

HIV/AIDS Policy in Africa

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Background

Since the discovery of the HIV/AIDS virus in the early 1980s, sub-Saharan Africa has been mostly affected by the disease, and its spread has been perpetuated by a variety of socio-economic and political factors. These varying factors pose a monumental task for policy makers in terms of effectively responding to and identifying policy interventions to combat the disease. Recognizing the epidemic's threat to human security in Africa, the UN Security Council devoted its meeting on 10 January 2000 to AIDS in Africa, the first time that the Council dealt with a development issue.

Although the disease has affected other regions of the world, no other region has experienced the same devastation as sub-Saharan Africa, in terms of lost of human life, lost of communities, and lost of human resources. The HIV/AIDS is also having a negative impact on sectors other than health, such as agriculture, education, and private sectors.

Despite efforts to educate the population of sub-Saharan countries of the disease, adults and children are acquiring HIV at a higher rate than ever before: the number of new infections in the region during 1999 was 4.0 million (UNAIDS, June 2000); 70% of the adults and 80% of children living with HIV in world are in Africa, most of whom do not have access to basic health care. Millions more are still falling prey to the virus every year. Africa has buried three-quarters of the more than 20 million people worldwide who have died of AIDS since the epidemic began. As children lose their parents and teachers, and hospitals, farms and factories their workers, the epidemic has become a full-blown development crisis (Economic Commission for Africa, 2000).

Upon closer inspection of the AIDS crisis, there are 16 countries in which more than one-tenth of the adult population aged 15-49 is infected with HIV. In seven countries, all in the southern cone of the continent, at least one adult in five is living with the virus. In Botswana, a shocking 35.8% of adults are now infected with HIV, while in South Africa, 19.9% are infected, up from 12.9% just two years ago. With a total of 4.2 million infected people, South Africa has the largest number of people living with HIV/AIDS in the world. While West Africa is relatively less affected by HIV infection, the prevalence rates in some large countries are creeping up. The Ivory Coast is already among the 15 worst-affected countries in the world. Nigeria, the most populous country in sub-Saharan Africa, over 5% of adults have HIV. The prevalence rate in other West African countries remains below 3%. Infection rates in East Africa, once the highest on the continent, hover above those in the West of the continent but have been exceeded by the rates now being seen in the southern cone.¹

Given the scale of the AIDS crisis, HIV/AIDS has serious implications for development as it affects the determinants of economic growth: financial, human and social capital (ECA, 2000). In recognition of the crippling effects of the disease, and its impact on human development, leaders attending the G8 Ministerial meeting in Okinawa, Japan, recognized the link between good health and economic growth. In the final communiqué, G8 leaders agreed that health is an essential factor in

¹ UNAIDS, "Report on the Global HIV/AIDS Epidemic" June 2000.

prosperity. How can Africa prosper given the emerging health crisis associated with HIV/AIDS and other infectious diseases?

In this context, most of the sub-Saharan countries affected by HIV/AIDS were in a state of economic decline well before the onset of the disease. Most of the economic instability is linked to the continent's entanglement with the debt trap following the 1980-1982 world wide recession and the consequent collapse of world commodity prices. As a result, many African countries were forced to adopt structural adjustment programs (SAP) prescribed by the Breton Woods institutions following the economic downturn in the early 1980s. Many were forced to adopt painful economic policies, which had a profound effect on the socio-economic and political systems in the continent. These included currency devaluation and unification of the exchange rate and the elimination of exchange controls; curtailment of expenditure to alleviate budget deficits; cuts in public wage bill and social sector programs; market liberalization within national economies; the elimination of subsidies and price controls; compression of real earnings and the liberalization of the labor market.²

This led to a radical definition of government and governance, eroding the ability of African regimes to govern and creating political and social tensions and uncertainties. As a result, policymakers in countries hard hit by the AIDS epidemic face tough decisions regarding the allocation of scarce public resources in an environment where many households are already in poverty.³

The impact of HIV/AIDS is being felt in every aspect of everyday life, and is negatively impacting the most vulnerable groups in African societies: women and children. The following is a brief summary of the impact of the disease on key groupings and in key sectors:

Women and children: The disease has been utterly devastating to women and children in sub-Saharan Africa, and with increasing HIV infection rates, they will continue to be negatively effected by the epidemic. As a result of the disease, the World Health Organization (WHO) estimated that ten million children would have been orphaned in the year 2000 alone. Many of these orphans will suffer a high rate of mortality, partly from being infected while still unborn and partly from the reduced standards of care that many of them will suffer when their parents have both died.⁴

However, the direct impact of the disease on women is only now being addressed. Because of women's disadvantaged position in the economic and political spheres, they are more vulnerable to the disease. They have little bargaining power to choose safer sex and little bargaining power over her partner's extramarital affairs. In addition, pregnant women infected with HIV are not given the proper prenatal care that would enable them to reduce the chances of infecting their children.⁵ Cultural factors that determine a woman's status, i.e. her ability to have children, impede the use of protection and may perversely increase a woman's exposure to AIDS at the cost of lowering her status.⁶ To compound the problem, the burden of caring for

² Bonny Ibhawoh, "Carrots for Friends and Sticks for Enemies": Confronting Structural Adjustment and the Neo-liberal Paradigm in Africa", Canada: 124.

³ Ibid, p. 124-127.

⁴ Peter Lewis, AIDS and Aid in Africa, Bath, UK: Center for Development Studies, 1992:6.

⁵ Jonathan M. Mann, M.D., et al., "AIDS in the World," Cambridge, Massachusetts: Harvard University Press, 1992:293.

⁶ Martha Ainsworth and Mead Over, "AIDS and African Development", The World Bank Observer, vol.9, no.2, July 1994: 226-228.

AIDS sufferers, whether in the home or in the hospital, usually falls on women, who would otherwise be engaged in farming or other productive work.

Health sector: sub-Saharan Africa's health sector was in a state of decline well before the onset of the disease. With the onset of AIDS, the health sector is being pushed to the limit. There is insufficient funds, infrastructure and health care professionals to adequately respond to the epidemic. We know that the health sector is negatively impacted by the disease, but it is very difficult to estimate the cost of treating AIDS sufferers, especially in the African context. Ideal treatments based on Western protocols are unlikely to be suitable or affordable in Africa. However, some countries are exploring alternative models of care, such as home-based care, which would reduce the burden on costly inpatient facilities.⁷

Education: Many AIDS affected countries are losing their teaching population to the disease, increasing the demand for more teachers, and increasing training and turnover cost. As a result of the disease, there is fear that parents will be less inclined to invest in children's schooling, reducing the productivity and the stock of human capital available to households and to the economy.⁸

Economy: The economic impact of the disease is far greater than previously imagined. According to Peter Lewis (1992: 6-8), all African economies will experience major setbacks because of the disease, mainly due to increasing shortage of technical skills and declining productivity. Lewis said that there is a need to get a more accurate idea of the costs of the epidemic, and that there is a need to change the emphasis of aid, moving away from industrial projects to projects that would have an immediate impact. Ainsworth and Over (1994:233) also advised that governments should assess more accurately the potential economic impact of AIDS, identify and implement programs to mitigate that impact, and target cost-effective prevention programs to the economically important sectors that are most sensitive to HIV infection, to reduce the economic impact in the long term.

Since most of Africa's economy derives from agriculture, the sensitivity of agricultural zones to the loss of labor from AIDS depends on five factors: the seasonality of the demand for labor, the degree of labor specialization by gender and age, the interdependence of labor inputs, economies of scale in labor, and the substitutability of labor-saving technologies.⁹ For example, in agricultural areas in eastern and central Africa, loss of life is already undermining regular patterns of planting and harvesting, and causing expensive and inefficient transitions to less labor-intensive crops.¹⁰

Productivity in non-agricultural activities is likely to suffer as well. Workers who fall ill due to AIDS will be less productive on the job and will be absent more often. Absenteeism is also likely to increase among healthy workers, as they take time off to attend funerals and care for those who are ill. Job turnover and training and recruitment costs will also rise.¹¹

⁷ Martha Ainsworth and Mead Over, "AIDS and African Development", The World Bank Observer, vol.9, no.2, July 1994:221-223.

⁸ Ibid, 231-232.

⁹ Martha Ainsworth and Mead Over, "AIDS and African Development", The World Bank Observer, vol.9, no.2, July 1994:227.

¹⁰ Jonathan M. Mann, M.D., et al., "AIDS in the World," Cambridge, Massachusetts: Harvard University Press, 1992:293.

¹¹ Martha Ainsworth and Mead Over, "AIDS and African Development", The World Bank Observer, vol.9, no.2, July 1994:227.

Mitigating the economic and social impact of AIDS includes learning how households cope with AIDS. Households are the fundamental economic decision-making unit in African economies, accounting for most agricultural production, informal self-employment, and consumption decisions. Illness and death from HIV/AIDS will affect resource allocation, production, consumption, savings, investment, and, above all, the well-being of patients and their surviving family members.¹²

Overall, Governments in Africa do know the characteristics of the disease and its epidemiology. First, AIDS is always fatal; there is no cure or vaccine. Second, AIDS in Africa is affecting primarily prime-aged adults in their most productive years. The skills and experience lost through adult deaths from AIDS represent a huge setback to efforts to raise the productivity of the work force. Third, in many African countries, the effects of HIV/AIDS are already being felt. Thus, there is an urgent need to invest in programs to prevent and slow the spread of HIV and to mitigate the economic and social impact of AIDS (Ibid, 204).

Policy Response to the AIDS Epidemic

Historical responses to infectious diseases

Between 1880 and 1920, Europeans and North Americans took the first collective steps toward reducing mortality through advances in medicine, public hygiene, and private hygiene. At this time, scholars argue that African mortality rates were actually rising as a result of the disruptions which accompanied colonial conquest. Allocation was highly skewed: Europeans received favored access, followed by Africans living in cities, with rural Africans receiving the least. Colonial governments, in an era of tiny budgets and no foreign aid, lacked the revenues to pay for comparable campaigns against all of the infectious diseases killing Africans, but some diseases, such as sleeping sickness, sufficiently frightened Europeans to elicit special programs.¹³

The end of WWII brought changes which utterly transformed colonial health care. These changes included advances in medicine and substantial increases in funding from colonial and international sources – foreign aid. These funds were distributed through UNICEF, USAID and the WHO, which played a far greater role in the delivery of services than its predecessor. Under colonial rule the health of Africans might be improved by individual programs but the subject was not the focus of a concerted policy.¹⁴

In the years since 1960, life expectancy has increased in most African countries, but the causes for that improvement are still hotly debated. Before the oil crisis of 1974, the newly independent states of sub-Saharan Africa made considerable improvements in the quality of health care provided for their citizens.¹⁵

However, during the mid-1970s, commodity prices received by African exporters began to fall relative to the cost of imported manufactured goods and the level of

¹² Ibid, 220.

¹³ Bruce Fetter, “Health Care in Twentieth Century Africa: Statistics, Theories, and Policies,” in *Africa Today* 3rd Quarter, 1993: 12-13.

¹⁴ Ibid, 16-17.

¹⁵ Bruce Fetter, “Health Care in Twentieth Century Africa: Statistics, Theories, and Policies,” in *Africa Today*, 3rd Quarter, 1993: 16-17.

foreign aid declined. These reductions in both foreign aid and domestic revenue caused real cutbacks in African health care. By the mid-1980s the momentum of health care improvement had finally dissipated: civil wars, under-funding of health services, political corruption and severe shortages of hard currency were underlying factors affecting health care policy.¹⁶

The facilities available to Africans have been allocated, however inequitably, through the dictates of those in power in national governments and in the international organizations which provided the resources.¹⁷ Thus the health care crisis in Africa was already acute before the impact of AIDS. Some African countries spend less than 1 percent of their GNP on health! This continuing under-investment in health care, together with an increasing economic crisis, had by 1980 led to increases in infectious diseases in many parts of the world. This created an ideal context for the spread of HIV and made it almost impossible for most developing country health care systems to launch an effective response.¹⁸

National AIDS Programs

In response to the discovery of HIV/AIDS in 1980s and to respond to the growing epidemic, developing countries, especially those in Africa, implemented national AIDS programs (NAPS). Today, NAPS are the mainstay government policy to respond to the epidemic. The function of NAPS is mainly to develop governmental strategies, under the auspices of the ministries of health in collaboration with other governmental ministries, non-governmental organizations, civil society organizations, and multilateral organizations.

The effectiveness of NAPS are dependent upon the early involvement of civil society and non-governmental actors, as well as the private sector in the development of HIV/AIDS programs and policies. However, the effectiveness of national response also depends on the overall commitment of governments and the political will to adopt proactive policies and programs. This political commitment on the part of governments also entails financial commitment, an issue that is problematic for many African governments faced with other 'pressing concerns and priorities'. However, the level of political commitment depends on how important HIV/AIDS is in terms of the government's overall development strategy.¹⁹

In developing countries, most HIV/AIDS programs were created in or after 1987, following the establishment of the WHO's Global Programs on AIDS (GPA). The creation of and support of national AIDS programs was a priority of GPA, which allocated more than half of its resources to this work.²⁰ The GPA was universally adopted as the blueprint for international and national efforts against AIDS.²¹

At the onset of the epidemic in the mid-1980s, national advisory committees were established. Initially, these national advisory committee consisted of representatives

¹⁶ Bruce Fetter, "Health Care in Twentieth Century Africa: Statistics, Theories, and Policies," in *Africa Today*, 3rd Quarter, 1993: 19.

¹⁷ *Ibid*, 21.

¹⁸ Jonathan M. Mann, M.D., et al., "AIDS in the World," Cambridge, Massachusetts: Harvard University Press, 1992:292.

¹⁹ *Ibid*, 279.

²⁰ Jonathan M. Mann, M.D., et al., "AIDS in the World," Cambridge, Massachusetts: Harvard University Press, 1992: 296.

²¹ *Ibid*, 11.

from the health sector, but as the socio-economic effects of the disease emerged, there were more representatives from civil society such as women's organizations, representatives from other government sectors and HIV-infected persons. This evolution coincided with a demand by policy makers and the public away from information on the nature of the pandemic and policy guidance towards action.²²

Since their inception in the late 1980s, national prevention programs have often operated on the assumption that traditional health education about HIV/AIDS would be sufficient to induce widespread behavior change. This has not been the case. Intervention programs are not as effective as was first hoped, but at the same time, there has been a global effort to fight AIDS, which creates an ideal opportunity to develop a coordinated global strategy, increase coordination of AIDS activities and boost global response to the epidemic.²³

However, those involved in the fight against HIV/AIDS, must contend with the prospect of a leveling off in prevention efforts. Cohen & Trussells (1996:3) contends that agencies and governments in developed countries are beginning to suffer from "donor fatigue," induced partly by the realization that the epidemic is unlikely to affect the developed world as first feared, and partly by an inability to see how financial commitment and effort expended on prevention thus far have affected the course of the epidemic. The most visible consequence of donor fatigue in Africa is the withdrawal of resident advisers of WHO's Global Program on AIDS from national AIDS control programs.

International Donor Assistance

Most of the sub-Saharan countries affected by HIV/AIDS do not have the financial resources required to effectively respond to the epidemic. As a result, many rely on official development assistance to carry out programs aimed at preventing HIV proliferation.

Countries affected by HIV/AIDS receive most of their financing through international donors such as bilateral, multilateral and international organizations. Although official development assistance (ODA) has declined steadily over the last few years, with relatively few exceptions, financial assistance for HIV/AIDS in Africa has steadily increased, mainly in response to the increasing prevalence of the virus in many sub-Saharan countries, especially those in the southern cone. However, the usage and effectiveness of such aid have been rarely debated or researched.

In 1997, to better coordinate, manage, and monitor the global response to AIDS, UNAIDS Program Coordinating Board commissioned UNAIDS, in collaboration with Harvard School of Public Health, to study multilateral and bilateral funding of national response to AIDS in developing countries and countries in transition. The final report of the study found that there were too many inconsistencies in the management of international financial assistance for HIV programs. These inconsistencies included the difference in the total of funds received by recipient countries and the total amount the ODA agency reported giving. For example, donors reported giving Tanzania US\$10 657 925 in ODA, but the government reported receiving US\$ 899 357, a difference of US\$ 9 758 568!²⁴

²² Ibid, 287.

²³ Barney Cohen and James Trussells eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 3

²⁴ UNAIDS et al., "Level and Flow of National and International Resources for the Response to HIV/AIDS 1996-1997", 1999: 26.

Impact of Intervention Programmes

The effectiveness of national programs against AIDS vary from country to country (see Annex II for a country by country response to the disease in Africa). Many programs are successful, while others are mismanaged and are under-financed. Failures are mainly due to the lack of coordination among government ministries and bureaucracy, which sometimes block passage of funds to the programs.²⁵ However, results have showed that HIV/AIDS interventions are working: increased public awareness of the disease, and condom sales are steadily increasing in sub-Saharan Africa.²⁶

Unfortunately, Governments everywhere were slow to respond to AIDS, and even slower in industrialized countries to develop comprehensive plans and programs. As a result, we are witnessing a variety of responses from governmental development agencies: direct support to country AIDS programs, more support to the non-governmental sector and support for a broader range of responses from individual UN agencies.²⁷ Mann et al. (1992) noted that this slow response coupled with the absence of clear strategies based on measurable targets and outcomes, the international system for supporting AIDS prevention and control at the national level may be degenerating into a series of short-term, uncoordinated, and reactive responses, increasingly subjected to domestic and foreign policy pressures rather than guided by the need for prevention and control of the global epidemic.

Lessons Learnt

The following is a summary of lessons learnt compiled by the UN Economic Commission for Africa for the African Development Forum 2000, which was held in Addis Ababa, Ethiopia, from December 3-7, 2000.

1. Getting the AIDS message out to broad populations – and following up with action

Examples of best practice:

Senegal: Muslim and Christian leaders have become advocates for HIV/AIDS prevention and care;

Tanzania: Traditional healers help dispel incorrect information about AIDS, reach people distrustful of medical systems, and distribute condoms.

2. Something for all, and special measures for those at greater risk

Examples of best practice:

²⁵ Institut Panos, "Le vrai coût du SIDA », 1994 : 205.

²⁶ Barney Cohen and James Trussells eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 2

²⁷ Jonathan M. Mann, M.D., et al., "AIDS in the World," Cambridge, Massachusetts: Harvard University Press, 1992:788.

Senegal: AIDS education and condom use programming has successfully reduced transmission of HIV among sex workers and their clients;

Ivory Coast: the Programme for STI/AIDS Care and Prevention among Female Sex Workers and their Partners have drawn the participation of three main groups: sex workers (both professional and non-professional); their clients and sex partners; and the owners and operators of locations where the sex trade occurs.

3. Implementing expanded responses

Examples of best practice:

Malawi: The process of creating Malawi's National HIV/AIDS Strategic Framework 2000-2004 shows how a broad-based national consensus can be built around a strategic planning process. It informed a wide range of groups and institutions about AIDS as an issue, built a sense of ownership among these groups and institutions and gave political leaders a high-profile document to commit to, with clear goals and principles.

Uganda: The development of Uganda's 2000-2005 National Strategic Framework for HIV/AIDS Activities illustrates the decisive role that must sometimes be played by national political leadership. President Museveni took personal charge of Uganda's HIV/AIDS planning process after it had lost momentum, and forced it back on track.

Zimbabwe: The Organic Cotton Project helps AIDS-affected smallholder farming families. The project is being implemented with the support of international NGOs, the national health authority and international donor agencies. The project illustrates the willingness of the Government to support innovative approaches from "outside" and it has the potential to extend capacity building beyond local areas to the national and international level.

4. Working in partnership with local community organizations

Examples of best practice

Burkina Faso (Gaoua): The struggle against AIDS involves existing organisations and different administrative sectors. These partners, with the support of Gaoua authorities, have designed a common plan, agreed on shared objectives, and mobilised their own resources;

Tanzania: The Kyela District Council has passed a ground-breaking by-law; aimed at addressing local behaviours that increase vulnerability to HIV/AIDS.

Factors Affecting the Effectiveness of HIV/AIDS Policies in Africa

Indebtedness: 39 of the so-called indebted poor countries identified by the World Bank, 32 are in Africa. Together they owe more than US\$ 2.2 trillion in debt. The lack of funds for an expanded response to AIDS has been worsened by high levels of foreign indebtedness. Across Africa, national governments pay out four times more in debt service than they spend on health and education. In order to mount an effective

national AIDS prevention strategy, countries in Africa will have to spend at least US\$ 1-2 billion a year, far more than is currently being invested. Relieving countries' debt burden is one of the more promising new approaches that could increase the funds flowing into programs to roll back the AIDS epidemic in Africa.²⁸ In sub-Saharan Africa, where the need for care is great, only small amounts of funds are allocated to care.

Lack of Financial Resources: Many countries and communities are confronting the loss of human capital because of the epidemic, but are lacking the money and expertise to adequately respond to the crisis. The cost of prevention can be seen when compared with what has been spent in industrialized countries, without international assistance. Often, the effectiveness of assistance are met with barriers linked to the three principal actors involved in HIV prevention: Northern or multilateral donors, southern Governments and non-governmental organizations. These barriers include bureaucratic delays, differences in perceptions and priorities, the lack of experience, denial, and political considerations. However, the resulting tension can be resolved if the principal donors and NGOs are represented on the committees responsible for national AIDS prevention programs.²⁹

Donor assistance to HIV/AIDS has increased substantially over time. In 1998, 14 of the largest donors in the OECD Development Assistance Committee provided US\$ 300 million for HIV/AIDS activities. However, ODA has not kept pace with the spread of the epidemic. Recent indications from donors are encouraging. For example, funding by the US for global HIV/AIDS activities increased by US\$ 100 million in 2001. The donor response to the International Partnership Against AIDS has also been positive. This is in response to increasing recognition that HIV/AIDS is not only a major threat to development, but also a threat to peace-building and human security in Africa. This has resulted in higher political awareness and more substantial financial commitments. An additional US\$ 180 million in donor funding for activities in Africa was announced at the historic Security Council meeting in January 2000. The challenge is to ensure that this growing enthusiasm results in concrete support to national HIV/AIDS prevention and control programs – in Africa and elsewhere. To do this, emphasis must be placed on building partnerships between donors and the most affected countries.³⁰

However, there is a perception that international donors impose conditions on the utilization of funds, and some of these restrictions may impeded the implementation of governmental programs and NGOs sometime feel that the funds can be better spent elsewhere. As a result, international NGOs such as Oxfam are seen as being more flexible and more understanding of national approaches to HIV prevention.³¹

Inadequate Data: Estimating the current rate of HIV infection with the data at hand is difficult because the available data consist of information on conveniently sampled sub groups of the population, such as pregnant women and blood donors.³²

Because of the lack of data, determining what impact prevention efforts have on the epidemic is one of the greatest challenges in HIV/AIDS prevention. In addition, monitoring systems created by national AIDS programs have generally not been sensitive enough to measure their own impact. A second measure of success will be

²⁸ UNAIDS, "Report on the Global HIV/AIDS Epidemic", June 2000: 114.

²⁹ Institut Panos, « Le vrai coût du SIDA, » Paris : 1994 : 209-210.

³⁰ UNAIDS, "Report on the Global HIV/AIDS Epidemic", June 2000: 113.

³¹ Ibid, 211.

³² Martha Ainsworth and Mead Over, "AIDS and African Development", The World Bank Observer, vol.9, no.2, July 1994:205-206.

document – and possibly - behavioral changes that reduce the risk of exposure to HIV. To date, the achievements of national programs have, therefore, been measured by the degree to which they have raised awareness about AIDS and distributed such commodities as condoms, more generally on the managerial efficiency with which activities are planned, implemented, and financed.³³

Slow Behavior Change: there are too many people in sub-Saharan Africa who are aware of AIDS but who continue to engage in high risk sexual behavior. This persistent and dangerous gap between awareness, attitudes, knowledge and human action is very probably sustained by contextual factors that influence individual actions.³⁴ Denial, fear, external pressures, social and sexual norms, other priorities, or simple economics can keep people from adopting healthier life-styles.³⁵ In addition, those that are already infected with HIV are unaware of their status and so represent a pool capable of passing the virus to new cohorts. Thus, changing human behavior to slow the spread of the disease will remain for the foreseeable future the first and only defense against HIV/AIDS in sub-Saharan Africa.³⁶

Mutangadura & Jackson (1998:4) noted that if there is an overriding feeling of hopelessness towards the future and what life has to offer, extensive education on HIV/AIDS may not make a difference in changing behavior, according to studies of 12-year-old girls in Malawi. Such feelings were also present in all adolescent groups studied, and how these feelings intensified in the rural poor.

Mann et al. (1992) cited complacency resulting from unrealistic expectations that the problem will soon be solved by vaccines and drugs, the perception that the epidemic has leveled off or peaked, and AIDS fatigue, as factors leading individuals not to protect themselves.

Status of women: Girls are more vulnerable than boys in terms of their social status and economic dependence upon others. Young girls are also physiologically more vulnerable to HIV infection than boys or older women, a risk exacerbated by partnerships with older men. Girls seem to use sexual relationships as a means of increasing their status, through material gain and to escape the extra responsibilities and pressures associated with their status at home (Mutangadura & Jackson (1998:6) (Becker et al., 1999).

However, young women are challenging these social constructs by demanding an equivalent education to that of their male peers, meeting with the opposite sex, engaging in sexual experimentation and deterring marriage. The attempts of young women to forge new paths in seeking economic security often result in their facing a range of dilemmas. Given that income-generating prospects for women are limited, they often find themselves in new relations of dependency. For example, 63 percent of women in Kampala cited economic reasons for seeking sexual partners outside of marriage or their primary union.³⁷

³³ Jonathan M. Mann, M.D., et al., "AIDS in the World," Cambridge, Massachusetts: Harvard University Press, 1992:298.

³⁴ Thomas M. Painter, "Livelihood Mobility and AIDS Prevention in West Africa: challenges and opportunities for social scientists" 199?: 659.

³⁵ Barney Cohen and James Trussells eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 9

³⁶ Barney Cohen and James Trussells eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 2

³⁷ Charles Becker et al., « Vivre et penser le sida en Afrique :Experiencing and understanding AIDS in Africa », Senegal : KARTHALA et CODESRIA , 1999 :324-325.

Women's vulnerability to HIV/AIDS will continue without fundamental changes in their social, economic and legal status. Income generating activities linked with HIV/AIDS prevention can empower some women to protect themselves from infection, but the scope of such activities is far too small to have a significant impact on the status of women in society or on the spread of the epidemic among women. Political commitment, human and financial resources, and true collaboration among health and development agencies and organizations are required to empower women through legal reform, education and greater access to employment and credit.³⁸

Women are under tremendous pressure: parental pressure to abstain, peer pressure to experiment, the possibility of alleviating economic hardship through sex and familial and institutional penalties (school authorities) as a result of pregnancies and ill health from HIV infection.³⁹

Quality of AIDS Education: The difficulty in discussing sex impedes efforts to prevent HIV and other sexual transmitted diseases. As a result, studies found that girls were beginning sexual relations without much knowledge about pregnancy and sexually transmitted diseases. Another handicap is that AIDS awareness campaigns were mostly aimed at adults, ignoring adolescent boys and girls. However, schools should at least share in the exercise of imparting information, especially in campaigns of AIDS prevention. However, instruction at this level can be restricted by prevailing political and religious ideology, or by limitations in the level of knowledge and openness teachers (Mutangadura & Jackson 1998:6).

Another impediment is that AIDS is often associated with practices often regarded as immoral or illegal, e.g. prostitution, infidelity and homosexuality. This results in the refusal of some policy makers to support educational and service delivery programs. It is therefore important to find educational language, concepts and images that are inoffensive and acceptable beyond the targeted groups.⁴⁰

Policy Recommendations

Developing alternative policies and programs entails knowing what works and applying it to the local or national context. This can be a difficult process when confronted with the many factors influencing the spread of HIV/ AIDS. Because of this, many of the authors suggest the development of a multi-sectoral and multilevel approach to HIV/AIDS policy and programs; making gender issues an integral part of all HIV/AIDS programs; developing tools for evaluation and policy-making; and fighting complacency.

Therefore, what are the appropriate steps to take to develop alternative policies and program. First, there is a need to address the root cause of poverty, which has enabled and facilitated the spread of the epidemic, pushing vulnerable groups to engage in high risk behaviors.

³⁸ AIDSCAP, "Making Prevention Work: Global Lessons from the AIDS Control and Prevention Project 1991-1997, Family Health International, 1998?: 87.

³⁹ Charles Becker et al., « Vivre et penser le sida en Afrique :Experiencing and understanding AIDS in Africa », Sénégal : KARTHALA et CODESRIA , 1999 :329.

⁴⁰ Kwaku Osei-Hwedie, ""AIDS: Individual, Family & Community: Psychological Issues in Journal of Social Development in Africa, 1994: 9, 2, 31-43

Addressing the economy: the state of sub-Saharan economies should be addressed and should be an integral component in the development of HIV/AIDS prevention policies and programs. In the past, academic research and policy had considered the disease as a public health problem, and not a problem of development. Today, there is consensus regarding the link between HIV and development, and that the economy affects the level and transmission of HIV. There are a certain number of studies that has addressed the issue, but not many have described the function of this relationship in African countries with high level of seropositivity. Understanding the impact of the disease on the economy and its consequence would enable the development of better policy response (ECA 2000).

Ibhawoh (1999:140) suggested that we look at possible alternatives to structural adjustment and neo-liberalism. As an example, Ibhawoh cited the United Nations Economic Commission's new thinking towards "neo-structuralism". The new thinking is development from within or what has been described as the "integrated approach". It emphasizes that growth, social equity, and democracy can be compatible. In order to promote growth with equity, ECLA supports the general move in the direction of trade liberalization, competitive exchange and export promotion, while still advocating a more central role for the state in the directing of economic policy

On Africa's future development, Ibhawoh wrote:

The only hope for genuine democracy and sustainable social and economic development in Africa lies in the adoption of moderate, conciliatory and egalitarian economic and social policies that recognize not only the inexorable workings of the market forces but also the critical importance of social equity and political stability in the development process.⁴¹

Multisectoral and Multilevel Action

Successful intervention programs should also be multidisciplinary and multifaceted and involve multiple contacts with target populations. Thus, National AIDS programs and policies should not be seen as the Ministry of Health programs. They require action, support and resources from Ministries of Finance, Planning, Education, Information, Labor, and Agriculture, etc., private sector and community groups including NGOs, as well as bilateral and multilateral donors. Effective working relationships between national authorities and community-based groups are essential to bring about the social response required to combat the epidemic.^{42 43}

Changes in policy can be shaped from the grassroots by carefully executed strategies to engage people at all levels of governmental, organizational and community hierarchies in issue identification and advocacy. Thus, policy identification workshops, involving NGO and government personnel, are most effective in developing policy issues and recommendations. Similarly, a multi-sectoral group of technical specialists, analysts and advocates brings complementary skills, perspectives and contacts to the policy development process. The best way to

⁴¹ Bonny Ibhawoh, "Carrots for Friends and Sticks for Enemies": Confronting Structural Adjustment and the Neoliberal Paradigm in Africa", Canada: 140-141.

⁴² UNDP, "Le Sida et l'Afrique: Un défi au développement humain," New York: 1995:23.

⁴³ Theresa M. Ndongko, "A Preliminary Study of the Socio-Economic Impact of HIV/AIDS in Africa," 1999:

reach policymakers is through their advisors, constituents and already committed peers.⁴⁴

According to UNAIDS (June 2000), effective national responses entail political will and leadership; societal openness and determination to fight against stigma; a strategic response; multi-sectoral and multilevel action; community-based responses; social policy reform to reduce vulnerability; longer-term and sustained response; learning from experience; and adequate resources.

Community Engagement: Communities should be empowered to strengthen their capabilities for coping with appropriate aspects of management and control of AIDS through effective decentralization of activities. Communities should develop supportive networks composed of neighbors, religious groups and clubs. This will be easily realized considering the African spirit of generosity and solidarity.⁴⁵

Improved AIDS Education: As noted above, despite HIV/AIDS prevention campaigns, many are still being infected and behavior change has been relatively slow. As a result, there is a pressing need to improve AIDS prevention messages in terms of form, content and targeting. A large part of the challenge consists of ensuring prevention messages are adapted to the socioeconomic and cultural contexts, the concerns and priorities of message recipients. However, insufficient attention is given to these issues in the preparation and dissemination of HIV/AIDS prevention messages. And better communications strategies are needed to effectively reach persons and groups that engage in and provide collective support for high-risk sexual networking among people on the move in Africa.⁴⁶

According to Cohen et al. (1996:6-10), to increase the likelihood of success, interventions need to be culturally appropriate and locally relevant, reflecting the social context within which they are embedded. They should be designed with a clear idea of the target population and the types of behaviors to be changed. In sub-Saharan Africa, there is an urgent need to design ways of targeting women and adolescents for prevention strategies. Basic principles of successful intervention programs include: learning about and adapting to local conditions; ensuring community participation; carefully targeting the audience; identifying effective strategies and messages; building local capacity; evaluating results; and using the results from evaluation studies for improvement. Successful intervention programs should also be multidisciplinary and multifaceted and involve multiple contacts with target populations.

And also, intensified and expanded child and adolescent education on sex and HIV/AIDS, with a strong emphasis on promoting self-efficacy and life skills, will be an essential step to female empowerment, changing male attitudes, and reducing gender inequity. Initiatives may involve increasing effective communications and guidance from parents and guardians; expanding family planning and health education to reach children and youth; peer education – has been proven to influence behavior change in children and youth; and community support and care for orphans and children through community based interventions (Mutangadura & Jackson 1998: 7-8)

⁴⁴ AIDSCAP, "Making Prevention Work: Global Lessons from the AIDS Control and Prevention Project 1991-1997, Family Health International, 1998?: 43.

⁴⁵ Theresa M. Ndongko, "A Preliminary Study of the Socio-Economic Impact of HIV/AIDS in Africa," 1999:

⁴⁶ Thomas M. Painter, "Livelihood mobility and AIDS prevention in West Africa: Challenges and opportunities for social scientists" 199?: 655.

Improving the Status of Women: throughout the course of the disease, women are the most vulnerable group affected by the virus. Governments can affect change to empower women by reducing financial necessity for multiple partnerships by changing laws to give women equal access to training and jobs, equal rights of inheritance and property ownership, equal access to education, and equal access to wage scales; enacting and enforcing laws against rape; building the capacity of women for collective action; and educating everyone of women's rights. Enhancing the status of women is a long-term strategy that would have many beneficial effects for development, in addition to the likely effect of reducing the transmission of HIV/AIDS.⁴⁷

Governments must also fight complacency and denial and ensure that they commit themselves to equity and justice in confronting the AIDS pandemic. Prevention programs must respond to these factors which do lead to the spread of the AIDS virus as the status of women in society and the socio-cultural and economic pressures that render young people vulnerable to HIV infection. Therefore special efforts should be made to keep these young girls in schools and provide them with skill based education that protect them against AIDS.⁴⁸

Effective Evaluation tools: Basic principles of successful intervention programs include: learning about and adapting to local conditions; ensuring community participation; carefully targeting the audience; identifying effective strategies and messages; building local capacity; evaluating results; and using the results from evaluation studies for improvement.⁴⁹

The Need for More Research: Building capacity for AIDS related research is needed to help sub-Saharan African countries to develop their own research capacity by strengthening universities and augmenting the technical skills of their researchers. However, no significant progress will be achieved until the region's governments understand that they must put AIDS more squarely on their research and policy agendas. Clearly, a major constraint on the amount of HIV/AIDS research that is undertaken is inadequate funding. Potential sources of funding include communities, private-sector firms, the public sector, and international donors. However, given the weak economic position of most sub-Saharan African countries, it will be difficult to persuade governments to pursue more vigorous research agendas in the near future.⁵⁰

According to Cohen & Trussels (1996: 18), the number of African scientists well trained to conduct research on HIV/AIDS must be increased by integrating more graduate students and young professionals into all new AIDS-related research initiatives; by establishing small grants programs to fund the projects of young researchers; and by adjusting the pay scales to attract and retain talented professionals; and provide other incentives for researchers to remain in their home institutions.

Not only there is an urgent need to increase the capacity to conduct research, but there is also a need to better synthesize and translate research findings into effective prevention and control programs and policies. Otherwise, prevention programs will

⁴⁷ Barney Cohen and James Trussels eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 11.

⁴⁸ Theresa M. Ndongko, "A Preliminary Study of the Socio-Economic Impact of HIV/AIDS in Africa," 1999:

⁴⁹ Barney Cohen and James Trussels eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 9-10.

⁵⁰Ibid, 17.

be only marginally based on local needs or tailored to local conditions, and research will be even more undervalued and under-funded. Researchers need to do a better job of drawing out the policy implications of their work, and planners and policy makers need to articulate more clearly to researchers what information they need for effective planning and programs.⁵¹

⁵¹ Barney Cohen and James Trussells eds., "Preventing and Mitigating AIDS in Sub-Saharan Africa", Washington, D.C., 1996: 19.

Annex I :

Profile of African Countries and their Response to HIV/AIDS

Country	National HIV/AIDS Policy (NAP)	Structures to support NAP	National Strategic Plan on HIV/AIDS	Clearly defined objectives/ strategies to implement NAP	Budget
Algeria	Y	Y			
Angola*	Y	Y	Y	Y	Y
Benin	Y				
Botswana*	Y	Y	Y	Y	Y
Burkina Faso*	Y	Y	Y	Y	Y
Burundi*	Y	Y	Y	Y	Y
Cameroon	Y	Y	Y		
Cap Verde*	Y	Y	Y	Y	Y
Central African Republic	Y	Y	Y	Y	
Tchad*	Y	Y	Y	Y	Y
Comoros		Y	Y	Y	Y
Congo			Y	Y	Y
Dem. Rep. of Congo	Y	Y	Y		Y
Djibouti		Y			
Eritrea	Y	Y	Y	Y	
Ethiopia	Y	Y	Y		Y
Gabon	Y	Y	Y		
Gambia	Y				
Ghana	Y			Y	
Guinea*	Y	Y	Y	Y	Y
Guinea-Bissau			Y	Y	
Ivory Coast			Y	Y	
Kenya*	Y	Y	Y	Y	Y
Lesotho*	Y	Y	Y	Y	Y
Liberia	Y	Y	Y	Y	
Madagascar	Y	Y	Y		
Malawi		Y	Y	Y	Y
Mali		Y			
Maurice	Y	Y	Y		Y
Mauritania		Y			
Mozambique		Y	Y	Y	Y
Namibia		Y	Y	Y	Y
Nigeria	Y	Y			
Rwanda			Y	Y	Y
Senegal*	Y	Y	Y	Y	Y
Sierra Leone		Y			
South Africa	Y	Y	Y	Y	
Sudan					Y
Swaziland*	Y	Y	Y	Y	Y
Tanzania*	Y	Y	Y	Y	Y
Togo	Y				
Uganda*	Y	Y	Y	Y	Y
Zambia		Y	Y	Y	
Zimbabwe	Y	Y	Y	Y	

Existence of National HIV/AIDS Policy in Key Sectors

Country	Agriculture	Education	Health	Army/ Police	Work- place	Sport	Others
Algeria		Y	Y	Y	Y	Y	Y
Angola			Y	Y			
Benin							
Botswana			Y	Y	Y		Y
Burkina Faso							
Burundi		Y	Y	Y	Y	Y	
Cameroon			Y				
Cap Verde		Y	Y				Y
Central African Republic		Y	Y	Y		Y	Y
Chad	Y		Y		Y		
Comoros							
Congo	Y	Y	Y	Y			
Dem. Rep. of Congo			Y				
Djibouti			Y				
Eritrea		Y	Y	Y	Y		Y
Ethiopia							
Gabon							
Gambia		Y	Y			Y	Y
Ghana			Y	Y	Y		
Guinea*	Y	Y	Y	Y	Y	Y	Y
Guinea-Bissau							
Ivory Coast							
Kenya							
Lesotho		Y	Y		Y		
Liberia		Y	Y				
Madagascar	Y	Y	Y	Y		Y	Y
Malawi			Y	Y			Y
Mali							
Maurice					Y	Y	
Mauritania							
Mozambique		Y	Y				
Namibia*	Y	Y	Y	Y	Y	Y	Y
Nigeria			Y	Y			
Rwanda							
Senegal			Y				
South Africa							
Sudan							
Swaziland			Y	Y	Y		
Tanzania			Y				
Togo							
Uganda*	Y	Y	Y	Y	Y	Y	Y
Zambia			Y				
Zimbabwe		Y	Y		Y		

Annex II :

Possible Areas of Intervention for Aid
Transparency in Africa

Proposed HIV/AIDS Strategy for Aid Transparency in Africa

Identification of areas for intervention
Country assessments of national responses to HIV/AIDS
Developing contacts within targeted countries
Methodology
<ol style="list-style-type: none"> 1. Creation of a pan-African consortium of independent inter-disciplinary groups to assess national responses, to identify best practices and failed interventions; 2. Monitor and analysis of donor assistance to combat HIV 3. From the consortium, the election of a monitoring committee to highlight trends in HIV policy and programs. 4. Development of an AIDS network, comprising of community groups and field workers 5. Policy workshops and seminars, with the ministries of health and planning/finance, Agriculture, etc.
Outcome
<ol style="list-style-type: none"> 1. Development of a multi-sectoral and multilevel approach to HIV/AIDS policy in Africa 2. Development of alternative policy and programs 3. Development of better evaluation tools to measure the impact of initiatives 4. Dissemination of results with policymakers, NGOs, civil society organizations, multilateral organizations and the general public 5. Increasing the capacity of African NGOs to monitor and evaluate HIV prevention programs and policies 6. Advocating for the implementation of findings in the development of HIV policy and programs 7. Transparency of donor assistance 8. Development of projects/program initiatives in targeted countries

