-	-	57,557	57,557
Dominica	-	-	-	-	-	-	-	743	743
Dominican Republic	1,086,000	625,000	-	-	-	-	-	287,894	1,998,894
Ecuador	-	-	-	-	-	-	-	13,692	13,692
El Salvador	-	-	-	-	-	-	-	246,755	246,755
Grenada	-	-	-	-	-	-	-	796	796
Guatemala	-	-	-	-	-	-	-	373,865	373,865
Guyana	-	-	-	-	-	-	-	37,519	37,519

Note: The grand total includes 1996 Population Account funding for contraceptive procurement of \$19,701,021.

Source: USAID Activity Code/Special Interest System 10/16/96 and USAID Worldwide Database and G/PHN/HN.

**USAID FY 1996
HIV/AIDS OBLIGATIONS BY COUNTRY**

Country	DEVELOPMENT ASSISTANCE		DEVELOPMENT FUND FOR AFRICA		ECONOMIC SUPPORT FUNDS	SPECIAL ASSISTANCE INITIATIVE	NEW INDEP STATES	POP ACCOUNT	FY 96 COUNTRY TOTAL
	Mission Core Funds	FS Funds	Mission Core Funds	FS Funds	Mission Core Funds	Mission Core Funds	Mission Core Funds		TOTAL FUNDS
Haiti	90,000	—	—	—	191,000	—	—	—	281,000
Honduras	108,000	905,000	—	—	—	—	—	448,976	1,461,976
Jamaica	791,000	500,000	—	—	—	—	—	3,438	1,294,438
Mexico	4,000	—	—	—	—	—	—	384,154	388,154
Montserrat	—	—	—	—	—	—	—	385	385
Nicaragua	—	148,000	—	—	—	—	—	284,687	432,687
Panama	—	—	—	—	—	—	—	5,887	5,887
Paraguay	—	—	—	—	—	—	—	1,454	1,454
Peru	100,000	—	—	—	—	—	—	1,072,295	1,172,295
ROCAP	4,514,000	60,000	—	—	—	—	—	—	4,574,000
St. Kitts	—	—	—	—	—	—	—	971	971
LAC Regional Total	9,875,000	4,543,946	—	—	191,000	—	—	4,969,309	19,579,255
WORLDWIDE									
PHNC	44,090,446	—	—	—	—	—	—	—	44,090,446
PPC	251,000	—	—	—	—	—	—	—	251,000
BHR	862,000	—	—	—	—	—	—	—	862,000
WORLDWIDE Total	45,203,446	—	—	—	—	—	—	—	45,203,446
GRAND TOTAL	96,825,446	15,210,554	4,453,000	—	1,216,000	—	—	19,801,021	137,506,021

Note: The grand total includes 1996 Population Account funding for contraceptive procurement of \$19,701,021.

Source: USAID Activity Code/Special Interest System 10/16/96 and USAID Worldwide Database and G/PHN/HN.