



Joint United Nations Programme on HIV/AIDS
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Accelerating Action against **AIDS** in Africa

UNDER EMBARGO
until 1300 GMT,
21 September 2003



Cover photo: Two children in the Kasungu district of Malawi, who struggled through the food crisis that swept through six Southern African countries in 2002. The cumulative effects of AIDS and drought had a devastating impact on the area.
Photographer: Ruth Evans

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Geneva, 2003

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Preface

AIDS has been a calamity for Africa.

HIV is a virus that spreads silently before it wreaks devastation and, because it is largely spread sexually, it targets young adults just as they are coming into the prime of their productive lives. Because these young adults are also at the time of life when they are starting families, AIDS has a cross-generational impact, leaving children without parents to guard and guide them, increasing their vulnerability to HIV infection, and creating a legacy of economic and social instability.

But even though AIDS has vastly compounded Africa's struggle for development, it has also brought in its wake forthright leadership, community resilience and courage in the face of almost overwhelming odds.

This report provides a snapshot of the action being taken across the African continent in response to the challenge of AIDS. It highlights governments working with all their ministries to deliver a full-scale response. It demonstrates progress in closing the gaps in the provision of HIV prevention and treatment. It shows the value of partnership between government, communities and businesses. It showcases the determination of African women to throw off the disproportionate burden that AIDS represents for them. And it makes manifest the voice of hope, in the many successful responses by young people in fighting the epidemic.

The scale of the challenge posed by AIDS in Africa is unprecedented in human history. Meeting the challenge therefore requires unprecedented commitment. It requires that the international community commit itself to providing resources and support commensurate with the challenge. UNAIDS, which brings together eight UN system Cosponsors in a joint focus on AIDS, is determined to boost its support for an expanded response to AIDS in Africa: assisting in the mobilization of resources; tracking both the state of the epidemic and responses to it; and helping governments, communities and businesses work together, while providing them with the knowledge and support they need to mount effective responses.

Above all, though, meeting the challenge of AIDS in Africa requires renewed commitment from African leaders themselves—from Parliaments to pulpits, corporate headquarters to market kiosks, urban centres to the most remote rural villages. This report shows leadership and commitment in action. It reminds us all of our obligation to redouble our own efforts in support of the struggle against AIDS in Africa, for the sake of all humanity.



Peter Piot
Executive Director
Joint United Nations Programme on HIV/AIDS

Introduction

AIDS has finally reached the top of the African agenda. More and more of the continent's political leaders, civil society and groups of people living with HIV are ringing the alarm bells against AIDS, taking concrete action themselves and demanding more action from others. Africa is rising to the challenge. The international community is also responding. Two years after the 12th International Conference on AIDS and STDs in Africa ended with an impassioned plea for more resources to fight the pandemic, money is beginning to flow to the continent in significant amounts. The World Bank's Multi-Country HIV/AIDS Programme (MAP) for Africa and the Global Fund to Fight AIDS, Tuberculosis and Malaria are fueling the African HIV/AIDS response to new heights. Recent funding commitments by Europe, Japan and the United States are inspiring hope of even greater achievements.

Such developments are welcome, but far from sufficient. According to a June 2003 analysis by UNAIDS, total funding for the response to AIDS in the world's low- and middle-income countries is only half of what will be required in 2005 to effectively confront the epidemic. Meanwhile, the spread of HIV in Africa remains relentless, infecting over 30% of the adult populations (15–49-year-olds) of four countries, and at least 10% in 12 countries. At least 60 million Africans have been directly impacted by AIDS: 30 million people are living with the deadly virus, more than 15 million have died from AIDS, and more than 11 million have lost at least one parent to the epidemic. But the number of those affected by the epidemic is much greater: parents and grandparents have seen their children and grandchildren die before their time; this year alone, nearly 1 million African schoolchildren will probably lose a teacher due to AIDS; and employers and workers have seen their enterprises suffer the impact of AIDS. In short, entire populations on the continent are being denied the schooling, health care, and economic means that would have been available if precious human and financial resources had not been swallowed up by this epidemic.

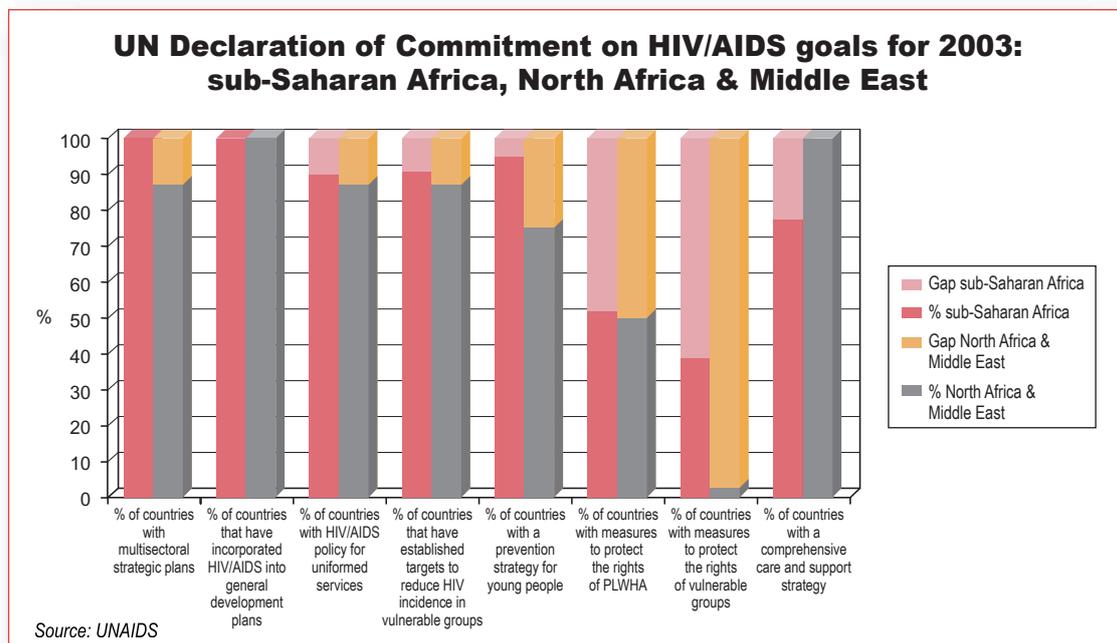
Southern Africa¹ has been particularly hard hit. The region is experiencing a humanitarian crisis accelerated by AIDS—a hint of the decimation of economies, public insti-

¹ In this report, Southern Africa is considered to encompass Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Six of these countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) were hit with drought and a food crisis in 2002. All but Zimbabwe have since staged fragile recoveries.

tutions and families that could occur in high-prevalence countries if the international community fails to act.

Facing potential devastation, many African nations have made AIDS a priority. National strategic plans against AIDS have been developed through participatory processes in nearly all high-prevalence countries. The UN Declaration of Commitment on HIV/AIDS, made at the 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS, and the Millennium Development Goals have set ambitious and measurable targets to be reached by Africa and the rest of the world in the coming years. But, if Africa is to meet these targets (in particular, the Millennium Development Goal of halting and beginning to reverse the spread of the epidemic by 2015), governments, donors and other stakeholders will have to move beyond advocacy, funding commitments and plans for action. Major intensification of the disbursement of funds, implementation of stronger programmes and the transparent monitoring and evaluation of those programmes are urgently required.

Figure 1



The UN Declaration of Commitment on HIV/AIDS provides a comprehensive set of targets that can be used to measure which aspects of the African response to AIDS are progressing well and which aspects require further attention. To assess progress, UNAIDS developed a National Composite Policy Index composed of indicators that

concern most of the policy issues raised in the Declaration. A detailed global analysis of this index is contained in the *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003*, produced by UNAIDS in September 2003. African countries' own reporting of progress towards selected UNGASS commitments to be achieved by 2003 is illustrated in Figure 1. The responses show broad progress in many areas, but in some—notably the protection of vulnerable groups and the provision of care—several countries are slipping behind the timetable of their commitments.

The chief goal of this report is to highlight successful initiatives that have inspired confidence that the continent can one day free itself of the virus, with or without a vaccine or medical cure. These examples prove that AIDS is a problem with a solution: human intervention works, even under the most difficult circumstances. The report also summarizes the challenges that Africa and the wider international community face as new resources are channelled into more effective efforts to confront HIV/AIDS on the continent. Three major challenges receive detailed attention:

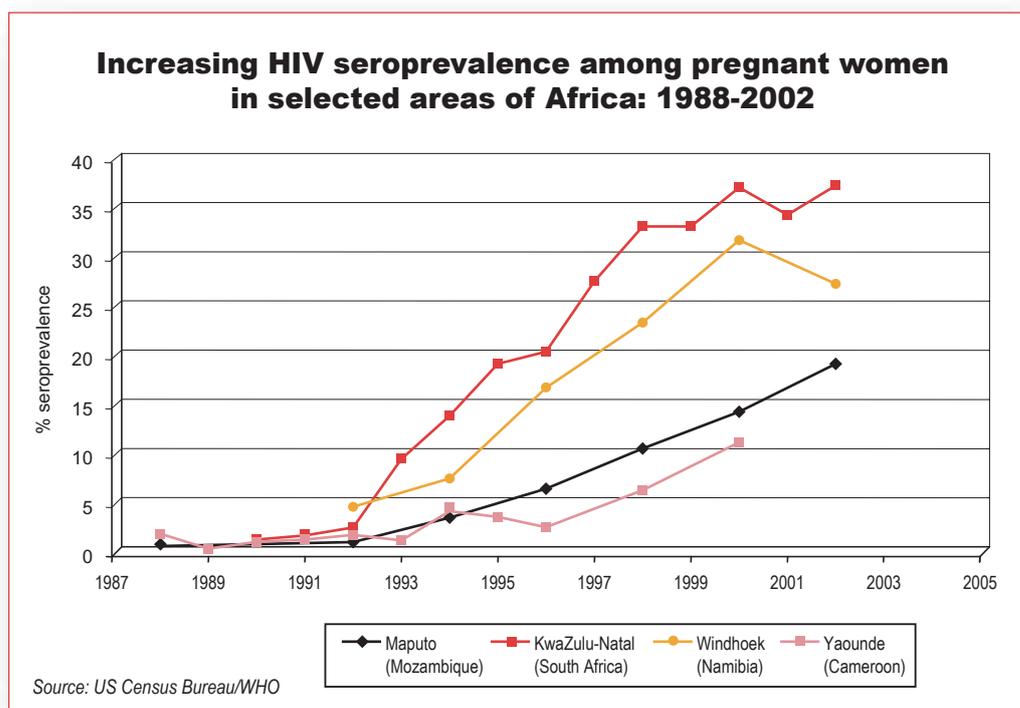
1. **The need to drastically scale up access to antiretroviral treatment as a key component of the response.** Prevention and treatment must be seen as two sides of the same coin; one cannot be separated from the other. Antiretroviral treatment improves and extends lives, and provides a boost to prevention strategies.
2. **The increasing impact of the epidemic on African women.** Because women are disproportionately affected by HIV/AIDS, there must be additional focus on women in the African response.
3. **The humanitarian crisis in southern Africa,** which has brought into sharp relief the need to integrate the HIV/AIDS response with broader development and humanitarian initiatives. In high-prevalence countries, where the impact of HIV/AIDS is extensive, the response must be equally so.

As the report's title suggests, accelerating action against AIDS on the continent is the overall challenge facing Africans and the international community in the coming years. If effective initiatives are scaled up and fundamental gaps addressed, the tide of the epidemic can truly be turned.

1. Africa's AIDS challenge

Recent studies reinforce the UNAIDS prognosis in mid-2002 that the epidemic is having a dramatic impact in many parts of Africa, accentuating the urgent need to scale up efforts to fight the virus. While there are general subregional trends in HIV prevalence, neighbouring countries often have epidemics behaving in very different ways. Conversely, trends can emerge among countries of different subregions. Antenatal clinic surveys in urban areas of several countries—Cameroon, Mozambique and Namibia—show increasing HIV prevalence, and perceived gains against the epidemic in South Africa may not be as significant as previously believed (see Figure 2).

Figure 2

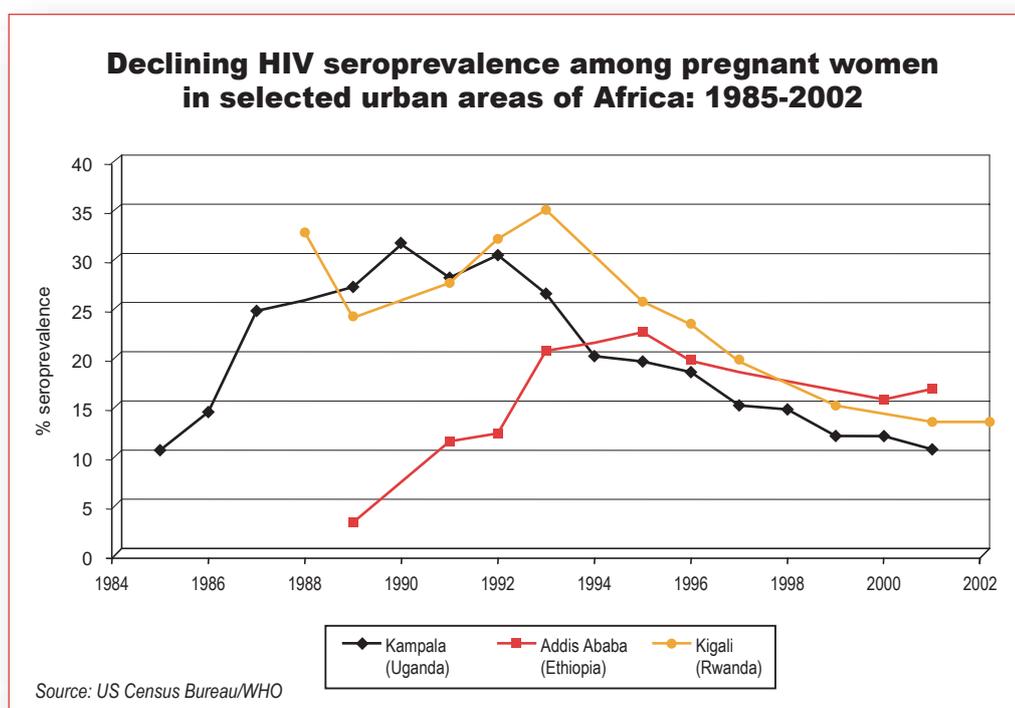


Surveillance of the epidemic by UNAIDS and the World Health Organization (WHO) shows that Southern Africa has the highest HIV rates in the world, and none of the 10 countries in the subregion shows clear signs of declining epidemics. In its 2003 HIV surveillance update, WHO's Regional Office for Africa reports that more than one in five pregnant women tested in Southern Africa in 2002 were infected with HIV—an especially alarming statistic considering that, at the end of 2001, only 1% of women

in sub-Saharan Africa had access to short courses of antiretroviral drugs to prevent mother-to-child transmission of HIV.

Overall HIV prevalence in East Africa is slowly declining, according to the WHO surveillance update. This view is reinforced by a UNAIDS analysis, which suggests that prevalence rates in urban antenatal clinics of Ethiopia, Rwanda and Uganda are decreasing (see Figure 3). In Uganda, the declines have been dramatic and sustained, with median HIV prevalence among pregnant women in major urban areas falling from over 30% in the early 1990s to less than 11% in 2001. These figures reveal rays of hope, reinforcing the fact that increased determination on the part of many countries to confront the epidemic and support their victims yields measurable gains.

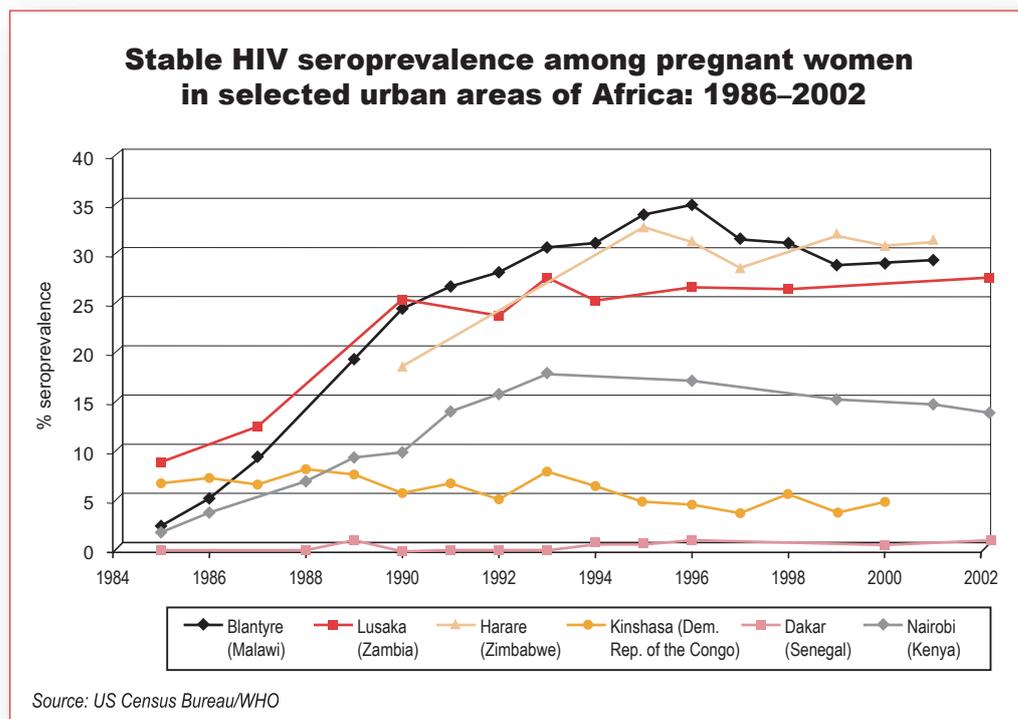
Figure 3



Antenatal surveys in urban areas of Kenya, Malawi, Senegal, Zambia and Zimbabwe suggest that their epidemics have stabilized (see Figure 4). Also, recent data from expanded surveillance systems suggest that HIV prevalence in rural areas of at least two African countries may be lower than previously estimated. In both Kenya and Zambia, the results from more rigorous surveys of rural antenatal clinics will likely bring down estimates of overall national prevalence, as well as the total number of infected persons.

Conflict and war, such as those in Côte d'Ivoire, the Democratic Republic of the Congo and Liberia, can increase the likelihood of an accelerated and inadequately monitored spread of the disease.

Figure 4



The Millennium Development Goal on HIV/AIDS call for the spread of HIV to be halted and reversed by 2015. With the most recently available data suggesting that gains against the epidemic in Africa have been sporadic, at best, it is too early to say whether the continent is on target to achieve this goal.

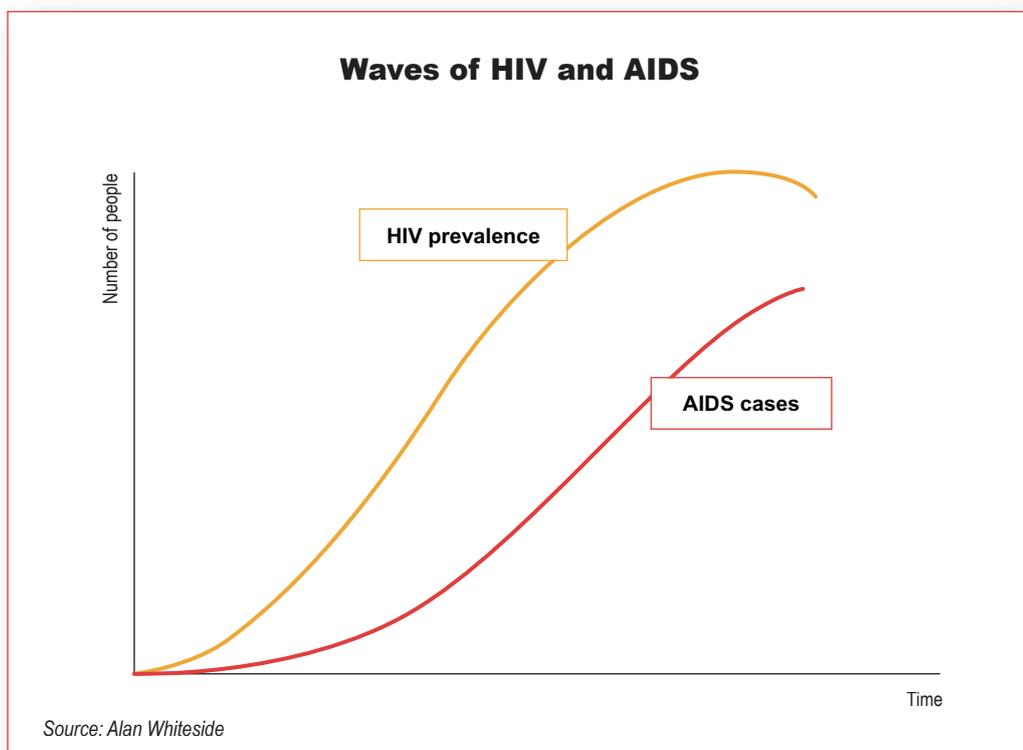
The interlinking impacts of AIDS

Going beyond the numbers

The raw numbers of people infected, prevalence rates and death tolls only reveal part of the impact of HIV/AIDS. To put Africa's challenge into perspective, it is necessary to deconstruct, humanize and analyse the string of statistics. HIV infects and kills people; it tears apart families, destabilizes communities, slows economies, disrupts social services and weakens democracies. Entire societies become vulnerable to implosion.

In Southern Africa, where the range of adult prevalence in 2001 was 5.5% to 38.8%, the epidemic's toll will grow dramatically over the next decade. Southern Africa represents a large portion of the countries where ever-greater numbers of people infected five or more years ago are now succumbing to serious illness and dying. To illustrate, nearly 760,000 people in the region were estimated to have died of AIDS during 1999. Two years later, the annual AIDS-related death toll rose to 920,000 people. This slow progression from climbing rates of HIV infection to rising numbers of AIDS deaths has been likened to a series of waves building and crashing against the worst-affected countries of Africa (see Figure 5).

Figure 5



HIV is the first wave of the epidemic, entering silently and virtually unnoticed. As the above graph shows, in the absence of effective treatment, HIV infection represents a portent of things to come. The onset of AIDS, the second wave, follows lethally behind, its effects no longer possible to ignore. In this way, today's HIV infection rates can be used to predict the likely impact of this epidemic in the future: the number of deaths, the extent of illnesses, and an estimate of the number of orphans. The 'AIDS wave' is now washing over Southern and Eastern Africa, devastating families and communities.

There is now also a growing realization that, behind the epidemic's first two waves, there is a third, potentially equally devastating wave—or perhaps, more accurately, an undertow that threatens to pull societies under: the impact that AIDS is having on the continent's economic, political and social service structures. The current demographic trends and curtailment of life expectancy in many African countries (Southern Africa, in particular) confirm that AIDS can slow down and even reverse the process of development.



Street children stand amid the rubble of a destroyed building in the city centre of Maputo, Mozambique.
UNAIDS/B.Neeleman

Economic impacts

As prevalence rates climb, entire economies become vulnerable. There is a growing body of evidence that AIDS is negatively affecting the cost of doing business. It does so directly, through added costs to the companies who pay for the treatment of sick employees and more expensive health and insurance benefits, and indirectly, through the costs of decreased productivity. In turn, loss of productive capacity reduces economic growth. For example, annual gross domestic product (GDP) has been estimated to drop by an average of 2.6 percentage points in countries with prevalence rates of over 20%. By the end of the decade, it is estimated that South Africa's GDP will be 17% lower than it would have been without this epidemic.

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The civil service, banks, justice systems and essential utility services, such as electricity, water and communications (many of which were in poor shape to begin with), all face the impacts of these same increased mortality and morbidity rates, as well as the resulting loss in productivity. The effect of the successive waves of the epidemic is again felt, but this time at micro level. Infected workers maintain their productivity levels for several years, their early struggles with the virus virtually unnoticed. When AIDS sets in, the individual's work capacity and productivity drop sharply. Skilled personnel are then lost, often resulting in a critical loss of skills, experience and institutional memory. It is much more than the sum of individuals lost. It goes to the heart of the ability of economies to grow. AIDS affects not only labour supply and economic output, but also product and service demand. Families struggling with a key wage-earner stricken with AIDS earn less money, and therefore spend less.

Deteriorating health services

The loss of productivity and economic growth translates into less tax revenue for government-funded services, undermining a nation's ability to respond to AIDS. In the hardest-hit African countries, already-fragile health systems are also being robbed of skilled staff just at the moment when they are most needed. Skilled doctors and nurses are dying. UNAIDS calculates that, in some countries, illness and death rates among



A mission hospital run by Catholic nurses in the United Republic of Tanzania. AIDS places heavy demands on the health systems of many countries. In some hospitals in Central and East Africa, 40% or more of beds are occupied by people with AIDS.
WHO/L.Gubb

health workers have increased five- or sixfold as a result of AIDS. In South Africa, an estimated 17% of primary health-care workers are infected with HIV, according to a study by the Human Science Research Council of South Africa. The study, released in August 2003 at South Africa's first National AIDS Conference, involved 2,000 health workers and 2,000 patients from 222 clinics and hospitals. Nurses accounted for almost half the infected, and doctors constituted almost 9%. Among non-professional health workers, prevalence was estimated at 20%. The study also found that 46% of patients in public hospitals had AIDS-defining diseases.

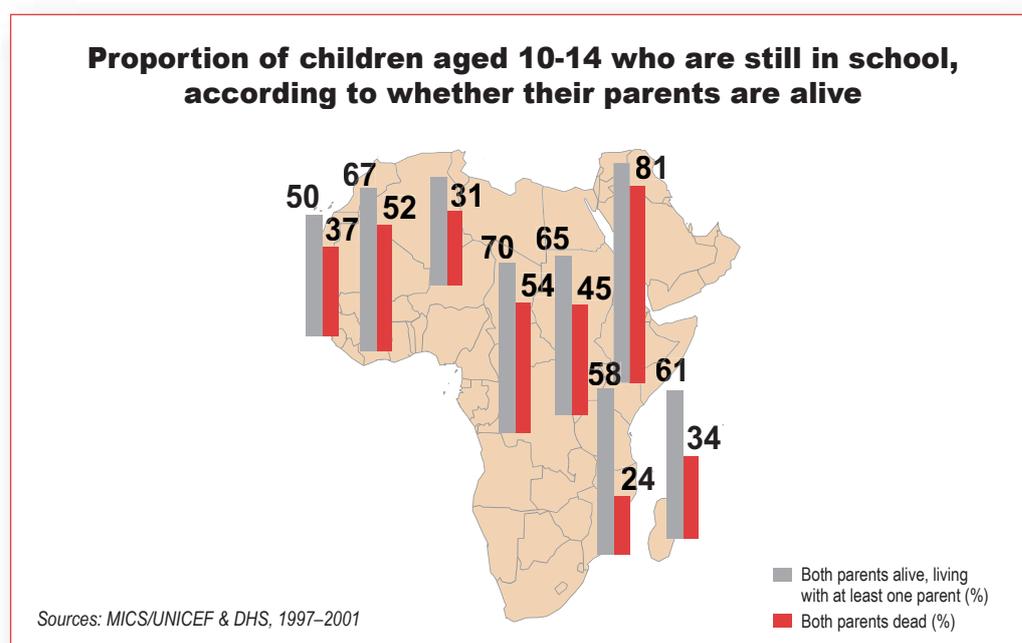
In addition, Africa is currently a net exporter of health workers because most countries on the continent are unable to compete with salaries offered in developed countries.

Education

Good-quality education is a powerful weapon against AIDS. Yet, across sub-Saharan Africa, only 57% of children are enrolled in primary school. The added impact of the AIDS epidemic on the educational system is undermining the fundamental right of every child to education, increasing the number of AIDS-related school dropouts, and raising young people's vulnerability to HIV infection.

In high-prevalence countries, substantial numbers of teachers are ill, dying or caring for sick family members. Management of the education system is also threatened by illness and death of qualified persons. At the same time, young people (especially girls) are being withdrawn from schools to help at home. A drop in school attendance is especially pronounced among orphans who have lost both parents to AIDS (see Figure 6).

Figure 6





Boys and girls in a village school, Konkon community, near Accra, Ghana. Including education on HIV prevention in schools is a key way to reach young people. *UNAIDS/L. Taylor*

From the UK Government's Department for International Development comes this chilling statistic on Malawi: of every 1,000 children starting primary school today, it is estimated that only two will complete their secondary education with enough qualifications to carry on to tertiary education; and, based on current projections, it is likely that one of those will become infected with HIV at some stage of his or her life. The long-term consequences for a poor country such as Malawi are impossible to quantify. The only certainty is that, if investing in education today is expensive, the price of tomorrow's ignorance will be even greater.

AIDS and food security

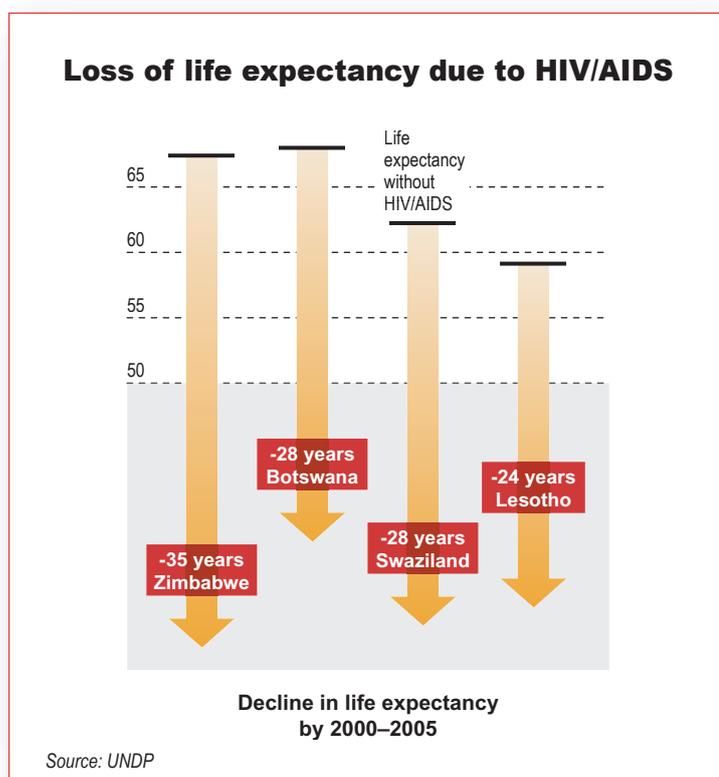
Some of the political, economic and social impacts of the epidemic have been evident for some time, especially in countries such as Uganda that were among the first on the continent to experience the effects of AIDS. Over the past decade, as the number of African countries with adult prevalence rates of over 10% has risen to 12, these impacts have intensified and become more apparent. In many cases, the impact has been much

worse than anticipated. Some countries in Southern Africa are now entering uncharted territory as adult prevalence rates climb past 30%. Three years ago, the 2000 UNAIDS *Report on the Global HIV/AIDS Epidemic* rang warning bells about the possible effects AIDS could have on food security in parts of Africa. Now, with some 6.5 million people in Southern Africa and growing numbers in the Horn of Africa facing severe food shortages, the reality has exceeded everyone's worst fears. The situation highlights the downward spiral created when humanitarian crises and high prevalence rates intertwine.

Nowhere is the devastation of AIDS more manifest than in the Southern African region. In 2001, 31% of the AIDS deaths in the world occurred in the 10 countries of Southern Africa, which was also struggling to cope with almost one-fifth of the world's children orphaned by AIDS. Parts of Africa are accustomed to periodic drought and crop failure. People have developed ways of coping with these setbacks. What is different about the current situation is the lethal addition of AIDS. In a continent where 80% of the population depends on small-scale, subsistence agriculture for their livelihood and food, the Food and Agriculture Organization of the United Nations (FAO) estimates that some 7 million African agricultural workers died from AIDS in the 25 most affected countries between 1985 and 2000. Another 16 million may die in the next 20 years unless an effective response is implemented. The loss of so many

people is arresting—and reversing—development efforts. According to the United Nations Development Programme (UNDP), AIDS is a major factor in the overall drop in development and standard of living—measured by its human development index (HDI)—in 6 of the 10 Southern African countries in the 1990s. Most of this drop in HDI can be attributed to a decrease in life expectancy, which is expected to continue to decline in the coming years (see Figure 7). The epidemic is stretching people's coping capacities to the breaking point.

Figure 7



Vulnerability assessments conducted in Southern Africa during the past year show that households affected by adult illness and death suffer greatly from reductions in agricultural production and reduced income. In Zambia, a 2002-03 vulnerability assessment revealed that farming families with a chronically ill head of household planted 53% fewer crops than households without a chronically ill person. HIV/AIDS and food insecurity in Southern Africa are feeding off each other. People who are ill are less able to obtain food in a crisis because they are too weak to farm their fields, to work for a wage, or to walk to markets or food distribution centres in search of food. Hunger and poverty may also increase the risk of HIV infection because it can drive people to adopt risky survival strategies (such as exchanging sex for money or food). The international NGO Save the Children, which has documented an increase in sex bartering by desperate young African women in conflict situations, reported in 2002 that the food crisis in Southern Africa appeared to be driving a similar trend.

AIDS and governance

The unrelenting loss of precious human resources in the countries most affected by HIV/AIDS has left them vulnerable to other crises: famines and droughts, and epidemics of other communicable diseases. Such conditions may also have long-term implications for political participation and the growth of democratic institutions. If voters are too ill to vote, if civil servants are dying too fast to maintain bureaucracies, and if parliaments and ministries are stymied by the challenges they face, will democracy survive in a world with AIDS? The epidemic is already associated with human rights violations, gender inequalities and marginalization of groups at high risk of infection, such as sex workers and men who have sex with men. Are we likely to also see a rise in political or religious extremism as the epidemic deepens? Will corruption increase as people become more desperate for expensive AIDS drugs? These are uncomfortable questions, but ones that are beginning to be raised by researchers.

African parliamentarians—the elected representatives of their constituencies—are already being affected by the virus. In Malawi, for instance, the former Parliamentary Speaker said during the opening of an AIDS awareness workshop in 2001 that several MPs had died of AIDS-related illnesses over the previous four years. A 2001 study on the impact of HIV/AIDS on the three Central Agencies of the Government of the Kingdom of Swaziland (the ministries of finance, economic planning and development) predicted a loss of 32% of staff to the epidemic by 2021. As a result, an additional 1.6% of staff will need to be replaced each year to maintain existing staffing levels.

And it is not just the State structures that are feeling these impacts. Civil society organizations are also highly vulnerable to loss of key individuals because they largely depend on the voluntary efforts of the motivated and energetic. Being sick or caring for sick relatives reduces time for voluntary work. Magnifying this impact is the fact that much of the advocacy and campaigning work, especially against the stigma and discrimination surrounding the epidemic, is being done by people living with HIV, whose own lives are foreshortened by illness and death. A study in KwaZulu-Natal, South Africa, generated hard evidence that AIDS undermines the capacities of local civil society organizations through loss of both staff members and volunteers. This study and the Malawi example mentioned earlier demonstrate that the attrition caused by HIV/AIDS undermines national AIDS responses and erodes the democratic process as well.

Ironically, AIDS has sometimes stimulated the democratic process. The rise of AIDS activism in hard-hit countries has displayed the power of public opinion and social mobilization when governments and the people they serve disagree. In South Africa, public pressure from civil society groups played a major role in the government's August 2003 decision to begin antiretroviral treatment in the public health system. Work to build the capacities of national legislators and local authorities in AIDS-related areas has also reinforced democratic mechanisms. And efforts to reduce AIDS-related discrimination have, in some cases, strengthened human rights legislation, leading to greater awareness of human rights and more confidence in demanding that they be respected.



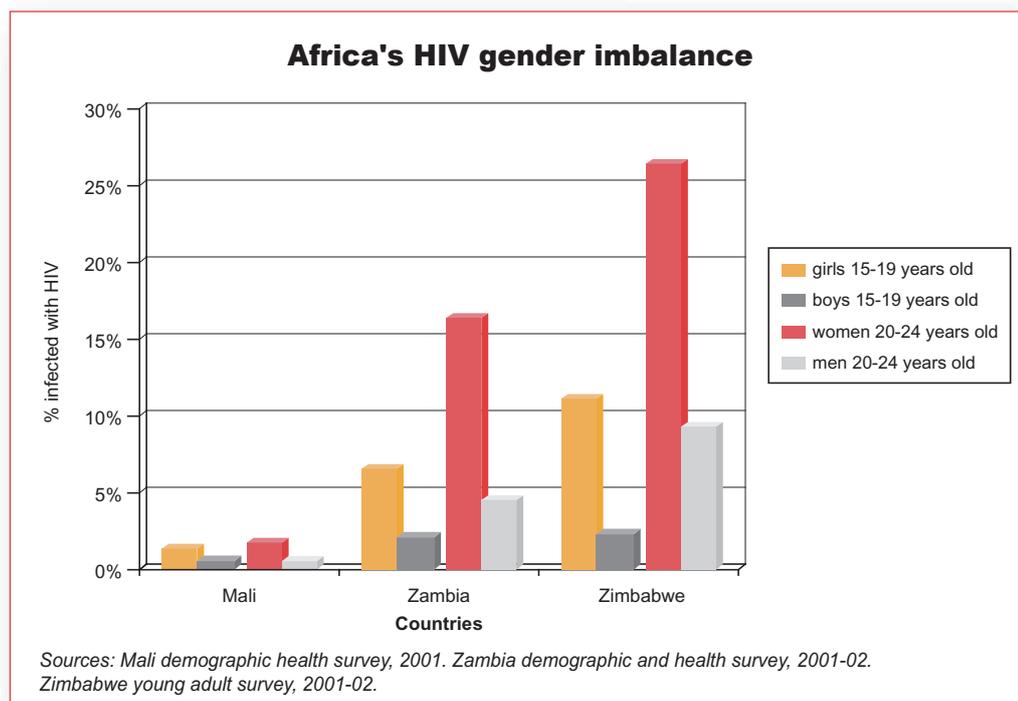
Mary, an HIV-positive woman, with her daughter (also HIV-positive) in a township of Soweto, South Africa.
UNAIDS/G.Pirozzi

Women and orphans—growing vulnerability

African women and AIDS

The appalling impact that HIV/AIDS is having on Africa's women is only now becoming fully apparent. Today, women constitute 58% of those infected in sub-Saharan Africa. In almost every country, prevalence rates are higher among women than men. The gender imbalance of infections appears greatest among Africa's young women—the continent's future (see Figure 8). Adolescent girls in sub-Saharan Africa are three-to-four times more likely to be infected than boys.

Figure 8



“This is something that should make all of us African men deeply ashamed and angry.”

—UN Secretary-General Kofi Annan, commenting on Africa's HIV gender imbalance at the 2001 African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases in Abuja, Nigeria.

What these figures show, above all, is the vulnerability of women and girls—a vulnerability rooted in limited sexual power or autonomy. As in most other parts of the world, a host of economic, social and political disadvantages limit women’s economic independence, educational opportunities, and access to health information and facilities. Age-mixing (that is, sexual relations between young women and older men) is a characteristic of many African societies with high HIV prevalence. Due to the power imbalances in these relationships, many young women are unable to negotiate safe sexual practices. Marriage on its own offers no protection against HIV for young women. A study in Zimbabwe showed that the majority of HIV-positive women were infected by their husbands. In a study among internally displaced women in Sierra Leone, more than half of the women surveyed said that their husbands had the right to beat them, and that it was a wife’s duty to have sex with her husband even if she did not want to.

Not only are women extremely vulnerable to infection, they also bear the brunt of care for the sick and dying. After years of doing so, many widows may themselves become homeless and outcast, as their husbands’ relatives claim the family home, land and, sometimes, children. Additionally, in community after community, elderly women are the economic and emotional safety net for grandchildren orphaned by AIDS. The extended family structure has been the most effective community response to the AIDS crisis, and women are at the centre of this structure. And, yet, very rarely are their needs addressed by AIDS programmes. As antiretroviral treatment programmes are intensified, it will be crucial to ensure that women with HIV benefit from them as much as men.

“We are just beginning to understand that, where AIDS is concerned, gender inequality is lethal. [...] We have never faced anything like this. What we are witnessing is a kind of Darwinian nightmare, whereby the survival of the fittest results in the annihilation of women.”

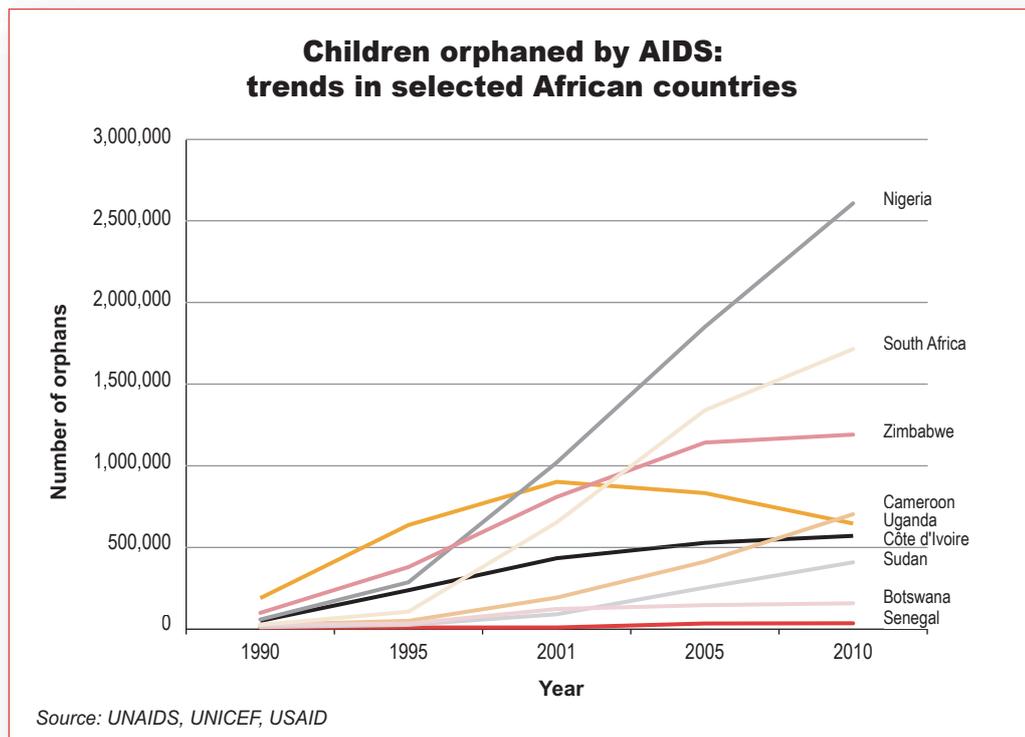
—Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa

Growing up alone

All this is having a devastating impact on the continent’s most vulnerable—Africa’s children. Once again, the statistics are overwhelming: more than 11 million African orphans now, 20 million by 2010 (see Figure 9 for selected country figures). Dealing with these astronomical numbers is a massive problem and, so far, there are few solutions. The extended family and the willing community simply cannot hope to

cope with such numbers by themselves. Many communities are already overwhelmed. In 12 countries on the continent, projections show that orphans will comprise at least 15% of all children under the age of 15 by 2010.

Figure 9



The impact of orphans on society is complex and multifaceted. Generally, there is a correlation between rising numbers of orphans and an increase in the number of uneducated, poorly socialized, malnourished and vulnerable young people, and this, in turn, heightens social instability. Having another mouth to feed pushes families further towards the edge, making other children vulnerable too. Losing a parent to AIDS also makes a child less likely to attend school and more likely to engage in full-time employment. A United Nations Children's Fund (UNICEF) review of 20 countries in sub-Saharan Africa found that children aged 5-14 who had lost one or both parents were less likely to be in school and more likely to be working more than 40 hours a week.

The long-term impact on the orphans themselves is difficult to ascertain. Grief over loss of parents, fear of the future, worries about immediate economic circumstances and discrimination and isolation are all difficult to quantify, but it does not take much to imagine the effects. Twenty years after the epidemic first appeared, a generation of

children orphaned by AIDS is emerging from a childhood deprived of stability, love and nurturing. What sort of adults will they become?

Even in countries where new infection rates have fallen, the numbers of children orphaned by AIDS will continue to rise for the foreseeable future because of the time lag between infection and death. In Uganda, for instance, the number of orphans under the age of 15 continued to climb even after the epidemic peaked and it is only now expected to decline from 14.6% in 2001 to a projected 9.6% in 2010. Even countries with effective responses to AIDS are only now waking up to the scale of the current and future orphan crisis. Immediate and sustained action needs to be taken at all levels—international, national and community.



Children in the playground of Hillbrow Children's Home in Johannesburg, South Africa. Children orphaned by AIDS, many of them HIV-positive, live at the home. *UNAIDS/G. Pirozzi*

2. The foundation of an effective response

There is a growing number of effective efforts to slow the epidemic's advance. But there is no magic bullet, no single formula that works everywhere. An effective response depends on a combination of prevention and treatment, as well as programmes to address the present and future impacts of AIDS. Different countries and circumstances require different strategies for implementation. Just as combination antiretroviral therapy attacks HIV in an individual on several fronts, national responses must include a range of approaches for maximum impact. The examples in this chapter illustrate how, if the proper framework is in place and if activities go to scale, Africa can reverse the course of AIDS.

The minimum enabling elements for effective national responses to AIDS in Africa are:

1. the commitment of African leaders from all sectors of society;
2. institutional mechanisms that foster sound policies and programmes to achieve measurable goals;
3. a broadening of responses to include as many sectors of society as possible, especially people living with HIV/AIDS; and
4. a reduction in stigma and discrimination against vulnerable groups and an expansion of efforts to ensure that the needs of marginalized and especially vulnerable groups are also met, including those of sex workers and their clients, men who have sex with men, prison populations, migrant workers and people uprooted by conflict.

Together, these elements create an environment in which African nations and their international partners can scale up prevention and treatment efforts, and mitigate the impact of AIDS.

Taking the lead

Effective responses to AIDS depend on strong leadership. Governments everywhere should support interventions that reduce the risk of infection among their citizens, especially the most vulnerable. It makes a dramatic difference when a nation's top leaders are committed and fully involved in the response. Communities are more likely to open up and become involved in the challenge to prevent new HIV infections and provide care for those already infected.

National leaders

In 1986, Uganda's President Yoweri Kaguta Museveni became one of the first African leaders to speak openly about AIDS. He recognized the threat early on when he discovered that his officer corps was experiencing high rates of HIV prevalence. Uganda was also the first country to establish a national AIDS commission, the first to launch a truly multisectoral response and the first to provide groundbreaking voluntary HIV counselling and testing services. Those steps were not without risk. For a while, Uganda was stereotyped and stigmatized as the global epicentre of AIDS. It would have been easier perhaps to remain silent, but vigorous and early intervention has been rewarded with unparalleled progress.

Similar steps are now being taken by leaders in other countries (see box on Botswana). In Kenya, the recently elected government led by President Mwai Kibaki has declared a new focus on fighting AIDS, and has backed up its pledges with action. The President has appointed an HIV/AIDS Cabinet Committee of nine members, which he personally chairs, and has declared his determination to drive Kenya's infection rate down from its current 15%. The country is scheduled to host the 2003 International Conference on AIDS and STIs in Africa. The renewed determination is being backed by resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank's MAP. A grant agreement signed in June 2003 between Kenya and the Global Fund will provide US\$37 million to the country's AIDS fight.

Botswana – a model of commitment

Botswana is, in many ways, a model African country: development efforts have reaped substantial gains, and a stable democracy thrives. Unfortunately, these successes have not been enough to prevent the country from becoming one of the worst HIV/AIDS-affected countries in the world. Prevalence rates have risen sharply from 18% in 1992 to 38.8% in 2002. It is currently estimated that approximately 330,000 people are HIV-positive. The high prevalence is now undermining the country's development efforts. Infant mortality rates have increased from 48 deaths per 1000 live births in 1991, to 56 in 2001, while life expectancy at birth is expected to decrease from 67 years to 47 years by 2010.

Yet Botswana refuses to give in to the virus. On the contrary. Under the leadership of President Festus Mogae, who chairs the National AIDS Council, Botswana has adopted a comprehensive multisectoral response that is largely financed by the government. It is estimated that, in the financial year 2002-03, the government spent US\$69.8 million on HIV/AIDS-related programmes, which represents 60% of total expenditures on HIV/AIDS in the country, excluding indirect costs.

Health promotion and intervention activities have been implemented all over the country. National information campaigns focus on modes of HIV/STI transmission and prevention, and consistent condom use, as well as the importance of the human and civil rights of people living with HIV. Care and support interventions for those who are HIV-infected and -affected have also been developed.

As the disease reaches its epidemic stage, mortality rates are expected to increase. With this in mind, the government made two important policy decisions: in 1998, it decided to initiate provision of free drug treatment for the prevention of mother-to-child transmission (PMTCT) of the virus and, in 2001, it approved plans for the provision of free antiretroviral treatment as part of the National Comprehensive Care Policy.

The pilot PMTCT programme began in 1999 in two sites—Gaborone and Francistown—and was rolled out nationwide in 2002. By December 2002, it was estimated that a 21.9% reduction in mother-to-child transmission had been achieved.

The antiretroviral treatment programme (known as 'Masa', a Setswana word meaning 'new dawn') was developed by the Ministry of Health, in partnership with the African Comprehensive HIV/AIDS Partnership (set up jointly with the Bill and Melinda Gates Foundation, the Merck Company Foundation, and the management consulting firm McKinsey & Company). (See box on page 61.) Of the 330,000 HIV-positive people in Botswana, about one-third require antiretrovirals. By July 2003, 10,415 patients had enrolled in the programme, 6791 were on antiretrovirals, and 486 had died—a stark reminder of the urgent need for action.

Part of that money will be spent on bringing antiretroviral therapy to 6,000 Kenyans over the next two years.

The MAP has provided US\$50 million, of which Kenya has already used more than US\$20 million. These MAP funds have strengthened overall national capacity to confront HIV/AIDS, supported action in a range of ministries, funded more than 1,000 civil society projects across the country, and put in place an accountability mechanism for the disbursement of funds.

Broadening leadership

Heads of State and Government are not the only political leaders who can make a difference in fighting HIV/AIDS. Cabinet-level ministers and African parliaments have crucial leadership roles in drawing up effective strategies, policies and programmes. Parliamentarians can also hold governments accountable for implementation of national AIDS plans. Dedicated politicians also act as conduits for communicating prevention messages to the areas they represent—both rural and urban—as well as relaying particular local needs and demands to policy-making bodies.

District assemblies and local governments have a vital role to play in drawing up and monitoring AIDS responses at local levels. In 1998, UNDP, the UNAIDS Secretariat and African mayors and municipal leaders formed the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa. The alliance has mobilized at least 70 municipalities from 17 countries to focus on more effective ways of confronting the devastating impact of the HIV epidemic on the continent.

The responsibility of leadership is not exclusive to governments. Mobilizing leaders in all walks of life—political, religious, educational and traditional—is essential for the viability of programmes and interventions. They set the example that spurs others to action. Presidents, priests, pop stars, parents, and people living with HIV all have a role to play.

Table 1

Holding the reins	
Countries with Presidents and Prime Ministers steering the AIDS response	
Country	Chair of national AIDS coordinating body
Botswana	President
Burkina Faso	President
Burundi	President
Cape Verde	Prime Minister
Congo	President
Ethiopia	President
Ghana	President
Kenya	Prime Minister
Madagascar	President
Mozambique	Prime Minister
Namibia	Minister of Health*
Niger	President
Nigeria	President
Senegal	Prime Minister
South Africa	Deputy President
Swaziland	President
Togo	President

* The President of Namibia is a member of the National AIDS Commission

Village chiefs, religious leaders, traditional healers and prominent local figures can also help inspire behavioural change and HIV prevention. Their voices are often the most influential within their communities, and they have the authority to ensure successful implementation of local initiatives. Their participation also enhances local ‘ownership’ of prevention, care and treatment efforts, and promotes more efficient implementation of national AIDS plans. Uganda’s decentralized system of government is thought to have been one effective component of its own national AIDS response—one that the new Kenyan Government is keen to emulate. In Mozambique, *currandeiros*, or traditional healers, have been trained in HIV prevention and given condoms to distribute. In villages in the United Republic of Tanzania, traditional birth attendants have been given sterile equipment, gloves and training in safe delivery.

Legislators—representing the will of the people

An underutilized resource in the African AIDS response is the legislative branch of government. Above all, legislators are the direct representatives of the people who voted them into office, and they have a responsibility to address their constituents’ needs on the floor of national parliaments. Legislators can spearhead legislation that:

- reinforces the rights of marginalized groups, such as men who have sex with men, and people living with HIV;
- ensures equitable access to treatment and care for men and women;
- protects the property and inheritance rights of widows and orphaned children; and
- addresses issues such as sex education in schools, the custody and care of children, and HIV testing and counselling.

Parliaments can also review traditional practices (such as female genital mutilation and the age of sexual initiation/consent) that may hinder HIV prevention, treatment, care and support. South Africa, for example, has passed an *Employment and Equity Act*, which expressly forbids



Traditional healers, or *sangomas*, who dispense traditional medicine and cures to the majority of the rural population in South Africa, have been drawn into the fight against AIDS. NGOs have taught the healers the importance of hygiene and education in fighting the spread of HIV. UNAIDS/L. Gubb

discrimination based on HIV status. The Act also prohibits compulsory HIV testing, except if such testing is determined to be justifiable under extremely restricted terms described by the Act.

Outside of parliament, legislators can also:

- help mobilize the AIDS response within their constituencies, and sensitize their constituents to the struggle against AIDS;
- educate their constituents and ensure that care and support programmes are set up within their communities;
- mobilize and engage community-based and faith-based organizations, traditional leaders, the private sector, trade unions, civil society and other members of parliament; and
- improve AIDS advocacy by publicly encouraging behavioural change, promoting prevention messages and speaking out against stigma and discrimination.

More and more legislators in Africa are focusing their attention on AIDS. For example, the Southern Africa Development Community (SADC) Parliamentary Forum has set up a Standing Committee on HIV/AIDS and developed a strategic workplan to strengthen many of the elements mentioned above. In addition, *The Handbook for Legislators on Law, Human Rights and HIV/AIDS*, a product of the growing partnership between the Inter-Parliamentary Union and UNAIDS, which was initiated in Namibia, has been instrumental in strengthening the involvement and actions of parliamentarians at national and regional levels.

Beyond borders: emerging regional initiatives

The global nature of the pandemic means that no country can fight AIDS alone. The disease does not respect national boundaries. Momentum is building across the continent for more vigorous, coordinated and concerted efforts to contain the epidemic.

Migrant labour markets, vulnerable travel corridors and trucking routes cannot be tackled unilaterally by any country. Regional cooperation also encourages the standardization of legal frameworks and policies on treatment and procurement of drugs. In West Africa, for example, a US\$16.6 million grant from the World Bank is funding the efforts of five coastal countries—Benin, Côte d’Ivoire, Ghana, Nigeria and Togo—to improve access to prevention and care services along a major transportation corridor linking Abidjan with Lagos. Vulnerable populations such as migrants, truck drivers and sex workers are targeted by this regional ‘corridor project’.

The New Partnership for Africa's Development (NEPAD)—perhaps the most important policy and economic initiative on the continent—has included AIDS in its health strategy, and plans to include it in other sectoral strategies in the near future. The SADC has also developed a comprehensive, multisectoral HIV/AIDS strategy. The Common Market for Eastern and Southern Africa (COMESA) has included AIDS in its gender policy and programme, and will soon mainstream AIDS into all its sectoral activities.

In February 2003, UN Secretary-General Kofi Annan established the Commission on HIV/AIDS and Governance in Africa (CHGA) to assist in the strengthening of African leadership responses to HIV/AIDS. Located within the Economic Commission for Africa in Addis Ababa, Ethiopia, CHGA is conducting a wide-ranging enquiry into the impacts of the epidemic in Africa and responses to it. UNAIDS is closely involved in the work of the Commission, which focuses its efforts on understanding the links between HIV/AIDS, good governance, development, peace and security.



On the Zambia-Tanzania highway, the African Medical Foundation has set up peer education programmes with truck drivers. The sticker on this truck reads, "Condoms prevent AIDS". *WHO/UNAIDS/L. Gubb*

As a follow-up to the Abuja Declaration of the African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, AIDS Watch Africa, under the leadership of Nigerian President Olusegun Obasanjo, is reinforcing the commitments of eight African political leaders to confront HIV/AIDS.

In 2002, the Organization of African First Ladies against AIDS (OAFLA) was established with support from UNAIDS and the International AIDS Trust. OAFLA, currently chaired by Gabonese First Lady Edith Lucie Bongo, gives AIDS issues a high political profile. At the July 2003 African Union (AU) Summit in Maputo, Mozambique, the OAFLA General Assembly called for sustained and effective efforts to reduce stigma and discrimination, mobilize financial and operational resources to confront the epidemic, and advocate effective treatment and care strategies. Another group of first ladies led by Chantal Biya of Cameroon, *Synergies Africaines*, promotes development in Africa and encourages the establishment of partnerships and effective actions against AIDS.

There are other examples of effective regional coordination on the continent, such as the Great Lakes Initiative (GLIA) in Central Africa. The World Bank trade union initiative is giving AIDS a much higher priority than was the case only a few years ago. The African Union and the United Nations Economic Commission for Africa (ECA) have both recently launched new AIDS units.

These regional bodies serve as powerful channels to bring about more concrete and broader-based national HIV/AIDS strategies. Much remains to be done, however, to enhance policy coherence among countries and to articulate African positions and needs in international negotiations. They must ensure that AIDS is seen as an integral part of poverty reduction and trade issues, economic and political stability and regional and global security.

National AIDS institutions

Most African countries now have institutional structures set up specifically to deal with HIV/AIDS. These national AIDS commissions are tasked with implementing policies for prevention and, increasingly, care and treatment. Some have also created AIDS ministries led by Cabinet-level officials dedicated to mainstreaming HIV/AIDS strategies into various sectors of government work.

But many African nations need to give the battle against AIDS a clearer operational framework. Declarations and national strategic plans must be transformed into concrete action. First, strategic plans must be prioritized and costed. And, as plans are put into action, periodic reviews by government and nongovernmental actors are needed to increase efficiency and accountability (see box on Kenya). As more global resources are now being channelled into AIDS responses, the issue of resource management is gaining greater prominence. The ability of African governments and institutions to provide adequate political and technical leadership for national responses is key to attracting sufficient amounts of external financing.

Kenya – Joint AIDS Programme Review

Kenya's commitment to building an effective and broad-based response to HIV/AIDS is also reflected in the establishment of a multisectoral review process for the Kenya National HIV/AIDS Strategic Plan for 2000-2005. The first Joint AIDS Programme Review, undertaken in May 2002, paved the way for regular examinations of progress and identification of gaps that push the response forward and reinforce national ownership. A second review was conducted in February 2003.

The government's National AIDS Control Council (NACC) coordinates the joint review process, while civil society groups, donors and other stakeholders assist with preparations, and financial and technical support. Five technical groups, each containing 10-30 representatives of key stakeholders and led by a senior NACC representative, provide the substance of the review, based around five broad strategic objectives contained in the National Strategic Plan: prevention and advocacy; treatment and care; planning and budgeting; monitoring and evaluation; and management and coordination.

During the first review, the technical groups identified goals and set milestones for their achievement by January 2003. Since then, the five groups have refined their specific technical areas and set additional targets for achievement. The entire joint review process has produced the following advantages:

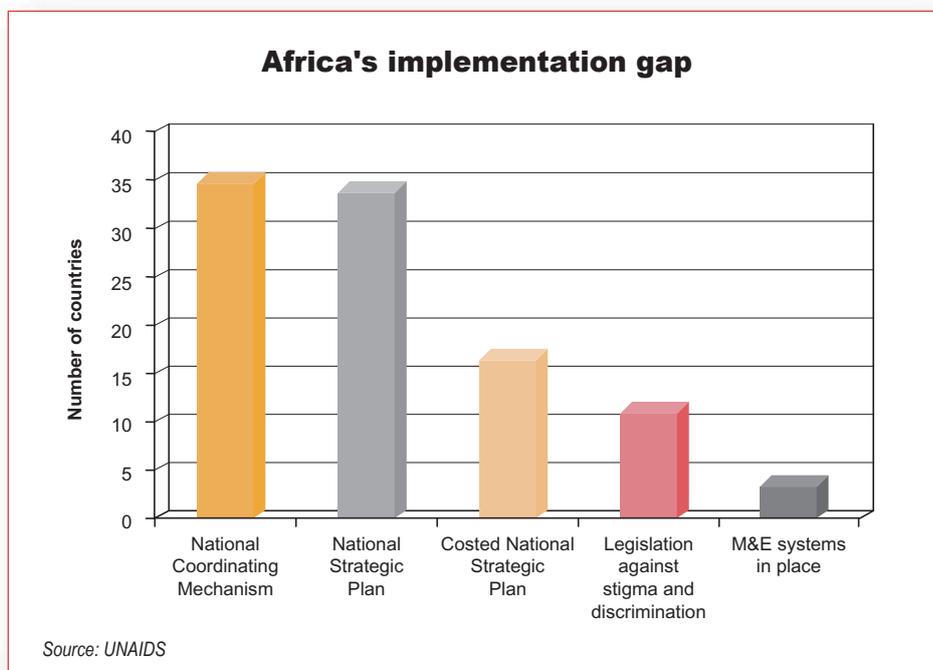
- It assists the government in linking the National HIV/AIDS Strategic Plan with other important policy-making processes, such as Kenya's Poverty Reduction Strategy Paper (PRSP) and its Medium-Term Expenditure Framework (MTEF).
- It functions as a coordination tool for the national response, emphasizing a multisectoral approach.
- It provides broad opinion on the achievements, shortfalls and direction of the response. Because all major stakeholders are represented, their various experiences are taken into consideration. This is especially valuable because of the current absence of a national monitoring and evaluation system.
- It has developed a basis for a planned monitoring and evaluation framework.

Challenges include the need for smoother functioning of the technical groups. Their diversity has highlighted the need for advanced planning and clearer membership guidelines and mandates. The process has also revealed a basic need by many stakeholders for greater access to information, and a specific need for a database to monitor progress based on the national strategic plan.

Key emerging issues relate to technical advancements in each group area, which will facilitate the achievement of current targets and the setting of new milestones at the next joint review in February 2004. Other emerging needs are the establishment of even greater links between the National HIV/AIDS Strategic Plan, the PRSP and the MTEF, as well as additional capacity to effectively utilize the increasing financial resources being made available to the national response.

The UNAIDS Secretariat, relying on its latest round of UNGASS surveys and additional research, has measured sub-Saharan Africa's 'implementation gap' (see Figure 10) by comparing the relatively large number of national AIDS councils and national AIDS strategies to the number of strategic plans that had been fully costed by the end of 2002; the number of countries that have reported compliance with a section of the UNGASS Declaration of Commitment that calls for enacted, strengthened or enforced legislation to eliminate all forms of discrimination against people living with HIV and to combat HIV-related stigma and social exclusion by 2003; and the number of countries that have set up systems to monitor and evaluate the implementation of their national AIDS plans.

Figure 10



Managing a truly multisectoral response is a major challenge. The epidemic is too often viewed as primarily a health-sector issue, even after government leaders agree on the building of a broad response. Adopting a multisectoral response does not mean just the introduction of HIV/AIDS focal points and HIV-prevention activities in various ministries or adding HIV/AIDS-specific initiatives to existing programmes. A multisectoral response entails incorporating the development implications of HIV/AIDS into core government policies, strategies and programmes. Efforts to increase a nation's capacity to manage a robust, multisectoral response will be further discussed in the next chapter.

In Zambia, there are increasing signs that its multisectoral efforts are paying off. Every government ministry now has an established budget line for tackling the epidemic. Projects to prevent transmission of HIV from mother to child are under way. But these initiatives urgently need to be expanded and improved upon, at an estimated cost of US\$51 million. This figure is in addition to the country's existing national HIV/AIDS budget of US\$560 million for the next three years—not a huge additional amount, considering the need.



A social worker from the NGO Kicosehp distributing nutritional supplements and providing counselling on nutrition. Her activities are part of the Kibera Community Self-Help programme in Kenya. Kibera is the largest slum area in Africa, with over 1 million people. HIV incidence is very high. *UNAIDS/G.Pirozzi*

Broadening the response

Given the enormous challenges, progress hinges on the collaboration of all major stakeholders: donors, governments, communities, religious groups, businesses, labour networks and infected and affected individuals (see box on Uganda partnership).

Community mobilization

Community action has proved to be one of the strongest weapons in the battle against AIDS. Schools, churches, the workplace and other forums that bring people together are effective tools in the armoury of HIV-prevention measures. The leaders of these groups are respected and influential within the community, and they provide opportunities for addressing risky behaviour and for expanding medical services and counselling. They can also reach out to the broader community, as each schoolchild or employee carries home with them the prevention messages they learn.

Strong community participation has been a major factor in Senegal's success in maintaining a low rate of prevalence in the general population. Peer education has been an effective tool in this mobilization of Senegalese communities. But the key to building

community-level responses is inspiring local ownership of the initiative. Communities must be able to say, “We accomplished something and are proud of it”. Long-term financial support, linking community groups to outside sources of information and facilitating horizontal communication among groups are other important aspects to consider as national and international players build community involvement.

Civil society

In an open and democratic society, government and civil society can complement each other in the struggle for socioeconomic development. The successes of organizations

The Uganda HIV/AIDS Partnership

Uganda’s progress in addressing HIV/AIDS has been built on determination, innovation and the highest political leadership. There has been broad understanding for many years that the epidemic must be confronted on as many levels as possible. This understanding is manifest in the Uganda HIV/AIDS Partnership, an innovative coordination mechanism that brings together a variety of stakeholders working at different levels in the area of HIV/AIDS.

The HIV/AIDS Partnership goes beyond traditional government-donor partnerships by encouraging participation of less vocal and less organized constituencies. It brings together the Uganda AIDS Commission (UAC), government ministries, district- and local-level authorities, UN and bilateral agencies, international and national NGOs, the private sector, academic institutions, faith-based organizations and networks of people living with HIV. Plans are under way to include a constituency of the media, culture and arts groups, and to ensure that the nation’s young people are fully represented.

Constituency representatives gather once a month for a Partnership Committee meeting. The Ministry of Health, the Ministry of Finance, the UAC Board and UNAIDS have permanent seats on the committee. Other Partnership Committee members are selected by their peers, and thus fully represent their constituency. They can therefore be held accountable, while at the same time participating in a democratic forum for debating and resolving issues on the same level as government and other prominent constituencies. This way of doing business differs from the often ad hoc appointment of one well-positioned NGO to serve as the so-called civil society representative.

Over the past year, the HIV/AIDS Partnership has proven instrumental in minimizing duplication and encouraging the pooling of efforts to scale up the national response. For instance, technical assistance from various donors and development partners was harmonized, through the Partnership, for the development of the national monitoring and evaluation framework. The Partnership also proves to be an effective promoter of transparency and accountability. Budgeting, fundraising and disbursement for the 2001 National HIV/AIDS Conference were fully coordinated by the Partnership, on the basis of a collectively-agreed-upon conference budget. In addition, the Partnership, with its wide range of collaborators, has widened the pool of technical and institutional resources available to the UAC. Admittedly, transparency and a culture of impartiality have not been obtained overnight. However, progress has clearly been made.

such as The AIDS Support Organization (TASO) in Uganda, the first indigenous nongovernmental organization in Africa to respond to the needs of people living with HIV, have been emulated across the continent. Civil society is not subject to the same political constraints as governments. Civil organizations can often respond quickly and imaginatively where cumbersome bureaucracies cannot. They can demand action from those with power and authority. But governments cannot just abdicate their responsibilities to civil society groups. They need to facilitate and support this work, help coordinate their efforts and provide a regulatory and enabling framework that monitors but does not inhibit their actions.

AIDS activism

One of the most encouraging political changes in Africa in recent years has been the coming of age of AIDS activism. Organizations are now more able to engage politically to demand their rights and to provoke action. As groups have gained experience in building strong and targeted campaigns, AIDS activists have also gained confidence and determination. Women have led many of these organizations and, in the process, have raised the profile of gender issues. In Ethiopia, the Save Your Generation Association campaigns vigorously on behalf of young people. Its activities include a theatre troupe that engages in participatory and entertaining means of prevention education, such as puppet shows, dramas and songs. The association also prepares and distributes information leaflets and trains youth counsellors.

The Society for Women and AIDS in Africa has become a key rallying point for African women as they push for equal access to treatment and prevention tools. In South Africa, where up to 5 million people are infected with HIV and approximately 1,000 people die from AIDS every day, the Treatment Action Campaign (TAC) has called loudly for universal antiretroviral treatment. Internationally known for its high-profile civil disobedience campaigns, TAC also advocates the prevention of new HIV infections, promotes treatment awareness among the general population and builds networks and alliances with unions, employers, religious bodies, women's and youth organizations, lesbian and gay organizations, and other interested groups in the community. The resolve of TAC has been epitomized in the actions of its HIV-positive chairman, Zackie Achmat, who refused for several years to take antiretroviral medications unless they were made available to all South African AIDS patients through the public health system. In August 2003, the government announced that it planned to develop an antiretroviral treatment programme.

Networks of people living with HIV

The determination of people living with HIV has been an indispensable part of building an effective response to the epidemic and a counterattack to the stigma and discrimination often faced by HIV-positive individuals. Personalizing the epidemic is a strong weapon against ignorance and fear. The involvement and activism of HIV-positive people has challenged societies to deal more openly with issues that might otherwise be taboo, especially where sex is concerned.

Stimulating the involvement of HIV-positive people in the African response is the Network of African People Living with HIV/AIDS (NAP+), founded in Dakar, Senegal, in 1993. The network unites people living with HIV across the continent.

Traditionally-dressed Shangaan women from rural Tzaneen, South Africa. Many of them have been widowed by AIDS and/or infected with HIV. They dance and sing songs they have composed about AIDS at a meeting of their support group, formed to help educate the vulnerable in this farming area about the dangers of the epidemic.
UNAIDS/L.Gubb



It trains and bolsters support groups or associations for people living with HIV, and serves as a forum for the exchange of ideas, experience and resources. NAP+ members include support groups for people living with HIV and 2 million HIV-positive individuals from more than 30 African countries.

Religious groups

Churches and religious organizations—in some instances hesitant to participate in the early days of the AIDS response—are beginning to respond as well (see box on ‘A New Robe’ in Swaziland). Religious leaders are waking up to AIDS. Retired Roman Catholic Bishop Barnabas Halem’Imana chairs the Uganda AIDS Commission. Anglican Archbishop Njongonkulu Ndungane of Cape Town has been a vocal AIDS advocate in South Africa, calling for the country’s epidemic to be declared a national emergency and for the national government to provide antiretroviral treatment to rape victims and pregnant mothers.

In Senegal, training sessions on HIV/AIDS have been held for Imams and teachers of Arabic. AIDS has become a regular topic in Friday sermons in mosques throughout the country, and senior religious figures have addressed the issue on television and radio. The President of Gambia’s Supreme Islamic Council, Banding Drammeh, recently announced that Imams, Islamic scholars and other religious leaders will embark on a nationwide campaign to disseminate the facts about AIDS and how it can be contained.

'A New Robe' in Swaziland

Efforts to increase the involvement of faith-based groups in Africa's AIDS response are exemplified by 'A New Robe' Parish Nurse Programme, a three-year effort by Maternal Life International and Caritas Swaziland that aims to meet the medical, physical, social and spiritual needs of people affected by HIV/AIDS.

Since its launch in January 2001, A New Robe has empowered parish nurses from the Catholic Church of Swaziland to reach out to tens of thousands of Swazis with HIV-prevention-and-care interventions. The initial 20 nurses trained by the programme have provided home-based care to more than 5500 clients and administered HIV/AIDS testing and counselling to over 300 people.

The programme was expanded in February 2003 to include nurses from eight other religious denominations (only 20% of Swazis are Roman Catholic), bringing the total number of trained nurses to 33. In addition, a group of 'parish care supporters' were trained to assist the nurses in the home-based care of AIDS patients.

The parish nurse model emphasizes human dignity as the foundation of care. Initially, the nurses provided medications and spiritual comfort. Later, their role was expanded to include treatment for common opportunistic infections and provision of prophylactic co-trimoxazole. As a result, they have been able to reach HIV-infected individuals who otherwise have little access to care. Since February 2003, additional focus has been placed on voluntary counselling and testing (VCT). This is considered critical, given the low availability of VCT in Swaziland, especially in rural areas.

The programme, now in its final year, is feeling the impact of the food crisis in Southern Africa along with its patients. Parish nurses are increasingly faced with meeting the sustenance needs of their patients, as well as their needs for medical care and spiritual comfort. As the nurses search for funding for a constant supply of drugs after 2003, they must also budget for a supply of food parcels to give to their patients. If further support is obtained, Maternal Life International and the Swaziland parish nurses plan to expand the programme to other countries in the region.

AIDS in the workplace

Many business leaders have gained a better understanding of the nature of the epidemic and its effect on their workforces and productivity. As a result, they are stepping up their local mobilization efforts. More companies are developing HIV/AIDS workplace policies and prevention programmes, based on the *ILO Code of Practice on HIV/AIDS and the world of work*. In addition, they are making provisions for care and support, ensuring that condoms are readily available to employees, and encouraging discussion with peers about how to prevent the epidemic spreading further (see box on DaimlerChrysler South Africa).

The benefits of corporate HIV/AIDS-prevention-and-treatment interventions are becoming clearer, not just on humanitarian or philanthropic grounds, but because such programmes make businesses in high-prevalence African countries more viable. An increasing number of companies (especially major mining companies in South Africa) are recognizing that investing in prevention programmes and the provision of treatment and care makes good business sense. A 2000 study on South African companies providing treatment and support to infected employees to extend their productive working lives found that the benefits from such programmes outweighed their costs. The authors cautioned that this cost-benefit analysis required more detailed research for confirmation, but noted that the continuing decline in the costs of antiretroviral treatment meant that such programmes were likely to become more cost-effective in the coming years. An analysis of 70 South African companies by FutureForesight, a firm

of HIV workplace economics specialists, has also shown the viability of funding HIV treatment. In the long run, the cost of prevention and treatment is lower than the cost of a never-ending cycle of losing and replacing skilled workers. And AIDS not only kills productive and skilled workers, it also causes higher absenteeism, higher health-care and pension costs, higher funeral payouts and higher training costs. The costs of care for the majority of Africans who do not have access to public or employer-provided treatment are also eating away at disposable incomes, which, in turn, reduces local markets for goods and services.

In West Africa, where approximately 6% of 15–49-year-olds are believed to be HIV-positive, Côte d'Ivoire's privately-managed electric utility, CIE, is viewed as a regional model that could be emulated by other African companies. One of the largest employers in the region, CIE has set up workplace anti-AIDS programmes that include condom distribution and AIDS education for communities near its offices, especially in areas where there is a high level of prostitution. The company also provides health facilities and confidential medical care to its 13,000 workers and their families. HIV-positive workers receive assurances from the company that they will not be fired because of their HIV status and, in a move that sets it apart from most others in the region, the company provides antiretroviral treatment to HIV-positive workers through a company fund that is partly subsidized by employee contributions. Managers say the company's policy is showing clear signs of success, with rates of sexually transmitted infections among workers having fallen by 65% since the beginning of the programme.

In Zimbabwe, factories with peer-education programmes have seen a fall in infection rates of up to 34%, compared with workplaces without such initiatives. In Côte d'Ivoire, the government now requires all businesses with more than 50 employees to

establish HIV/AIDS committees to implement prevention programmes, educate the workers about potential risks and encourage behavioural change. Cameroon is also working to ensure that half of all businesses have AIDS education programmes for workers in place within the next two years.



PHAKAMA actors wearing miners' helmets, used to demonstrate the problem of AIDS in South Africa's mines. PHAKAMA (Rise, Stand Up) is a participative theatre group from Sheshego township near Pietersburg, South Africa. UNAIDS/L. Gubb

DaimlerChrysler South Africa's HIV/AIDS Programme

In 1991, DaimlerChrysler South Africa (then Mercedes Benz South Africa) first responded to the AIDS pandemic when it adopted its first HIV/AIDS workplace policy. The corporation has since widely expanded its AIDS-related initiatives. In 2000, it entered into a three-year, public-private-partnership with GTZ, the German Government-owned corporation for international development cooperation. The 2001-2003 partnership aims to strengthen DaimlerChrysler South Africa's HIV/AIDS Workplace Programme into a needs-based initiative that prevents new infections among employees, dependents and their communities; ensures comprehensive treatment, care and support; and provides a platform for meaningful community involvement.

The public-private partnership delivers:

- information, education and communication services centred on a peer educator approach;
- comprehensive treatment, care and support services and the creation of a non-discriminatory environment in which voluntary counselling and testing for HIV is promoted (with ongoing access to appropriate antiretroviral treatment remaining a cornerstone);
- an extensive community involvement component in partnership with families, health-care professionals, traditional healers, government and nongovernmental organizations; and
- corporate social responsibility, advocacy and leadership in the field of HIV/AIDS.

Addressing vulnerability, stigma and discrimination

Reducing Africans' vulnerability to HIV infection is fundamental to reversing the spread of the virus. The interrelationship of risk, vulnerability and the impact of the epidemic is now clear. Decreasing the risk of infection slows the epidemic. Decreasing vulnerability decreases the risk of infection and the impact of the epidemic. Decreasing the impact of the epidemic decreases vulnerability to HIV/AIDS. This positive cycle of simultaneously reducing risk, vulnerability and impact is an essential feature of an expanded response to AIDS.

Poverty and vulnerability

Previous sections of this report outlined how AIDS can cause individuals—and entire families—to slide into poverty. The reverse is also true. Poverty, underdevelopment and the inability to choose one's own destiny fuel this epidemic. Poverty may reduce an individual's ability to avoid becoming infected. For example, lack of income may lead people to engage in high-risk, income-generating activities such as sex work. Sex workers may engage in sex without condoms for the sake of higher fees. Poverty is also associated with lower education, which may, in turn, be associated with lower awareness of measures to prevent HIV infection. Also, the poorer the individual, the less likely that individual will be to have access to treatment, care, preventative interventions and education.

Action against AIDS must be part and parcel of poverty reduction and development strategies. Development simply cannot be sustained without addressing the challenge of AIDS. In 30 of the world's poorest nations (most of them south of the Sahara) per capita incomes have been declining steadily. Especially in Southern Africa, AIDS is eroding the development gains of the past 50 years and reversing improvements in life expectancy. One tool that can be better utilized to mainstream AIDS in development work is the Poverty Reduction Strategy Paper (PRSP), which maps out a country's approach to poverty reduction, providing a framework for technical and financial support. A UNAIDS review in early 2002 of the first generation of 25 full and interim PRSPs in sub-Saharan African countries analysed how well they tackled AIDS. The study revealed progress in mainstreaming—progress that has continued in more recent PRSPs—but the figures also show that far more could be done to fully exploit the potential of PRSPs, which often become the basis for national development plans.

Crippling debt burdens are also undermining the ability of many African governments to tackle the pandemic. Malawi, for example, spends the same amount servicing its debt as it does on health. Zambia pays about US\$125 million a year on its debt—more than two-thirds the amount it spends on health, education and welfare combined.



A 15-year-old sex worker waits for a customer, sitting on a step at night on a street in Dar es Salaam, United Republic of Tanzania. UNICEF/HQ96-1508/G. Pirozzi

The World Bank/IMF Highly Indebted Poor Countries (HIPC) Initiative provides an opportunity for donors and governments to combine debt relief with the response to the HIV/AIDS epidemic. The initiative helps mobilize and scale up interventions using a multisectoral approach (see box on Cameroon debt relief). However, such debt relief needs to be extended to more countries and deepened in those already receiving relief. Many of the countries supposed to be benefiting from the HIPC Initiative still spend over 15% of government revenue on debt servicing—money that is desperately needed for health and education.

Human rights, stigma and discrimination

The bravery of people living openly with HIV, as well as greater overall understanding of the virus, has lessened the barriers of stigma, discrimination, denial and shame that hindered action against AIDS during the early days of the epidemic. But, as the epidemic reaches further and deeper into societies, so does the fear that surrounds it. In many countries and communities, the shame and stigma associated with being HIV-positive have reinforced denial and hindered effective action. Friends and family die “after a long illness”, never of AIDS. Stigma and discrimination undermine prevention efforts and have powerful psychological consequences for people living with HIV.

Debt relief and AIDS – lessons learned from Cameroon

Cameroon, with 40% of its population living below the poverty line and almost 12% of adults infected with HIV, began receiving debt relief in October 2000 under the World Bank/IMF Heavily Indebted Poor Countries (HIPC) Initiative. The move immediately freed about US\$100 million per year over a three-year period for expenditures on health care, primary education, HIV prevention and other critical social services.

Implementation of HIPC-funded programmes, including an emergency AIDS plan, began in October 2001. Programming has focused on condom distribution, prevention of mother-to-child transmission (PMTCT) of HIV, youth education and the establishment of 10 voluntary and anonymous HIV-screening centres. Specific initiatives include: the distribution of 7 million condoms; the training of peer trainers for HIV education of students, military personnel, sex workers and other groups; and the erection of 15 educational billboards on major roads. The funds were also used to purchase reagents and consumables, including breast-milk substitutes for PMTCT, for church hospitals and voluntary screening centres.

The HIPC Initiative has contributed to significant advances in the availability of antiretroviral therapy to AIDS patients. After negotiations between the government and the pharmaceutical industry in 2001, the cost of a month's supply of antiretroviral treatment fell from US\$700 to US\$125. HIPC subsidies further reduced the cost to US\$40. The HIPC funds also helped the government reduce by one-third the cost of viral burden examinations, from US\$100 to US\$65. These two initiatives have made it possible for almost 6,000 patients to gain access to antiretrovirals and receive acceptable support.

Another major outcome (and requirement) of HIPC has been the drafting of a Poverty Reduction Strategy Paper (PRSP), which is expected to be completed in 2003. An interim document produced by the Ministry of Economy and Finance was presented for evaluation by civil society, the private sector and other stakeholders. This process resulted in recommendations for greater resources to be devoted to education, communicable disease control, HIV/AIDS and malaria.

Although Cameroon has made notable progress against poverty and AIDS through the HIPC Initiative, many challenges remain. The spread of HIV in the country is still far outpacing the implementation of strategies to control the epidemic. Streamlining of the HIPC funding process would help Cameroon better utilize the benefits of debt relief. Similarly, there is a need for better coordination between the National AIDS Control Council (CNLS) and the Ministry of Economy and Finance's Technical Monitoring Committee for Economic Programmes (CTS) during the implementation of AIDS-control programmes using HIPC funds. Lastly, the scale of the epidemic is not adequately reflected in the draft PRSP, which relegates AIDS to a sub-element of the health sector, rather than a primary, cross-cutting issue. The full PRSP is expected to include a section on the multisectoral aspects of AIDS.

“We must use an ‘AIDS lens’ to scrutinize the realization of human rights, and use these rights as a platform to increase the effectiveness of AIDS responses.”

—Dr Peter Piot, Executive Director, UNAIDS, in a speech to the 59th Session of the United Nations Commission on Human Rights in March 2003

Stigma is a result of many factors: ignorance, traditional beliefs, prejudice, absence of widespread treatment or a cure, irresponsible portrayal of the epidemic in the media, fears about death, and deep-rooted taboos about sexuality, illness and drug use. Positive legislation, education and dialogue are the main weapons that can be used against it. People living with HIV are often their own best ambassadors, but politicians, religious leaders, teachers and employers must be their allies too.

Discrimination against people living with HIV or those believed to be infected is a clear violation of their human rights. The principle of non-discrimination is central to human rights frameworks and practices. All international human rights instruments and the African Charter prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, fortune, birth or other status. Recent resolutions of the UN Commission on Human Rights have clearly stated that the term “or other status” should be interpreted to cover health status in general and HIV/AIDS in particular. They have confirmed that “discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards”.

As part of its broad efforts to confront AIDS in Africa, the Anglican Church has made fighting stigma and discrimination a priority. In Uganda, a special effort is made to ensure that people living with HIV are welcomed into the church. In Nigeria, the church uses up-to-date information on HIV/AIDS to counter local myths and profiteering. In Burundi, the church has included HIV/AIDS education as part of its post-conflict resettlement activities.

Effective action will necessitate widespread and enduring changes in society’s attitudes and values at local and national level, involving, among other things:

- mobilizing all sectors of society against the epidemic;
- raising awareness through dissemination of information and education campaigns;

Fighting discrimination against HIV-positive job applicants

Haidongo Nghidipohamba Nanditume vs. Namibian Minister of Defence

Nanditume, a former rebel soldier, brought a discrimination suit against the Namibian Minister of Defence in 2000 after he applied for a position with the Namibian Defence Force, but was rejected on the basis that he was HIV-positive. Nanditume claimed that this was contrary to domestic laws and guidelines on employment.

The defence argued that an HIV-positive individual was not a suitable recruit for the armed forces. Nanditume and his lawyers argued that merely being HIV-positive should not be grounds for refusing employment as this did not necessarily mean that an individual would not be able to perform in a military capacity. They stated that a CD4 test and a viral load test would be better indicators as to whether an individual would be unfit to serve, and not merely an HIV test. It was also noted that the Namibian Defence Force did not dismiss individuals who contracted HIV subsequent to employment, but strived to accommodate such people by reassigning them to less strenuous activities.

The court ruled that it could not be said that Nanditume was unfit to serve, as neither a CD4 test nor a viral load test was carried out, and a regular medical test had pronounced him fit. It ordered the Namibian Defence Force to carry out not only an HIV test, but also CD4 and viral load tests to determine the fitness of recruits. The court ruled that no individuals should be excluded from enlistment on the basis that they are HIV-positive, unless their CD4 count is below 200 and the viral load is above 100,000—in other words, unless a person is suffering from AIDS. Lastly, the court ordered the Defence Force to accept Nanditume's application, providing that subsequent CD4 and viral load tests deemed him fit to serve.

Jacques Charl Hoffman vs. South African Airways

The case was brought against South African Airways in 2000 to challenge its policy of refusing to employ HIV-positive people as cabin attendants on the grounds that they could not be inoculated against yellow fever, posing a health hazard to themselves and others. It was also stated by the defendants that HIV-positive people would not be suitable as they would not live very long.

Hoffman based his argument on expert medical opinion, including the fact that HIV-positive people could indeed be inoculated for yellow fever as long as their CD4+ count was not below 350. The court also heard that antiretroviral treatment could enable individuals to live normal lives so that, for the purposes of employment, they would be fit and would pose no risk to other employees, passengers or themselves.

The medical evidence was so compelling that the airline changed its policy in the middle of the proceedings. However, the court went on to consider whether any constitutional rights had been violated by South African Airways. It was held that the airline had discriminated against HIV-positive people as the airline's grounds for refusing employment had no basis in reality but were merely due to prejudice. The court also ordered the airline to employ Hoffman and pay his legal costs. Justice S. Ngcobo stated at the end of the proceedings, "We must guard against allowing stereotyping and prejudice to creep in under the guise of commercial interests. The greater interests of society require the recognition of the inherent dignity of every human being, and the elimination of all forms of discrimination. Our Constitution protects the weak, the marginalized, the socially outcast, and the victims of prejudice and stereotyping. It is only when these groups are protected that we can be secure that our own rights are protected".

- monitoring human rights violations, and taking legal action to counter discrimination and seek redress;
- continuing advocacy;
- greater empowerment of people living with HIV;
- tackling broader issues of racial, gender or sexual inequalities that fuel discrimination;
- training health, educational and legal personnel to promote better understanding and allay unfounded anxieties;
- encouraging people to determine their serostatus; and
- providing treatment, care and support.

Litigation

Litigation is an essential strategy in reducing stigma and discrimination and in fostering the implementation of human rights at national level. The Universal Declaration on Human Rights (Article 8) states, “Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or law”. Litigation holds governments accountable for action or inaction. When private actors are sued or prosecuted, litigation provides the necessary testing and enforcement of law and public policy. Litigation can also empower the socially disadvantaged, including those groups most vulnerable to infection, and can also influence legal and policy reform.

Litigation has been used extensively to test and advance HIV/AIDS law and policy in many countries and in many different contexts. Common law areas include discrimination, treatment access, HIV transmission, civil responsibility and liability, inheritance, workplace injury compensation and family matters.

The recent growth of HIV/AIDS litigation in Africa can be attributed to at least two factors: an increase in the number of violations, as well as an increase in protection. The law is increasingly being used to enforce positive action. (See box on fighting discrimination against HIV-positive job applicants.)

3. Closing the gaps

The task is a daunting one, but HIV/AIDS is not an unstoppable force. It can be turned around and, after two hard, painful decades of experience and accumulated knowledge (much of it gained in Africa), African governments and the international community are beginning to understand where the brakes of the epidemic are. They now need to apply them more thoroughly. As noted in an April 2003 World Bank progress report on the global fight against HIV/AIDS, “Without significant changes in the way the epidemic is addressed, there is little chance of meeting the Millennium Development Goal that encompasses halting and beginning to reverse the spread of HIV/AIDS by 2015”. This chapter highlights the gaps in many national responses, which deserve special attention in scaling up action against AIDS in Africa.

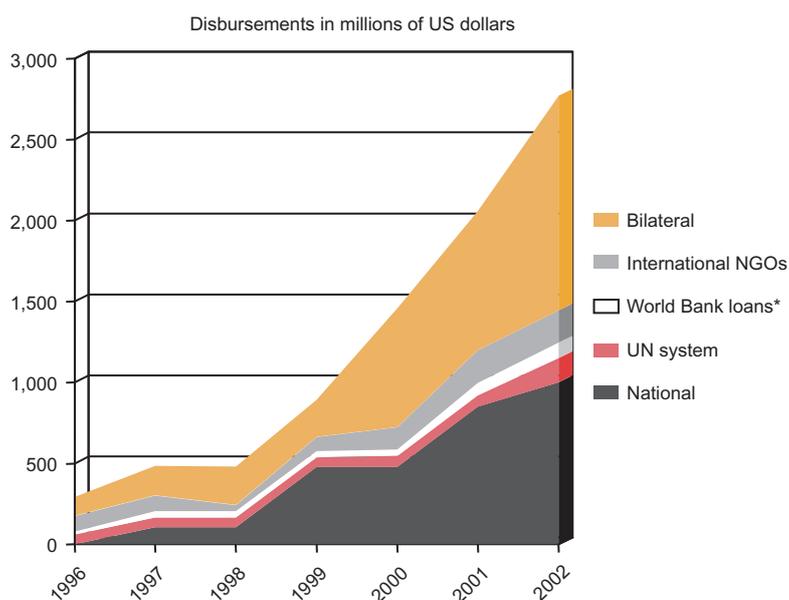
Resource gaps

The depth and breadth of AIDS in Africa presents enormous challenges. Even though national and international funding for AIDS in low- and middle-income countries has increased considerably since 1996 (see Figure 11), the resource gaps are large and growing (see Figure 12).

In sub-Saharan Africa, international spending on HIV/AIDS has risen well above the approximately US\$550 million figure documented in 2000—the last year regional statistics were compiled. However, the UNAIDS Secretariat estimates that the increase in spending is not keeping pace with the need. The 2000 spending figure would have to be multiplied by 10 times over seven years to reach sub-Saharan Africa’s estimated resource needs in 2007: US\$5.5 billion (see Figure 13).

Figure 11

AIDS spending in low-and middle-income countries



Source: UNAIDS

* Grant component of concessional loan disbursements

Figure 12

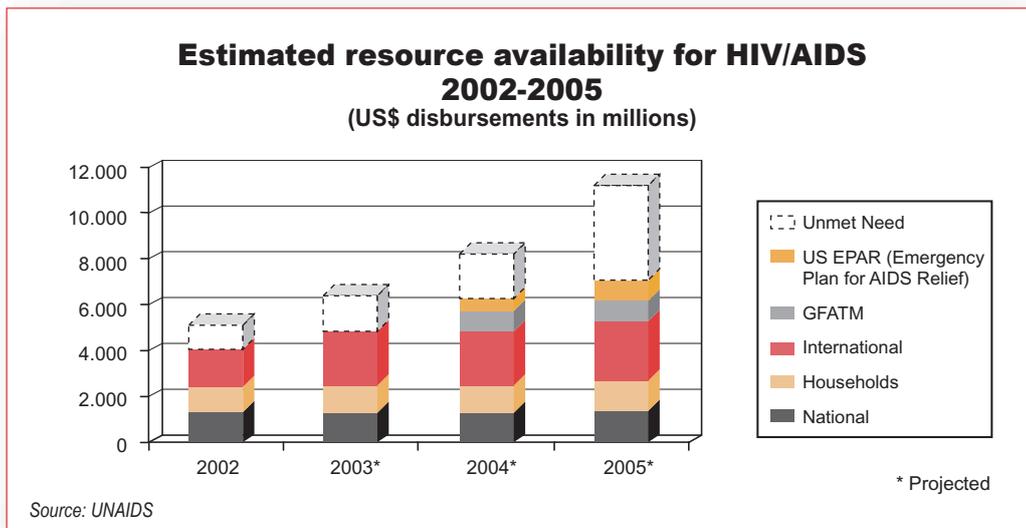
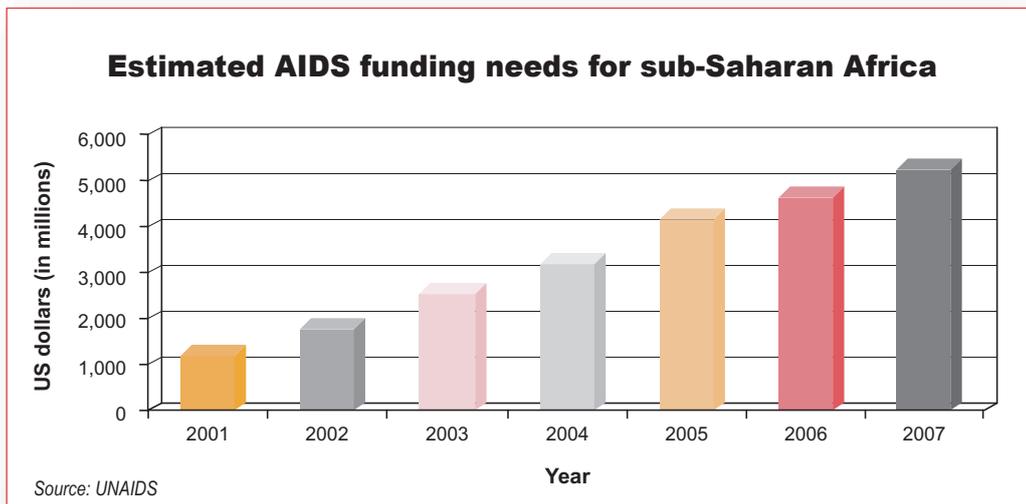


Figure 13



African commitments

African governments are devoting more of their own resources to AIDS—a trend that Africa’s leaders have pledged to continue. In April 2001, the Heads of State who signed the Abuja Declaration committed themselves to increasing domestic spending on health to 15% of national budgets. This means a significant increase in spending on AIDS initiatives in most countries. Nevertheless, it will still only go a small way towards meeting the enormous needs generated by AIDS. The UNAIDS Secretariat documented expenditures of about US\$250 million on AIDS by sub-Saharan African governments in 2002—roughly 13% of the region’s budgetary needs that year. The addition of undocumented spending may bring this amount closer to UNAIDS’ recommended spending share of 20% of total projected programming capacity for the region. However, the total reflects the difficult state of public finances on the continent—a situation that will

Intensifying and decentralizing HIV/AIDS efforts in South Africa

A nationwide, multisectoral and sustainable response to AIDS in South Africa requires that HIV/AIDS programmes be funded by regular, public-sector budgets. The Government of South Africa has recognized that, if the budget process and funding flows follow a vertical model, government HIV/AIDS prevention, treatment and care services will not be able to achieve the integration and scale required for a response matching the severity of the epidemic. The South African funding strategy for AIDS (initially laid out in the National Integrated Plan for HIV/AIDS (NIP) in 2000) utilizes flexible funding channels to more effectively finance interventions led by provincial governments.

Over the next three years, South Africa's National Treasury plans to allocate R8.46 billion (US\$1 billion) towards fighting HIV/AIDS and fortifying the health sector so it can better withstand the impact of the epidemic. Some of these funds are channeled to provincial governments and earmarked for particular AIDS interventions. However, the bulk of funds are sent to the provinces through a block grant mechanism that does not oblige provinces to allocate the funds to AIDS.

The earmarked funds, known as conditional grants, serve as the cornerstones of the NIP. Driven jointly by the departments of health, education and social development, the NIP began with three primary programmes: voluntary counselling and testing, life-skills education, and community- and home-based care and support. National government departments provide technical assistance, coordination and programme support to the provincial social service departments responsible for implementation. In the current budget, earmarked funds for AIDS interventions jumped to R333.6 million (US\$43.2 million), compared to only R55 million (US\$7.1 million) in 2001-02. This increase has been focused on a rapid roll-out of programmes for the prevention of mother-to-child transmission (PMTCT); provision of post-exposure prophylaxis (PEP) drug treatment to women who may have been exposed to the virus due to rape; step-down care facilities; and training of medical personnel in AIDS care.

In addition to funds earmarked for AIDS, the South African Government has also introduced another budgeting channel that makes more funds available to provinces, but leaves it up to the provinces to allocate those funds for HIV/AIDS interventions. In 2002-03, the first year of this initiative, R400 million (US\$52 million) was made available in this manner. Then, in 2003-04, this figure increased to R1.1 billion (US\$140 million). The less direct method was chosen in recognition of the fact that provinces needed the authority to utilize these funds for a general strengthening of the health sector. In 2003-04, this funding mechanism represents over 55% of the total amounts dedicated for HIV/AIDS in the national budget. Over the medium term (2003 to 2006), R5.45 billion (US\$710 million) will flow to the provinces through this channel.

From a public finance perspective, given the great boost from the National Treasury in recent budgets, one of the greatest challenges for the government's response to HIV/AIDS in the immediate future is its capacity to properly manage and spend these new resources.

Source: Research Unit on AIDS and Public Finance, Institute for Democracy in South Africa

come under further strain as the epidemic continues to erode economic growth. A case in point: a year after the pledge was made to devote 15% of national spending to health, only two countries had reached the target.

Some countries have adopted innovative financial means to tackle the epidemic. In Zimbabwe, for instance, despite the political turbulence of the past few years, a 3% surtax on personal and corporate income has been levied to raise money for grass-roots work on AIDS. The money is targeted at the training of peer group educators, as well as counselling and care in the community. Such initiatives can help enhance national ownership and responsibility in the battle against AIDS, giving added value to prevention campaigns and encouraging behavioural change.

Much of the spending on HIV/AIDS, however, comes not from governments or donors, but from individuals. Ninety per cent of medicines in Africa are paid for by individuals, not government programmes. A full course of antibiotics to cure pneumonia or an STI can cost low-paid, unskilled workers up to a month's wages. According to WHO, a Tanzanian has to work the equivalent of 500 hours to pay for TB treatment, whereas a Swiss has only to work an hour and a half. Some medicines can be even more expensive in developing countries than in industrialized nations, with local duties, taxes, distribution costs and dispensation fees driving up over-the-counter prices by 30–45%. This out-of-pocket spending disproportionately affects the poor. Illness and death within the family often mean that households lose vital income just when they incur increased expenses. Money is needed for care, hospital fees, funerals and simply surviving from day to day. As debts build up, valuable livestock and assets are sold in

a desperate attempt to cope. Income in AIDS-affected households can be less than half that of the average household.



A group of street children in Maputo, Mozambique, inform pedestrians about the risks of unsafe sex and demonstrate the proper use of condoms to prevent HIV infection. This activity is organized by the Baixa Centre, created by *Médecins du Monde*. UNAIDS/B. Neeleman

New international commitments

International spending on AIDS programmes in developing countries has grown substantially in recent years. Projected spending in 2003 by donor nations, international lending institutions, the UN system, private foundations and nongovernmental organizations is expected to be US\$2.6 billion, compared to US\$1.2 billion in 2001. Approximately US\$1.6 billion of donor spending in 2003 comes from the governments of 12 industrialized nations (see Table 2).

It appears that spending will continue to increase. In May 2003, US President George W. Bush signed legislation authorizing an increase in US Government spending on HIV/AIDS, from US\$5 billion to US\$15 billion over the next five years. Other leaders of industrialized countries have since signalled similar resolve. This is a welcome indication of the priority given to AIDS programmes, but only if pledges are followed by swift disbursements.

Table 2

Projected 2003 AIDS spending by industrialized nations		
Country	Budgeted	Projected Disbursements
US	838.3	576.8
UK	408	452.1
Germany	133.7	107.1
Japan	95	85
Canada	93.8	66.3
EC	93.2	65
Netherlands	82	65
Norway	50.8	50.8
Ireland	44.9	40
Australia	39	39
Italy	36.4	25.0
France	36.3	25.0
Other*	49.5	40
TOTAL	2,000.9	1,637.1
All figures in millions of US dollars		
* Austria, Belgium, Denmark, Finland, Greece, Luxembourg, New Zealand, Portugal, Spain, Sweden and Switzerland		
Source: UNAIDS		

International lending institutions are also increasing their contributions. The World Bank's Multi-Country AIDS Programme (MAP) for Africa had already disbursed US\$106.3 million to African countries by July 2003, and has committed to disbursing more than US\$800 million to 23 African nations (see Table 3). MAP funding is comprehensive and flexible. It supports all aspects of national AIDS programmes, including basic prevention through antiretroviral therapy, as well as impact mitigation. The MAP is multisectoral, funding the HIV/AIDS plans of all sector ministries encompassed in the national plan.

And the MAP puts special emphasis on civil society. Half of the money provided by the World Bank is flowing directly to civil and community organizations so that they can implement their own programmes. In addition to funding activities, the MAP helps countries strengthen their capacity in implementation, financial management, and moni-

Table 3

World Bank MAP and Global Fund commitments as of end July 2003 (in US\$)		
Country	MAP	Global Fund (years 1 and 2)
Benin	\$23 million	\$11.3 million
Botswana		\$18.6 million
Burkina Faso	\$22 million	\$7.3 million
Burundi	\$36 million	\$4.9 million
Cameroon	\$50 million	
Cape Verde	\$9 million	
Central African Rep.	\$17 million	\$8.2 million
Côte d'Ivoire		\$26.9 million
Eritrea	\$40 million	
Ethiopia	\$59.7 million	\$55.4 million
Gambia	\$15 million	
Ghana	\$25 million	\$2.8 million
Guinea	\$20.3 million	\$4.8 million
Kenya	\$50 million	\$39.6 million
Lesotho		\$10.6 million
Liberia		\$7.7 million
Madagascar	\$20 million	\$3.7 million
Malawi		\$58.7 million
Mauritania	\$21 million	
Mozambique	\$55 million	\$29.7 million
Namibia		\$26.1 million
Niger	\$25 million	
Nigeria	\$90.3 million	\$28.2 million
Rwanda	\$30.5 million	\$8.1 million
Senegal	\$30 million	\$6 million
Sierra Leone	\$15 million	
South Africa		\$60 million
Swaziland		\$29.6 million
Togo		\$14.2 million
Uganda	\$47.5 million	\$36.3 million
United Rep. of Tanzania	\$70 million	\$6.5 million
Zambia	\$42 million	\$42.3 million
Zimbabwe		\$10.3 million
TOTAL	\$813.3 million	\$557.6 million
All figures have been rounded to the nearest US\$100,000.		
Source: World Bank and Global Fund		

toring and evaluation. This is enabling them to deal effectively with the rapid increase in external funding, as well as expediting the flow of funds to those who are carrying out programmes. As a result, greater accountability, responsibility and financial responsibility on the part of African governments are bringing in their wake a greater willingness on the part of donors to support national plans.

Another significant boost in the global response has been the creation in January 2002 of a major financing mechanism—the Global Fund to Fight AIDS, Tuberculosis and Malaria. This new public-private mechanism aims to channel funding from various donors to country-level initiatives to combat these three diseases. In its first two rounds of funding-proposal review, the Global Fund had approved about US\$557.6 million in grants to support national AIDS programmes in Africa over a two-year period. By July 2003, signed grant agreements totalled more than US\$238.4 million, and more than US\$15 million of that grant money had been disbursed.

Integrating support

As AIDS responses have grown more complex, expanding from the health sector to encompass every sector of government and society, the number of different agencies supporting the response has also grown. Donors, nongovernmental organizations, research institutions, funds and foundations all have an important role to play in supporting national responses.

The situation in Southern Africa highlights the importance of coordinating HIV/AIDS-related initiatives with humanitarian efforts. The UN system's response to the food crisis in the region has been managed by the Regional Inter-Agency Coordination and Support Office (RIACSO). AIDS initiatives were part of this coordinated approach. The humanitarian response helped to avert illness, starvation and death in the region. It also analysed and took into account the full destructive impact of AIDS in the region, especially the effect it is having on food security (see box on RIACSO).

RIACSO

The Regional Inter-Agency Coordination and Support Office (RIACSO) was created to coordinate the UN humanitarian response to the food crisis that struck six Southern African countries in 2002. The RIACSO partners—FAO, IOM, OCHA, UNICEF, UNDP, WFP, WHO and the UNAIDS Secretariat—recognized the need to better understand and measure today's complex crises, and to expand the vision and response to vulnerability, including the impact of HIV/AIDS on social sectors and households. Results of vulnerability assessments in the region indicate that households affected by adult illness and death are characterized by lower food production and lower household income. These households are likely to resort to short-term coping strategies that can permanently weaken their longer-term ability to cope with future shocks, including sales of income-generating assets such as livestock and reduction of expenditure on schooling. At a broader level, health, education and other sectors are equally vulnerable to collapse as a result of AIDS.

Whereas the food crisis is gradually being contained, the Southern African AIDS crisis is a continuing threat, in terms of both a humanitarian emergency and a long-term development crisis. Compounded by governance issues, the crisis has resulted in the collapse of coping mechanisms and has undermined the recovery system. There is an immediate need for a different kind of approach to save people's lives and livelihoods. In the worst affected countries and regions, the epidemic alone might warrant emergency programming in its own right, irrespective of climatic conditions.

Prevention gaps

The right to information is a fundamental human right. This includes the right to information on how to prevent HIV infection, which is especially important for young people. At the end of 2001, 30% of the nearly 30 million people infected with HIV in Africa were between 15 and 24 years old. Half of the newly infected are in this age group—young men and women entering their most productive years. Progress in countries such as Uganda, which tackled the epidemic early and vigorously, proves that education, abstinence, fidelity, condom use and access to voluntary counselling and testing (VCT) can change the course of the epidemic.

The focus now must be on scaling up an effective combination of prevention and treatment initiatives. Treatment and prevention are inextricably linked. Evidence from low- and middle-income countries with growing antiretroviral treatment programmes

(including Brazil, Chile, Côte d'Ivoire, Senegal and Uganda) strongly suggests that the number of people seeking voluntary counselling and testing tends to increase when treatment is available. Without treatment, those at risk have very little reason to seek diagnosis, especially if stigma and discrimination are the most likely outcome.

Targeting young people

Providing young people with the skills, information, tools and services to protect themselves from HIV infection is a critical factor in halting its spread. The UN Declaration of Commitment on HIV/AIDS reinforced this, specifically requiring that, by 2005, 90% of young people (aged 15–24) should have access to prevention, including services to develop the life skills needed to reduce vulnerability to HIV infection. For its *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003*, UNAIDS conducted a survey to measure progress towards this goal. Of the 12 countries in sub-Saharan Africa that responded, Botswana appeared to be making significant strides, embarking on a major effort to engage schools in the country's AIDS response. Botswana has initiated a national distance-learning television programme that targets teachers and students in primary, secondary and tertiary institutions. Modelled on Brazil's successful *TV Escola*, the programme provided televisions and video machines to 325 of the country's 979 schools, technical colleges and education centres.

Such efforts are certainly needed. According to data collected within the past several years, more than 60% of teenage girls (aged 15–19) in 21 African countries have at



Straight Talk newspaper, Nairobi, Kenya. Two editorial board members look at the letters the newspaper has received from readers. *Straight Talk* is a local newspaper produced by young people for young people. The project, started in 1995, is supported by UNICEF and the Ford Foundation. UNAIDS/G.Pirozzi

least one major misconception about AIDS or have never heard of AIDS. Less than half of young women (aged 15–24) in 10 sub-Saharan countries (out of 23 sub-Saharan countries surveyed in 2000) were aware that the risk of HIV can be reduced by using condoms. In 8 of those 10 countries, less than half of the young women surveyed were aware that the risk of HIV can be reduced by limiting sexual contact to just one partner. Among men, practice of basic prevention

methods varies considerably among countries. Condom use among young males (aged 15-24) during their last sexual encounter with a non-regular partner has been measured at 88% in Botswana, but less than 33% (one-third) in Cameroon, Ethiopia, Guinea and the United Republic of Tanzania.

Teaching prevention in schools

The UNAIDS Inter-Agency Task Team on Education has stressed that education for HIV prevention should begin early (before children and young people are exposed to risks) and should be sustained over time. In this regard, schools have an important role to play in reducing risk and vulnerability associated with the epidemic. Studies have shown that the better educated children are, the better able they are to use their knowledge, skills and confidence to protect themselves from HIV. In Zambia, where more than 20% of adults are living with HIV, adolescents with more years of schooling are less likely to have casual sexual partners and more likely to use condoms than are their peers with less schooling.

The Inter-Agency Task Team has identified six areas that must be prioritized as school systems promote AIDS education:

1. Efforts to ensure that teachers are well prepared and supported in their teaching on HIV/AIDS.
2. Preparation and distribution of scientifically-accurate, high-quality teaching and learning materials on HIV/AIDS, communication and life skills.
3. Promotion of life skills and peer education with children and young people, and among parents and teachers themselves.
4. Elimination of stigma and discrimination, with a view to respecting human rights and encouraging greater openness concerning the epidemic.
5. Support for school health programmes that provide a safe and secure school environment for both teachers and pupils, in combination with school health policies, skills-based health education and school health services that explicitly address HIV/AIDS.
6. Promotion of policies and practices that favour gender equality, effective learning, peer education, and primary and secondary school completion.

Mabathogna High School in Maseru, Lesotho. Students review and comment on some HIV-prevention material jointly produced by UN agencies, local NGOs and the Government of Lesotho. *UNAIDS/G. Pirozzi*



Voluntary counselling and testing

Voluntary counselling and testing (VCT), woefully unavailable in many parts of Africa, facilitates both prevention and treatment. Knowing one's HIV status is a prerequisite for making informed decisions. VCT starts before an HIV test, with counselling of individuals so that they can make an informed choice about being tested. This is a cornerstone of the voluntary nature of counselling and testing. As more individuals in a community undergo VCT, the benefits are innumerable. Knowledge of serostatus can be a motivating force for both HIV-positive and HIV-negative people to practise safer sexual behaviour. Individuals can also better plan their lives. Expectant mothers who discover they are HIV-positive can seek measures to prevent the transmission of the virus to their children. HIV-positive men and women can learn how antiretroviral treatment can ward off AIDS. Post-test counselling is key to informed decision-making. Counselling of HIV-positive and HIV-negative individuals also helps dispel the stigma and discrimination surrounding AIDS. The increase in information and understanding encourages more people to determine their status, especially when an increase in VCT is combined with an increase in access to antiretroviral treatment.

The UNAIDS Secretariat has identified five general principles for the proper delivery of VCT services:

1. VCT services must be confidential. Test results must be revealed only to the person being tested, and everything discussed between a counsellor and a client, both pre- and post-test, must be confidential unless the client decides otherwise.
2. The decision to take advantage of VCT services must be voluntary.
3. All clients accessing these services should be offered both pre-test and post-test counselling.
4. Clients who test HIV-positive must not be discriminated against.
5. Clients should be given access to on-going prevention, care and support services.



Blood being taken for an HIV test in the AIDS ward of Kenyatta Hospital in Nairobi, Kenya. *UNAIDS/G.Pirozzi*

Mother-to-child transmission of HIV

“[An HIV-positive woman] was already in advanced labour and very anxious about her condition. We wanted her to get the drug that will prevent the spread of HIV infection to the baby. We found out that only Mbabane Hospital had the drug. Finally [she] delivered without the special drug. It was just as if someone has died in our maternity unit. We know that the baby is infected.”

—a parish nurse in Swaziland

Another pillar of prevention is the short-term use of antiretrovirals to prevent mother-to-child transmission (PMTCT) of HIV. Reducing the number of HIV-infected newborns begins with the prevention of HIV in mothers and the prevention of unwanted pregnancies. If an HIV-positive woman becomes pregnant, short-course antiretroviral treatment reduces the risk of transmission to her newborn by up to 50%. The chances of mother-to-child transmission can also be reduced by delivering babies by caesarean section and by replacement feeding of newborns.

At the end of 2001, only 1% of African women in need had access to PMTCT treatment. However, individual countries are making strides—especially Botswana, which has reached 34% coverage. In South Africa, the Demonstration of Antiretroviral Therapy (DART) Project is playing a lead role in the scaling up of VCT and PMTCT in the country. Implemented by the Perinatal HIV Research Unit of the Chris Hani Baragwanath Hospital in Soweto, DART provides VCT services, including rapid on-site testing, at the hospital and two community health centres. Pregnant mothers determined to be HIV-positive are offered PMTCT services including antiretrovirals, modified midwifery practices that minimize MTCT, and instruction on safer infant feeding practices. Counselling is offered every step of the way.

Treating sexually transmitted infections

Untreated sexually transmitted infections (STIs) greatly increase the risk of HIV transmission. A person with an untreated STI is up to 10 times more likely to pass on or acquire HIV during sex. A genital ulcer can increase threefold the risk of HIV infection from a single exposure. WHO and UNAIDS estimate that 340 million curable STIs occur annually worldwide among people aged 15–49, and 85% of these cases occur in developing countries. In rural South Africa, nearly 9% of adults have

syphilis and almost 5% have gonorrhoea. Fifty per cent of all patients attending STI clinics in Swaziland in 2000 also tested HIV-positive. Yet only 14% of Swazis in need can currently access STI treatment.

Treatment gaps

“We can no longer accept millions of needless AIDS deaths simply because we are poor Africans. We know antiretroviral treatment is feasible in our countries and we are launching a movement to demand antiretroviral treatment that won’t take ‘no’ for an answer.”

—*Milly Katana, Health Rights Action Group, Uganda*



Doctors and nurses from the Central Hospital of Maputo in Mozambique make weekly home-care visits to AIDS patients—such as this 25-year-old woman—who are too weak to go to hospital. *UNAIDS/B. Neeleman*

While their demands for treatment grow louder by the day, millions of Africans living with HIV remain deprived of care, treatment and support, including antiretroviral therapy, prevention and treatment of opportunistic infections, psychosocial support, and palliative care. Since 1996, the use of antiretroviral medicines has dramatically reduced AIDS-related illness and death in countries where it is widely accessible. Yet, at the end of 2002, only 1% of people in need of antiretroviral treatment in sub-Saharan Africa were able to access these life-saving medicines. This inequity confronts national and international leaders with a humanitarian, human rights, health-care, and socioeconomic development emergency of monumental proportions. Considering the scale of the epidemic on the continent, Africa faces daunting challenges in scaling up care, treatment and support to its people, but has the most compelling reasons to overcome these challenges.

Throughout Africa, there is a rapidly growing movement to ensure that Africans gain access to the same treatments widely available to people living with HIV in industrialized countries (see box on Pan-African HIV/AIDS Treatment Access Movement). While HIV treatment prolongs lives and reduces human suffering among people living with

HIV, it is also a practical investment for society. It enables those living with HIV to continue contributing to the well-being of themselves, their families and communities, and society at large. When medical care is well-integrated into prevention efforts in a country, the two elements of the response mutually reinforce each other. Prevention efforts reduce the number of people in need of care and reduce the demands on already-strained health systems. Access to care provides a powerful incentive for people to determine their HIV status and avail themselves of prevention services.

Access to treatment and care is also a matter of human rights. International human rights instruments include the right to the highest attainable standard of physical and mental health. African governments, under Article 16 of the African Charter on Human and People's Rights, have committed themselves to promoting and protecting the right to medical care. In practice, the non-availability, non-accessibility and non-affordability of HIV/AIDS-related medication and therapies, along with inadequate care and support, undermine this commitment. Courts in a number of countries around the world, including in Africa, have ruled that access to HIV care is a constitutional right. For example, in July 2002, South Africa's Constitutional Court, in the context of a case concerning access to nevirapine for prevention of mother-to-child HIV transmission, ruled that the HIV-related services at issue were within the scope of the socioeconomic rights protected by the country's constitution.

Pledge for treatment

The Declaration of Commitment on HIV/AIDS, adopted unanimously by the UN General Assembly Special Session on HIV/AIDS in June 2001, calls on all 189 Member States to "make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled antiretroviral therapy". Two years after the Declaration was made, access to antiretrovirals is

"We are angry. Our people are dying..."

In the push for expanded antiretroviral treatment in Africa, there is growing momentum and vigour among civil society groups across the continent. **The Pan-African HIV/AIDS Treatment Access Movement** was launched by AIDS activists and organizations from 21 countries following an August 2001 meeting in Cape Town, South Africa. The movement expressed frustration with existing treatment policies and committed itself to a declaration of action that states:

"We are angry. Our people are dying. Without treatment, the 28 million people living with HIV/AIDS (PLWHA) on our continent today will die predictable and avoidable deaths over the next decade. More than 2 million have died of HIV/AIDS in Africa just this year. This constitutes a crime against humanity. Governments, multilateral institutions, the private sector, and civil society must intervene without delay to prevent a holocaust against the poor. We must ensure access to antiretroviral treatment as part of a comprehensive continuum of care for all people with HIV who need it. In this regard, at a minimum, we call for the immediate implementation of the World Health Organization goal to ensure antiretroviral treatment for at least 3 million people in the developing world by 2005. Together with our international allies, we will hold governments, international agencies, donors and the private sector accountable to meet this target."

increasing, but not nearly fast enough. As noted earlier, at the end of 2002, antiretroviral treatment was being provided to an estimated 50,000 people in sub-Saharan Africa, or about 1% of the 4.1 million people in need of such treatment. In North Africa and the Middle East, 3,000 people are receiving antiretrovirals—43% of the 7,000 in need. According to recent surveys, the countries with the largest percentages of people in need receiving antiretrovirals are Botswana, Equatorial Guinea, Gambia, Morocco and Uganda. In Southern African countries hit by food crises (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe), antiretroviral treatment coverage remains very limited (see Figure 14).

Launching treatment programmes

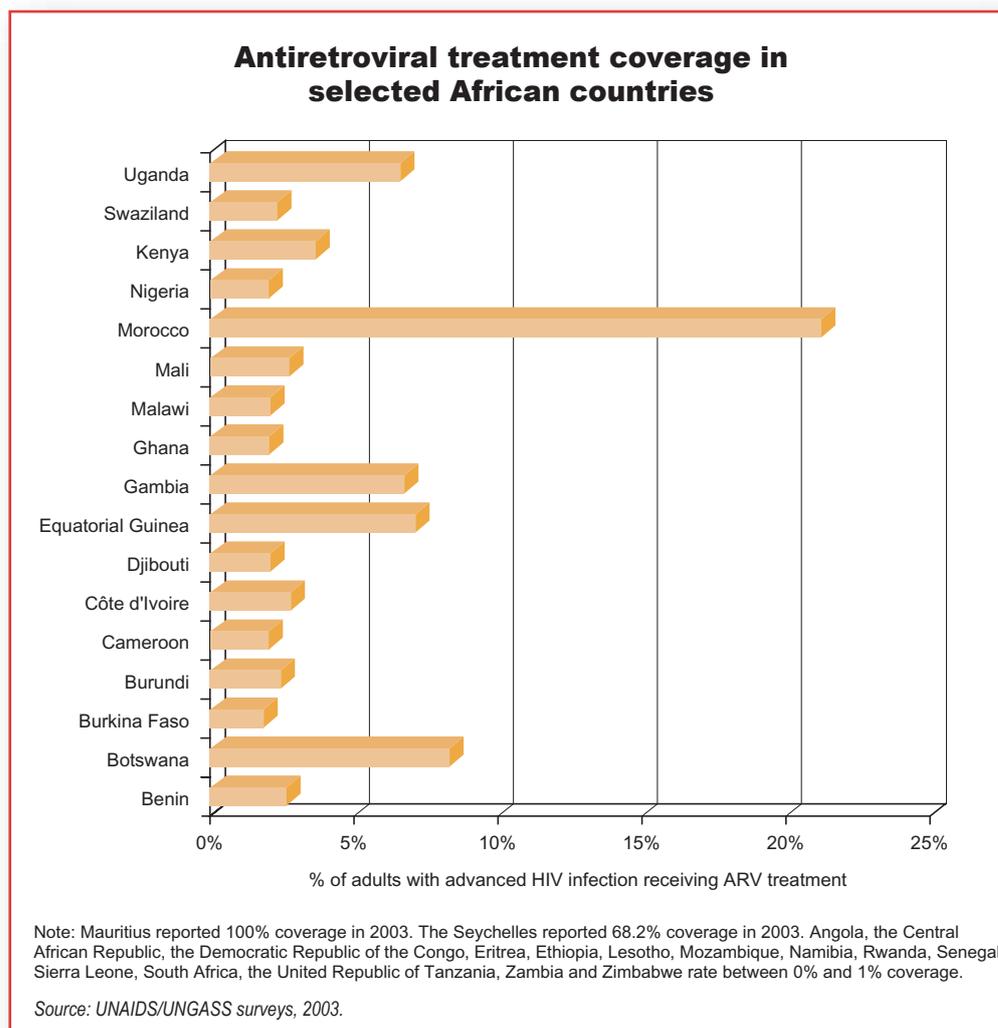
A number of African nations have taken important steps in the public provision of antiretroviral treatment (see box on Botswana's MASA programme). Uganda's Joint Clinical Research Centre introduced assisted antiretroviral treatment in 1991, as part of a study of AZT. In 1998, the government expanded its work in this area as part of the UNAIDS Drug Access Initiative, also carried out in Cote d'Ivoire, and the first public sector pilot projects of their kind demonstrating that antiretrovirals could be used safely and effectively in resource-limited settings. Uganda has steadily expanded antiretroviral treatment through NGO service providers, employee health programmes, research and pilot projects, although it is still not widely available through the public health system. According to recent data, the total number of people accessing antiretroviral treatment in Uganda is about 10,000—one of the highest totals in Africa. However, with about 80% of those accessing antiretrovirals obtaining them through private health facilities,

over 95% of these people pay for their medicines out of their own pocket. The National ART Committee recently developed a national antiretroviral treatment policy and relevant guidelines for costing and implementing a national programme.



A social worker from the Kibera Community Centre taking a patient's blood pressure. The Kibera Community Self-Help programme includes a support group for people living with HIV. *UNAIDS/G. Pirozzi*

Figure 14



Senegal's swift and thorough response to AIDS (including comprehensive prevention programmes and a growing antiretroviral treatment initiative) has enabled the country to keep adult HIV prevalence below 1%. In August 1998, Senegal launched the Senegalese Initiative on Antiretroviral Therapy and, since then, it has continued to expand antiretroviral treatment within the country. Following a pilot phase in Dakar from 1998 to 2000, the government embarked on a scale-up phase involving decentralization of services in four regions, with plans calling for roll-out to all regions within the country by the end of 2004. The programme, which utilizes both branded and generic medicines, includes flexible fees that provide low-income patients with access either free of charge or for a nominal fee. The government has reported 80% adherence to treatment regimens programme-wide.

Nigeria is Africa's most populous nation with 120 million people, including 3.5 million infected with HIV. In April 2001, Nigerian President Olusegun Obasanjo ordered the commencement of free antiretroviral administration as part of a comprehensive care programme for the public sector. Nigeria utilizes both brand name and generic medicines for antiretroviral treatment.

Botswana: The MASA Antiretroviral Programme

The MASA ('new dawn') antiretroviral programme was set up in 2001 with technical and financial assistance from the African Comprehensive HIV/AIDS Partnerships (ACHAP), a collaboration between the Government of Botswana, the Bill and Melinda Gates Foundation, the Merck Company Foundation, and the management consulting firm McKinsey & Company. A team representing a wide range of expertise was put together and commissioned to develop detailed implementation plans and ultimately launch the programme. They started by commissioning a comprehensive study of the potential demand for antiretrovirals and how well-situated the country was in terms of funds and human and physical resources to provide the treatment.

Recruitment and training

One of the biggest gaps identified by the study was skilled personnel to provide the treatment; everywhere, Botswana's health services were operating with shortages of staff, and there was practically no expertise in treating HIV/AIDS. A big recruitment drive was initiated to bring on board not only extra doctors, nurses and pharmacists, but also new types of counsellors to help patients adhere to their drug regimens. The MASA team turned to the Harvard AIDS Institute, which was already conducting clinical research in Botswana and helping the Ministry of Health upgrade its laboratory services to co-develop a training course consisting of 12 basic lectures covering everything from virology and immunology, to drug interactions and side-effects of antiretrovirals. By mid-2003, over 700 people had completed the training course. It has become the standard training package, used also to train private practitioners and health personnel employed by the big mining houses that run their own hospitals.

Medicines

With no experience in antiretroviral treatment, the MASA team looked for combinations that had been shown to be effective elsewhere. Another major concern was minimizing the risk of drug resistance, and this, too, affected the choice of drugs, as well as the guidelines drawn up for their use. They chose 10 brand-name antiretrovirals offering a fairly wide range of combinations and flexibility in prescribing. Antiretrovirals are treated in much the same way as narcotics. They are kept under lock and key, and removing them from safe storage requires the signature of two people.

Management

When the MASA programme began, doctors, nurses, pharmacists and counsellors were keeping their patient records in hand-written files—a system that was inefficient and open to abuse, generating unwieldy piles of paper. Now the MASA team has developed a computer-based patient management system that will be introduced everywhere in due course. The challenge was to create a system that enabled the programme to track patients, to see what drugs they were given and when, and to monitor adherence and health parameters. All patients are given identity numbers, and all the drugs prescribed to a patient are recorded, along with the dates when they should return for a re-supply. If the patient does not return on the correct date, it is immediately apparent.

The challenge ahead

Botswana is breaking new ground, learning to deal with an epidemic that is one of the worst in the world and with distinctive features, so there are many questions needing answers. Will the drugs behave the same way in the people of Botswana as they do elsewhere? Will the side-effects be the same? Do genetic or behavioural variations make a difference? Research is a core part of the antiretroviral programme, and the computer-based system, with its powerful capacity to gather data, serves the purposes of research also. It can organize data according to gender, age groups, or topic, pulling out, for example, all the data pertaining to CD4 counts, or viral load.

The biggest challenge in expanding the programme remains shortages of staff and specialist skills. But reaching people in villages beyond the tarred roads and airstrips presents formidable challenges too. Another lesson learned from experience so far is that programmes should not wait until everything is in place and conditions are ideal before introducing antiretrovirals. Doctors and nurses are already spending much of their time caring for people living with HIV, since the majority of cases they see in the hospitals and clinics are HIV-related.

(Excerpted from an upcoming UNAIDS Best Practice report, Stepping Back from the Edge: vision, activism and risk-taking in pursuit of antiretroviral therapy.)

In Cameroon, the government has used debt relief funds from the World Bank/IMF Highly Indebted Poor Countries Initiative to subsidize the provision of generic antiretroviral drugs through public health facilities. The programme, which has brought the monthly cost of treatment down to US\$20 per individual, has led to a rapid increase in treatment—from a few hundred people to more than 7,000 receiving treatment.

In a landmark decision widely hailed both within and outside South Africa, the South African Cabinet announced in August 2003 that the government plans to begin public-sector provision of antiretroviral drugs. The country's Department of Health is expected to develop a plan detailing when and how the drugs will be made available by the end of September 2003.

“...antiretroviral drugs do help improve the quality of life of those at a certain stage of the development of AIDS [...] Government shares the impatience of many South Africans on the need to strengthen the nation's armoury in the fight against AIDS. Cabinet will therefore ensure that the remaining challenges are addressed with urgency, and that the final product guarantees a programme that is effective and sustainable.

—8 August 2003 statement by the Cabinet of the South African Government on its decision to include antiretroviral treatment in the public health system

ARV treatment in the workplace

Most antiretroviral treatment in Africa to date has been provided through the private sector, available to well-off individuals through private practitioners or through the employee health-care programmes of large corporations. Some of the continent's economic giants (including DaimlerChrysler South Africa, De Beers and the Debswana Diamond Company) have recognized the effectiveness and economic imperative of investing in treatment for their workforces. The London-based mining conglomerate AngloGold has begun providing antiretrovirals to HIV-positive employees at its mines in South Africa. An estimated 30% of AngloGold's 40,000 workforce is HIV-positive. The cost to AngloGold for antiretroviral treatment will be approximately US\$2-3 per patient per day. The company estimates that treatment of employees at risk of developing AIDS will save up to US\$5 (or up to 2%) in the cost of producing an ounce of gold, compared to the projected increase in costs if no action were taken.

Regional and international treatment initiatives

Around the world, and particularly in Africa, governments are considering the advantages of regional collaboration in scaling up treatment access, in addition to their policy and programming efforts within their respective countries. At the end of 2002, the countries of the Economic Community of West African States (ECOWAS), supported by the West African Health Organization, WHO and the UNAIDS Secretariat, convened in Dakar a regional consultation to further the design and implementation of an initiative to urgently scale up access to treatment. The Southern African Development Community Secretariat recently revised its HIV/AIDS strategic framework and called for an enhanced multisectoral response. The Maseru Declaration on HIV/AIDS, adopted on 4 July 2003 by the Heads of State of the 14 member countries, commits them to action in the area of care and treatment of people living with HIV/AIDS with antiretroviral therapy.

At an international level, the African Member States of the World Trade Organization (WTO) have played a leadership role in negotiating and following up the WTO *Declaration on the TRIPS Agreement and Public Health*, also known as the Doha Declaration. The Doha Declaration, which specifically refers to HIV/AIDS, affirmed that international trade rules can and should be interpreted and implemented in a manner supportive of governments' right to protect public health and, in particular, to promote access to medicines for all.

Despite these milestones at international, national and community levels, many challenges lie ahead in scaling up universal access to HIV care, treatment and support throughout Africa. It has proved difficult, for example, to build consensus in Uganda on critical issues such as the criteria for deciding who will access free antiretrovirals first in the public sector. Similar tough decisions will have to be made by other African governments as public ART is expanded progressively towards universal access.

Yet, a number of important international developments enhance the possibility of bringing HIV treatment to many more people living with HIV in Africa. Firstly, there is unprecedented high-level political commitment to treatment access in many African countries. Secondly, there has been a dramatic reduction (more than 90% in some cases) in the price of antiretrovirals offered to all sub-Saharan African countries. As of June 2003, the least expensive brand-name antiretroviral combination recommended by the World Health Organization to all sub-Saharan African countries was priced at approximately US\$675 per patient per year, while the least expensive WHO-approved generic combination was priced at approximately US\$300 per year. In a continent where 290 million people live on less than a dollar a day, even these prices are too

high for wide-scale private purchase. They do, however, make it far more realistic for governments, international donors, and the private sector to implement treatment programmes on a mass scale.

Efforts to secure greater sustainable financing to scale up access to care were advanced by the agreement of the two major multilateral funding entities—the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria—to include HIV treatment within the scope of activities that they will fund, and bilateral donors such as the United States have made important commitments. The Global Fund has reported that 86% of its global HIV grants include provision for activities to strengthen pharmaceutical and medical distribution systems, and 76% of all HIV grants provide for procurement of antiretrovirals and other medicines and commodities. WHO, which is the lead UNAIDS Cosponsor in the area of HIV care and treatment, has taken a number of important steps to support HIV treatment access in countries. These include the dissemination of treatment guidelines for scaling up antiretroviral therapy in resource-limited settings, the inclusion of 12 antiretrovirals in the *WHO Model List of Essential Medicines*, and the undertaking (with support from UNICEF and the UNAIDS Secretariat) of quality assessment—known as the ‘pre-qualification project’—for both brand-name and generic HIV-related medicines. Strengthening of health systems and increasing the capacity of human resources in the health and social service sectors in countries remain critical. Despite these challenges, the potential to scale up HIV care, treatment and support has never been more promising.

The gender gap

The vulnerability of African women and girls to HIV infection is integrally linked to underlying gender inequalities, societal norms and discrimination. Sustained changes in this vulnerability will require fundamental shifts in the relationships between men and women, and in the way societies view women and value their work and contributions. In the last two decades, much has been learned about the reduction of the HIV/AIDS gender divide. Now the problem is implementing these strategies on a scale that can make a real difference to African women and their families.

As girls and young women are at particular risk, strategies to prevent HIV infection among them and reduce the impact of the epidemic on their everyday lives should include:

- national legislation that affirms equal rights for women;
- income-generating opportunities for women;

- prevention education for girls and young women to foster risk-avoidance life skills;
- education programmes for young people that address gender-related cultural and social norms and develop more equitable behaviour;
- provision of condoms and other barrier methods, especially those that can be controlled by women (e.g., microbicides);
- voluntary counselling and testing centres and other HIV-related health services that are friendly to women and girls;
- programmes to improve the socioeconomic conditions of girls and young women;
- zero tolerance of rape and abuse of women and girls;
- gender-sensitive HIV prevention, care and support; and
- support to women who provide care to family members.

Gender and HIV/AIDS in Sierra Leone

Sierra Leone's decade-long conflict has been marked by extraordinary levels of sexual violence against women and girls. Rape and enslavement for sex and labour by the rebels, together with the combined effects of prolonged conflict, pervasive human rights abuses, and massive forced migration in one of the poorest countries in the world have had a devastating impact on the health and well-being of Sierra Leonean women, providing a fertile breeding ground for HIV. Sierra Leone is now entering a post-conflict reconstruction phase, and the presence of UN peacekeeping forces, the interest of international and regional development agencies, and the gradual resettlement of displaced populations are opening up new opportunities for HIV/AIDS programming.

Accurate statistics for HIV/AIDS in Sierra Leone are simply not available, but the existing patchwork of information strongly suggests that HIV infections are on the rise. Prevalence rates appear to be higher among the security forces. In the general population, basic knowledge regarding AIDS is minimal.

In February 2001, the UNAIDS Secretariat took part in a joint mission to Sierra Leone (which included representatives from the Department of Peacekeeping Operations (DPKO), the United Nations Population Fund (UNFPA) and the United Nations Development Fund for Women (UNIFEM)) to assess the HIV/AIDS situation for the United Nations Mission in Sierra Leone (UNAMSIL). Based on the information gathered, the UNAIDS Secretariat and UNIFEM began a collaborative effort to integrate a gender approach within all initiatives in Sierra Leone, including the ongoing AIDS work with the peacekeeping operation. The project is supervised by a Programme Coordinator on Gender and HIV/AIDS. The key objective is to ensure that gender equality and human rights are integrated into key policies, programmes and activities that address AIDS in the context of humanitarian assistance, particularly in order to minimize and reverse HIV infection rates among UN peacekeepers, national armed forces and the civilian population. It also aims to gain greater insight into the gender implications of AIDS and the effects of the epidemic on the basic human rights of women in Sierra Leone, support women in gaining effective skills to negotiate safe sex and condom use, and ensure the strengthening of national policies on gender and AIDS.

The UNAIDS Secretariat/UNIFEM effort aims to ensure that gender and rights sensitivity is included in the work of Sierra Leone's National AIDS Secretariat (NAS). UNIFEM has also provided support to women's organizations working on AIDS by linking their activities to the work of the government and donors, and is currently implementing activities to strengthen the capacity of the Truth and Reconciliation Commission to address violations of women's rights. A planned gender division within the Ministry of Social Welfare, Gender and Children Affairs will facilitate the mainstreaming of gender equality in government policies and programmes.

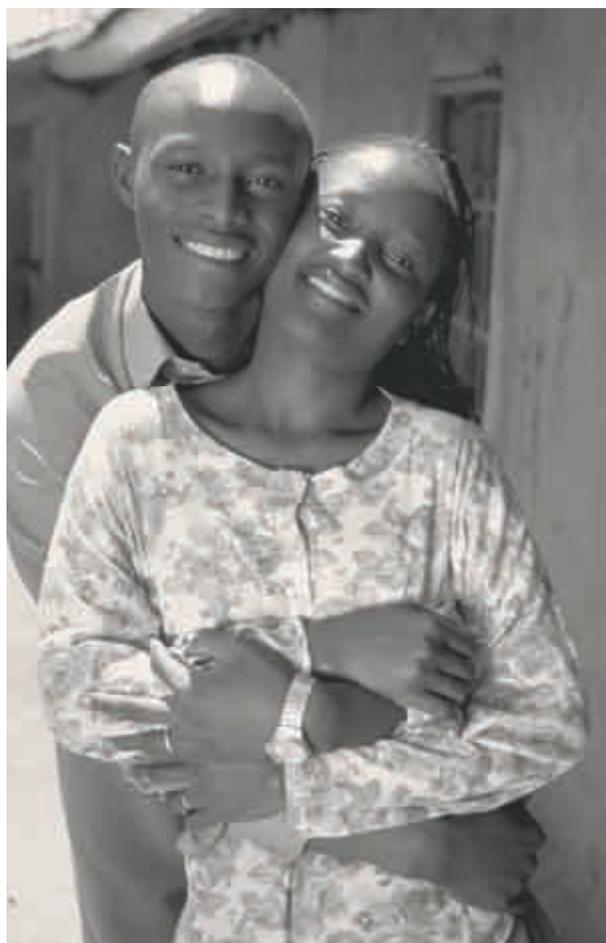
UNAIDS is developing similar programmes in Angola and the Democratic Republic of the Congo.

Most of these interventions have already been tested (see box on Gender and HIV in Sierra Leone). An increasing number of agencies involved in home care (including TASO in Uganda and the Catholic Diocese of the Copperbelt in Zambia) are taking an integrated approach by providing material welfare support, paying school fees and providing micro-credit to widows. Rwanda has recently passed a law allowing women to inherit land. In Zambia, community-based home-care programmes have entered into a partnership with the Zambian police's Victims' Support Units that informs women about their inheritance rights and provides legal protection and assistance to victims of gender-based violence. In Senegal and South Africa, the United Nations Development Fund for Women (UNIFEM) and the Society for Women in Africa have tested new approaches for empowering women to negotiate safe sex.

The United Nations Girls Education Initiative, spearheaded by UNICEF, seeks to increase the proportion of girls completing primary and secondary education, as a means of improving their economic independence and life skills, as well as increasing their knowledge about HIV. The Committee on the Elimination of Discrimination against Women (CEDAW) has called upon all nations to disseminate information about HIV transmission and methods of protection as one strategy among many for reducing gender-based discrimination.

Earlier this year, UNAIDS launched a Global Coalition on Women and AIDS with the aim of increasing the synergy, visibility and effectiveness of efforts related to women and AIDS. The Coalition seeks to catalyse action, facilitate collaboration and support the scaling up of innovative efforts that involve and benefit women and girls. It aims to create an unprecedented global movement to mitigate the impact of AIDS in women's daily lives. Specifically, the Coalition seeks to:

- prevent HIV infection among girls and young women;
- reduce violence against women;
- protect the property and inheritance rights of women and girls;



Saul Nassilah (21) and Florence (27) are HIV-positive and work as peer educators at the Kibera Community Centre in Kenya *UNAIDS/G.Pirozzi*

- ensure equal access of women and girls to care and treatment;
- support improved community-based care, with a special focus on women and girls;
- promote access to new prevention options for women, including microbicides; and
- support ongoing efforts towards ensuring universal education for girls.

Capacity gaps

One of the greatest barriers to expanding high-impact, cost-effective AIDS interventions is the limited human and technical capacity of developing nations. Along with providing additional financial resources for programmes, donors must also support the establishment of systems, incentives and mechanisms needed to manage a robust AIDS response. The World Bank has stated that low national capacity is a major constraint to the disbursement of MAP funds. Donor governments and international organizations need to better combine their short-term efforts to fill capacity gaps (usually via outside human and technical resources) with long-term efforts that build local capacity. In some countries, AIDS is eroding national capacity faster than international efforts can be implemented to prop it up. This diminishing capacity can result in populations being denied access to health care, education, food supplies, safe water and sanitation.

Many African countries could also make better use of vast latent capacity. Too many countries continue to equate national capacity with government capacity alone. Engaging a wider range of actors (especially in civil society and the private sector) could bring a stronger, broader set of skills to the table more quickly than building it from scratch.

Budgeting and costing AIDS plans

Support for the budgeting and costing of national AIDS plans is a critical—and, unfortunately, often neglected—aspect of the funding process (see box on National Strategic Plans). Costing of activities and budgeting of national action plans provide managers and decision-makers with an estimate of the financial resources needed for implementing a desired package of activities in order to achieve a set of objectives over a defined period. A national plan that is well-costed and budgeted is a powerful advocacy and resource mobilization tool. Donors are more willing to disburse funds to national programmes that have detailed AIDS plans. For some, it is a prerequisite. For example, the coherence and transparency of the strategic, multisectoral plan launched by Burkina Faso in 2001 immediately attracted an additional US\$150 million from international and bilateral donors.

Strengthening National Strategic Plans

Analysis of National HIV/AIDS Strategic Plans (NSPs) and donor funding proposals in Southern and Eastern Africa has revealed an overall weakness in the budgeting and costing of AIDS programmes. Most countries' NSPs are poorly costed, or simply not costed at all. Major reasons for this include a lack of capacity at the country level, as well as a lack of appropriate technical assistance given to such countries by donors and international organizations.

NSPs play an important role in resource mobilization, particularly if they have clear goals, objectives and strategies, and are fully costed and prioritized. On the other hand, poor costing of HIV/AIDS programmes, or a complete absence of costing, has a serious negative impact on efforts to scale up the HIV/AIDS response. In particular, poor costing can lead to:

- inaccurate national estimates of the amount of resources that have been mobilized and allocated for AIDS over a given period;
- insufficient budgetary allocations for AIDS programmes;
- lack of prioritizing among AIDS programmes;
- fragmented and uncoordinated flows of resources for AIDS;
- inefficient use of savings from the Highly Indebted Poor Countries (HIPC) Initiative; and
- poor monitoring and evaluation of AIDS programmes.

In order to assist countries in this area, the UNAIDS Inter-Country Team for Eastern & Southern Africa (ICT/ESA) has developed a budgeting and costing framework that provides a template for countries to use in the development and review of their NSPs and/or funding proposals to the Global Fund and other donors. The framework, distributed along with a set of guidelines, also assists in the identification of critical activities and inputs for AIDS programmes, as well as the prioritization of AIDS expenditures within the overall national budget framework.

UNAIDS has organized a series of workshops to assist African governments in the use of the framework. The first workshop in September 2002 was attended by nine Southern African countries. A second, in January 2003, included Eastern African and island countries, as well as the East, Central and Southern African Health Community (ECSAHC). Useful feedback was received from both workshops, and this has been incorporated into a new edition of the framework.

Monitoring and evaluation

A fundamental aspect of an expanded AIDS response is the ability to understand the progress of the epidemic and evaluate the impact of efforts to combat it. There is currently little consistency across countries in what epidemiological data and other strategic information are collected and how they are stored and retrieved for use. The result is limited national expertise to produce strategic information and convert it into strategic analysis, stronger policy and a sustainable expansion of the national AIDS response. This situation is further complicated by insufficient outside technical support available for improved data collection and analysis at country level. In addition, national AIDS responses are not optimally using information technology as a strategic aspect of their work. Evaluation of country responses requires the development of technical and methodological skills within national AIDS councils.

UNAIDS Country Response Information System

Improved information and informed analysis are critical for the development of sustained expanded national responses to HIV/AIDS. Some countries have developed HIV/AIDS surveillance systems while other countries are collecting information on resources allocated for HIV/AIDS programmes and projects. Responding to the needs at the national and global levels for improved information and analysis, UNAIDS embarked in 2002 on an ambitious plan to establish information systems to support national AIDS responses.

The Country Response Information System (CRIS), which is housed in national AIDS councils or their equivalent, will contain national and subnational indicators, programmatic information and key data pertinent to each national response. CRIS is a user-friendly system consisting of an indicator database, a project/resource-tracking database, a research inventory database and other important information. The country-level CRIS will be complemented by the Global Response Information Database (GRID), based at the UNAIDS Secretariat. The GRID, to be launched in early 2004, will support strategic analysis, knowledge-based policy formulation and subsequent programming via the Internet.

African governments and donors are increasingly working together to establish monitoring and evaluation systems to address these issues. These systems go hand in hand with accountability mechanisms that ensure funds are wisely spent. UNAIDS itself is accelerating efforts to build national capacities to track the current status, future course and impact of the epidemic. A key component of these actions is the establishment of the Country Response Information System (see box).

UNAIDS future directions

In December 2002, the UNAIDS Programme Coordinating Board (PCB) recognized the need for intensification of UNAIDS' efforts at country level—in particular, the strengthening of local capacities to scale up national AIDS responses. The UNAIDS Secretariat and its Cosponsors* are currently refocusing their HIV/AIDS strategies to respond to the PCB's decision.

In this respect, the UNAIDS Secretariat has identified the following key areas of national responses in need of further UN support as additional funding becomes available:

- Strengthening of national AIDS coordinating bodies and regional and national leadership initiatives.
- Fostering of partnership forums that include civil society and the private sector.
- Empowerment of civil society, especially people living with HIV/AIDS.

* The United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

- Generation of strategic information, such as country progress reports and regional trend analyses.
- The establishment of country response information systems to track, monitor and evaluate national responses.
- Encouragement of government-led participatory reviews of the response that include broad input from civil society, the private sector, donors and other stakeholders.
- Placement of technical experts to plug short-term capacity gaps and develop long-term local capacity.



A little boy refills his plastic container
at a communal water tap for shanty
dwellers near Pietersburg, South Africa
UNAIDS/L. Gubb

Conclusion

The stakes could not be higher. The effects of AIDS in Africa are eroding decades of development efforts. In high-prevalence countries, families are unravelling, economies are slowing down, and social services are deteriorating. In Southern Africa, where HIV prevalence is higher than anywhere else in the world, AIDS has exacerbated food insecurity, demonstrating how the epidemic and humanitarian crises intertwine. These impacts have been particularly severe for African women and young people, especially those who have lost one or both parents to AIDS.

But the situation is far from desperate. There is a growing number of efforts to reverse the course of AIDS. Senegal has demonstrated that the growth of HIV in developing countries can be halted at low levels of prevalence, and Uganda has shown a sustained reduction in its epidemic. The success of these efforts is due to a combination of factors, including:

- strong political leadership;
- the setting up of dedicated national AIDS programmes;
- the broadening of the response to include civil society, religious organizations, the private sector and networks of people living with HIV;
- a reduction of stigma and discrimination faced by those infected with HIV; and
- the protection of groups particularly vulnerable to infection.

An increasing number of African nations are assembling these building blocks into stronger AIDS responses. As they do so, African governments and the international community must address specific gaps:

- More financial resources are needed, along with reinforced human and technical capacity, and greater programming efficiency and transparency.
- Basic prevention and treatment initiatives are not widely available in Africa. Prevention strategies not only contain the epidemic, but also provide a solid base for care and treatment. HIV care—in particular, antiretroviral treatment—saves lives, reduces human suffering, and allows people living with HIV to continue contributing to their families, communities, and the economic well-being of their nations.
- A gender gap is increasing African women's vulnerability to infection and likely denying them equal access to prevention and treatment initiatives.

AIDS is now recognized as one of the developing world's largest impediments to achieving the Millennium Development Goals. Failure to meet these goals in Africa would be a failure on the part of the entire international community. The growing number of effective prevention and treatment efforts in Africa proves that a massive expansion of the epidemic need not be inevitable. AIDS is not unstoppable in Africa. A reversal of the spread of HIV by 2015 can still be achieved by a concerted and determined effort. The extent to which HIV/AIDS affects all of our futures will depend on the actions we take today.

“The cost, whether measured in human misery today, or in loss of hope for tomorrow, is simply too high. We have to turn and face [HIV/AIDS] head on.”

—UN Secretary-General Kofi Annan

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together eight UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its eight cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners—governmental and nongovernmental, business, scientific and lay—to share knowledge, skills and best practices across boundaries.

Produced with environment-friendly materials

Accelerating Action against **AIDS** in Africa

AIDS has finally reached the top of the African agenda. More and more of the continent's political leaders, civil society and groups of people living with HIV are ringing the alarm bells against AIDS, taking concrete action themselves and demanding more action from others. Africa is rising to the challenge. The international community is also responding. Action against AIDS in Africa is accelerating, but not fast enough. The spread of HIV on the continent remains relentless. At least 60 million Africans have been directly impacted by AIDS: 30 million are living with the deadly virus, more than 15 million have died from AIDS, and more than 11 million have lost at least one parent to the epidemic.

This report highlights successful initiatives that have inspired confidence that the continent can one day free itself of the virus, with or without a vaccine or medical cure. These examples prove that AIDS is a problem with a solution: human intervention works, even under the most difficult circumstances. AIDS is not unstoppable. The Millennium Development Goal of reversing the spread of HIV by 2015 can still be achieved by a concerted and determined effort. The extent to which HIV/AIDS affects all of our futures will depend on the actions we take in Africa today.



Joint United Nations Programme on HIV/AIDS

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