



2004 USAID Summer Seminar Series

August 3: HIV/AIDS: Mitigating the Impacts on Development and Complex Emergencies

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Synopsis

The effects of the HIV/AIDS pandemic on public health are well-known: more than 40 million are currently infected with HIV, and approximately 29 million have already died of AIDS since the pandemic began. Every day, more than 8,200 die from this disease. As bad as these numbers are, HIV/AIDS is having an increasingly devastating impact on other development sectors as well. In countries where the pandemic is most advanced, HIV/AIDS is eroding human capital, degrading organizational capacity, fragmenting social and economic networks, and disrupting the transfer of knowledge and skills that are vital to socioeconomic performance and development. These changes produce a self-reinforcing downward spiral that becomes increasingly more difficult to arrest the longer it continues.

This session will start with a 20-minute presentation on “Mitigating the Impacts of HIV/AIDS on Development” by Richard Cornelius (Senior Policy Advisor for Health, PPC/P) on new policy guidance from PPC on programming to mitigate the development impacts of HIV/AIDS. The presentation will focus on the following issues:

- What is the rationale for supporting efforts to mitigate the development impacts of HIV/AIDS?
- What are the costs and benefits of cross-sectoral collaboration on mitigation programs?
- What are examples of best practices from the field?
- What are some of the practical funding and organizational considerations to consider?

The second part of the session will be a 20-minute presentation on the scope and nature of “HIV/AIDS and Complex Emergencies” by Peter Salama (HIV/AIDS Senior Advisor, Africa Bureau). The presentation will focus on the following issues:

- What is the scope and nature of the HIV/AIDS problem in complex emergencies?
- What are inter-agency recommendations to address the problem in complex emergencies?
- How is this problem being addressed?
- What can be done to improve our efforts, and what is the way forward?

Notes

Richard Cornelius, USAID/PPC

Cornelius set the stage for this Summer Seminar on HIV/AIDS by pointing out that 29 million have died of AIDS-related causes and 40 million people are currently infected. The world has mobilized political and financial energy to fight HIV/AIDS, coordinating multilateral and bilateral partners, especially in the health sector. The United States has pledged \$15 billion dollars over a five-year period under the President’s Emergency Plan for AIDS Relief (PEPFAR).

The Plan aims to treat up to two million people with antiretroviral (ARV) drugs, to prevent seven million new infections focusing on 15 key countries where the disease is most prevalent, and to provide care and support for 10 million individuals that are infected or affected by HIV/AIDS.

Cornelius heavily stressed that HIV/AIDS affects every sector of development. HIV/AIDS threatens to reverse development gains and destroy the fabric of societies in which it is prevalent. Diminished social and economic infrastructure in turn creates an environment where HIV/AIDS pandemic can flourish. On the economic front, HIV/AIDS generates a depletion of manpower, particularly in the most productive age groups.

Administrator Natsios has called for an Agency- and development-wide effort to combat the negative consequences of the epidemic. USAID’s Bureau for Policy and Program Coordination is drafting policy guidance that supports all sectors of missions in

mitigating the impacts of HIV/AIDS in high-prevalence countries, including facilitation of impact assessments in each sector as well as support for new information to aid in government decision-making.

The cumulative impact of HIV/AIDS aggravates old development problems in new ways with respect to educational and economical infrastructure due to teacher mortality and loss of labor. Agricultural production has decreased as a result of reductions in the amount of land being cultivated, often because women lose their land if their husband dies. HIV/AIDS also affects military capacity; and Cornelius noted that the military is also a critical “vector for infection” of civilian populations. The rapid spread of HIV/AIDS creates intense pressure on government investment in training and equipping of personnel. Human resource losses mean difficulties in everything from resource planning to providing social services.

PPC’s policy guidance is suggesting a number of tactics for missions to combat the impact of HIV/AIDS and requires relatively little resources. First, missions and governments need to change their how they think about HIV/AIDS. They need to understand that it affects more than just the health sector and to create a space for dialogue among all sectors of development. Second, it is imperative that missions take actions to expand their awareness of the scale and nature of the HIV/AIDS problem and mount an effective response.

Cornelius also suggested some medium- and long-term activities to ameliorate the epidemic, including collaborative efforts at the community level and mobilization of existing services, including agriculture extension services. LDC governments should also revisit policies and procedures to take account of the social and economic impacts of HIV/AIDS. Additional resources naturally are leveraged during the process of broadening sectoral development approaches to include HIV/AIDS. For example, the Mobile Task Team project funded by the Africa Bureau at USAID and implemented by the University of Natal, South Africa—works to build low cost systems to monitor the impact of HIV/AIDS on teacher workforce and school attendance in several countries.

Cornelius concluded his presentation by outlining several roles that health workers can play a role in facilitating mitigation interventions in non-health sectors, like participating in local donor coordination.

Peter Salama, HIV/AIDS and Complex Emergencies: Challenges and Progress

Salama chose to discuss HIV/AIDS and complex emergencies in Africa because the continent is home to the world’s majority of people with HIV/AIDS, people who suffer from food insecurity, and refugees. The rate of HIV prevalence in Africa increased from about 0 to 5 percent in 1985 to 39 percent in most countries in 2001 and has yet to peak. One of the most significant factors of the continued spread of HIV/AIDS is the burgeoning numbers of orphans left behind. There were one million AIDS orphans in sub-Saharan Africa in 1990; currently, there are 12 million.

Salama highlighted some important global trends in HIV/AIDS. First, up to 60 percent of those infected in Africa are women. Second, researchers are using better methods of acquiring data, like population-based surveys. Third, access to treatment (the theme of the Bangkok 2004 conference) is the linchpin of the President’s Emergency Plan and the World Health Organization’s (WHO) Three by Five initiative. Finally, there has been an increase in resources for HIV/AIDS: from one to seven billion dollars from 2000 to 2005.

Salama then went on to discuss the role of HIV/AIDS in complex emergencies. According to Toole (1997), a complex emergency is “a situation that affects large civilian populations and usually involves a combination of war or civil strife, food shortages, and population displacement resulting in significant excess mortality.” A conflict-affected population has two options: (1) to move domestically becoming internally displaced peoples (IDPs) or (2) to cross the border and become refugees. Either option leaves them vulnerable to military and sex workers.

Surveillance systems are readily in place for monitoring the major causes of death in complex emergencies, for instance malnutrition and diarrhea. However, these surveillance systems do not exist for HIV/AIDS. According to Salama, HIV/AIDS is not just underestimated but is under-programmed for. Some of the many causes of increased HIV/AIDS risk in complex emergencies are the disruption of societal structures and mores and economic vulnerability of women and unaccompanied children (UAC).

The risk factors for conflict and displaced persons vary according to HIV prevalence of the area of origin and the surrounding host population, as well as the length of time of the conflict. Behavioral change, gender violence, transactional sex, and reduction in resources and services all increase HIV risk. However, it is also possible that complex emergencies actually decrease the risk of infection due to the remoteness of most refugee camps from the general population, which leads to a reduction in mobility and accessibility. In 2003 in Africa, HIV prevalence was significantly less in countries of origin than in countries of asylum (UN High Commission for Refugees, 2004).

The major challenges of HIV/AIDS in complex emergencies: donor coordination, inclusion of HIV/AIDS refugees into proposals and interventions, HIV/AIDS protection, and operational research. He spoke to the coordination challenge by outlining the UNAIDS program, the “Three Ones.” The “Three Ones” is UNAIDS’ web site attempt to have all governments to agree to three major principles: (1) one national strategic plan, (2) one national coordinating body, and (3) one national monitoring and evaluation plan.

With respect to government intervention, only 43 percent of asylum countries in Africa had a national HIV strategic plan. In addition, only 23 percent of GFATM-approved (Global Fund to fight HIV/AIDS, Tuberculosis and Malaria) proposals include proposals for state activities for refugees. Protecting displaced people from HIV/AIDS involves addressing gender violence, discrimination, and stigma. Host countries should not require mandatory testing or deny asylum, resettlement, or right of return according to HIV status. UNHCR was reluctant at first to provide testing and counseling services for fear of stigmatizing the refugees; however, this has changed in the last four years.

There are many questions that can be answered by operational research in the area of HIV/AIDS and complex emergencies, especially with respect to the unique context which complex emergencies can bring. Recent examples of operational research success can be demonstrated by the development of standardized assessment and measurement and evaluation tools as well as the integration of displaced peoples and surrounding communities in Uganda.

Samala described a 2004 situation analysis of HIV/AIDS in post-conflict Liberia to bring to light program issues and relate them to longer-term development programs supported by the U.S. government. In Liberia, and in West Africa in general, it is very rare to see HIV/AIDS prevalence rate above five percent. This is likely due to high rates of male circumcision in West Africa. However, recent studies vary and may be unreliable due to the post-conflict human situation.

Samala briefly pointed out the instability due to internal civil warfare in Liberia for more than a decade. He emphasized the unusually high prevalence of systematic rape—including multiple rapes and child sex slaves—as part of the war strategy.

In order to capture the situation in Liberia, Samala met with the National AIDS Control Program (NACP), US mission, UN agencies, IOs and NGOs. He also conducted field visits, interviews and debriefings. Samala used HIV prevalence in blood donors and extrapolated the data in order to estimate HIV prevalence in the country. Using the blood donor population offered Samala a more unbiased sample than would blood taken from those voluntarily seeking an HIV test. The study showed that HIV prevalence in blood donors has steadily increased since 1994. According to the study, five percent of the Liberian population is HIV positive, which amounts to 75,000 PLWHA, with young women, mobile men, and commercial sex workers left the most vulnerable.

In terms of the behaviors that contribute to the spread of HIV/AIDS, Samala lamented that gang rapes, multiple rapes and sex slaves—one-third of women in refugee camps underwent rape counseling. These attacks significantly increase the spread of HIV/AIDS because they involve high numbers of partners and high numbers of sexual acts over time. He talked about AIDS awareness statistics; for example, 75 percent of Liberians believe PLWHA look sick and thin.

Though the responses to war in Liberia were not commensurate with the goals of HIV/AIDS awareness and prevention, there is hope that church networks and HIV pioneers will bring the issue of HIV/AIDS to center stage. Salama presented a conceptual framework wherein he charted biological, social, economic, and political factors that lead to the vulnerability in HIV women. He also called attention to the 42,000 'double orphans' (children who have lost both parents) in Liberia and the consequences, such as country instability, that a large population of uprooted children present.

Salama concluded his presentation on HIV/AIDS and complex emergencies by recommending several actions, including determining the level of HIV prevalence in an area, standardizing and improving care and treatment practices, and expanding non-institutionalized care for orphans.

Food, Nutrition and HIV/AIDS: Evidence and Priority Actions for AIDS Prevention, Care and Treatment Programs—Peter Salama

HIV/AIDS and nutrition are "inextricably inter-related." Malnutrition is widespread in children and in pregnant women resulting in health complications, such as stunted growth and micronutrient and iodine deficiency disorders. Orphaned children are at a greater risk of undernourishment.

HIV/AIDS exacerbates the negative effects of malnutrition, including increased susceptibility to secondary infections due to a weaker immune system. HIV directly affects nutrition by increasing energy requirements, reducing dietary intake (due to oral sores or depression), and contributing to nutrient malabsorption and loss (diarrhea) and metabolic changes (impaired and increased nutrient utilization).

Nutrition in turn affects AIDS. Because HIV infection increases energy requirements, food intake must be enough to compensate for the loss in calories. If not, weight loss occurs. Loss of lean body mass was shown in a study by Wheeler et al. (1998) to strongly predict the risk of illness and death in HIV-positive adults. In addition, deficient levels of micronutrients (MNs) are associated with more rapid disease progression. To compound this finding, studies have suggested that people living with HIV/AIDS (PLWHAs) have larger MN deficiencies than the general population. Some MNs (Vitamin A, iron, and zinc), if taken in too high amounts, have been found to produce dangerous consequences. More studies are underway to determine the nature of these relationships.

Samala outlined a few outcomes of nutrition intervention and improvement on the progression, transmission, and survival of HIV/AIDS. First, high energy/protein food supplements support weight gain, but the gain is mostly fat, not lean muscle mass. Samala emphasized that, contrary to the beliefs and strategies of many organizations, increased protein intake does not prevent

or reverse muscle wasting. Second, studies have shown micronutrient supplements to have widespread positive consequences, such as increasing survival rates in adults with advanced disease. Though nutrition interventions can offer PLWHA many benefits, the impact depends on the type of intervention, duration, and underlying nutritional status.

There is a myth that nutrition, care, and counseling can be discarded after starting antiretroviral (ARV) treatment, but Salama showed research that this is not true. Two of the most common reasons for not adhering to ARV treatment in a 2003 study were nausea and vomiting, which could be ameliorated through nutritional counseling. In addition, about one-third of patients commencing ARV treatment developed muscle wasting.

Samala concluded by recommending actions for nutrition in HIV-care, including education and counseling, targeted or prescribed supplementation, and other food interventions. He also outlined a twelve-point 'Proposed Framework for Action' that suggested guidelines from improving HIV/AIDS advocacy and awareness to training and supervising health workers.

Question and Answer Session

Early efforts to take a multi-sectoral approach to the HIV/AIDS epidemic were stymied by the fact that development assistance funds are appropriated for specific accounts. Given the inherent multi-sectoral nature of many HIV/AIDS programs, what restrictions remain on the use of PEPFAR funding with respect to spending it on purposes that appear not be directly related to AIDS, but that are? Are there still significant problems with using PEPFAR funding in [office business centers] OBCs and other multi-sectoral programs?

Yes, there are still some issues. With respect to the child survival and health account, Congress expects HIV/AIDS funds to be used specifically for HIV/AIDS prevention, care, and treatment. Earlier in my presentation, I emphasized some low-cost ways of integrating HIV/AIDS into all sectors of the development portfolio. These are things that should be done. Over the last few years, the President has increased the development assistance budget. In addition, there are opportunities for collaborative efforts between the health and other sectors for fighting HIV/AIDS. For example, agricultural workers have been used to distribute condoms.

Is there anything that you all are working on that deals with capacity issues in general? In particular, are you addressing the global policy issues that are impinging heavily upon capacity constraints in developing countries—especially the flight of health care workers out of the developing and into developed nations?

First, certainly PEPFAR is acutely aware that human capacity is a barrier to achieving the established goals. Health sector capacity is stretched thin already. More money is going to improve capacity constraints. There is some concern that human capacity will be removed from child survival projects and redistributed to HIV/AIDS programs because that is where the money is. They are aware of these problems and have included them in the five year strategy. As I said earlier in my presentation, loss of human capacity is one of the foremost problems resulting from the AIDS crisis.

Regarding your case study on Liberia, can you talk about what you've seen in terms of existing programs to deal with HIV/AIDS in the DDR situation? What do the peacekeepers have in place? Did you see NGOs or other interested groups dealing with the guys with guns?

The UNFPA and the International Rescue Committee are supporting counseling services, HIV awareness, and condom distribution as part of the demobilization process. One of the challenges in the demobilization facilities is that people are only there for a short time—one to two weeks. Voluntary counseling and testing in camp situations makes it hard to maintain confidentiality, which could lead to negative consequences. Therefore, we've decided to push for VCT more generally throughout the country.

It seems that in the hot spots when things are exploding, U.S. government's Office of Planning, Finance and Budget isn't keen on funding HIV/AIDS interventions in Iraq. Is there any talk of including HIV/AIDS in hot beds like Iraq?

We are funding several HIV/AIDS awareness projects in the health sector and are looking to expand multi-sectorally. We do have a memorandum agreement with Global Health to provide condoms and test kits. If you wish to access those two sources, I have a procedure and policy and that is free.

What are national governments of post-conflict areas doing to reinforce local statutory rape laws? How do you plan to address gender discrimination? I see a focus on HIV/AIDS prevention and treatment, but not on the social, emotional, or spiritual aspect. Who is funding the social-emotional underpinnings of the AIDS epidemic?

With respect to gender discrimination, we need tangible programs that address gender discrimination—i.e., counseling services and women's health programs. Regarding your question on the legal system, many times the legal system is broken down; therefore, we cannot be totally reliant on it. UNICEF and USAID are advertised as one of the core programs addressing the issue of female exploitation. The refugee environment, more specifically, is mandated by UNHCR to ensure that women are protected both in terms of the legal environment under refugee law and under practical programs that can reduce women's risk—such as, placement of latrines.

Fighting gender discrimination and empowerment of women have long been a critical priorities for USAID. Many of the development activities endorsed by USAID are geared toward women's empowerment. For example, USAID supports family planning and reproductive health programs for women.

Food, Nutrition, and HIV/AIDS

The issue isn't about treating the victims; it's about changing the social institutions that create a fertile environment for the spread of HIV/AIDS. I think it's absolutely essential to work with the Africa government to tackle the fundamental problem of gender discrimination that makes women so susceptible to HIV/AIDS infection.

I couldn't agree more. Women shouldn't have to choose between short-term treatment programs and programs that address the longer-term underlying social ills that perpetuate the AIDS epidemic. It's not an either/or decision. It's important to note that it was not the donor governments that advocated for access to treatment. It was the African people. For example, in South Africa, people turned out by the thousands because they didn't want to die from AIDS.

You mentioned cross-sectoring in terms of how agencies work together. You mentioned 'scaling up'—where does infrastructure or long-term development fall into this equation? How do we provide equipment, when the USAID budget allocates very little toward infrastructure. How can we match out budget priorities with our policy priorities?

On the question of infrastructure, I can only talk about the President's Emergency Plan (available on the State Department's web site: www.state.gov). In the PEPFAR there is actually a lot of money going into both the human and physical, in terms of laboratories and health clinics.

There is a significant amount of money going for equipment in PEPFAR. You are right about the importance of coordination amongst agencies and donors. Historically, different donors have a comparative advantage in providing different types of assistance. Some donors are more willing or more prepared to provide one type of equipment than another.

Zinc has been shown to enhance immune system. There has been a recent study by Johns Hopkins about Diarrhea. Do you know of any studies in HIV/AIDS using zinc?

The data coming out on micronutrients needs to be inspected. The current data suggests that vitamins B, C, and E have positive effects in terms of decreasing HIV transmission from mother to child. However, vitamin A, zinc, and iron may have detrimental effects on morbidity and mortality in certain dosages. We need much more data on what dosages are most beneficial.