

**NATIONAL AND INTERNATIONAL  
STRATEGIES TO FIGHT AGAINST HIV/AIDS  
IN AFRICA**

*A Policy Research Report*

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## **Abstract**

### **Nearly 34 million deaths have been attributed to HIV/AIDS, two decades after its appearance.**

Analyses of the epidemiology of HIV reveal a close correlation between the Human Development Index (HDI) ranking, poverty indices, and the gender development indices leading to the conclusion that poor human and gender development is an incubator for the disease. World Bank cross-country regressions suggest that, as a result of HIV/AIDS, per capita incomes growth reduced in sub-Saharan Africa by 0.7 percent per year from 1990 to 1997.<sup>1</sup> UNAIDS estimates that HIV/AIDS, combined with tuberculosis and malaria, is claiming 5.7 million infants, children, young mothers and fathers (in the most productive age groups) a year. And ninety-five percent of new infections occur in developing countries, especially sub-Saharan Africa.<sup>2</sup> While the relationship of HIV/AIDS to the absence of sustained human development is generally accepted, how to respond effectively is not always clear given the unique behavioral, cultural, and religious barriers encountered in each country.

At the international level, efforts by international organizations (led by UNDP, WHO, and UNICEF) to develop effective and coordinated responses led to the establishment of the Joint United Nations Programme on HIV/AIDS—UNAIDS and its International Partnership Against Aids in Africa (IPAA). Over the decade major multilateral and bilateral aid partners—IFI's, EU, CIDA, SIDA, DfID, USAID, etc. have attempted strategic adjustments to integrate HIV/AIDS concerns more effectively into program frameworks. At the national level, since 1985 nearly every country in sub-Saharan Africa have developed some program framework and now claim to have in place national strategic plans on HIV/AIDS. Two core priorities are common to these plans: 1) prevention of the spread and 2) the provision of care and support to sufferers.

At both the international and country levels, results vary but enough people are not being reached to slow the spread of the disease, especially in those countries that are hardest hit leading inevitably to the question—what strategies work given the range of tools available for implementation? After reviewing international and country case studies, this paper argues that poor human development and the HIV/AIDS pandemic are so closely related that only a holistic approach can achieve meaningful results. But this holistic approach goes beyond “upscaling”; which has now been introduced as the new conceptual frame for HIV/AIDS programming. It requires nothing less than a governance approach coupled with a changed attitude of those who lead in Africa towards greater empathy for the people they lead.

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<sup>1</sup> Bonnel René; HIV/AIDS: Does it Increase or Decrease Growth in Africa?; World Bank, November 6, 2000

<sup>2</sup> UNAIDS; Confronting AIDS: Public Priorities in a Global Epidemic;

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## Introduction

A common assumption made by development planners is that by addressing income and development aspects of peoples' lives, African Governments can deal with the background of HIV vulnerabilities and make significant inroads in the struggle against the pandemic. Moreso, improved human capability is seen as a key of sustainable development and the fight against the spread of AIDS.

Countries have been formulating and putting into action frameworks for AIDS prevention and control since 1985. Thirty-one African countries had complete HIV/AIDS Strategic Plans by the end of 2001. In another 12, plans were being developed in 2002. Emphasizing short to medium term solutions, these frameworks describe major strategies requiring support from external partners and from the African Governments themselves. Invariably, the structure of the first line response requires the establishment of a national control programs to deal with sentinel surveillance and advocacy activities under or through Ministries of Health. Experiences vary but enough people are not being reached to slow the spread of the disease.

Sub-Saharan Africa remains the epicenter with approximately 3.4 million new infections annually.<sup>3</sup> Antenatal clinic data reveal infection rates of 30 percent or more in several countries—Botswana, South Africa, Swaziland. In 16 countries at least 10 percent of the adult (and most sexually active) population 15-49 are infected with AIDS. In Burkina Faso, Cameroon, Cote d'Ivoire, Nigeria and Togo adult prevalence exceed 5 percent. Between 2.3 and 2.7 million Africans will die of AIDS or AIDS-related causes in 2002 and nearly 2 million children will be orphans. Life expectancy has now fallen to 47 years from 62. While the epidemiology of the disease is more fully understood, the other dimensions—social, economic, and political are only now being appreciated.

Sub-Saharan Africa is also beset with poor human improvement indicators. Human Development Index value (composite of life expectancy, per capita income, adult literacy, and gross enrollment) for 1999 was 0.467 compared to 0.564 for South Asia, 0.648 in Arab States, 0.719 in East Asia and the Pacific, and 0.760 in Latin America and the Caribbean<sup>4</sup>. HDI value for OECD High Income countries stood at 0.928 in 1999. Sub-Saharan Africa is the only region of the world where GDP per capita annual growth rate was negative when examined over the periods 1975 to 1999 and 1990 to 1999.

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<sup>3</sup> UNAIDS/WHO; *AIDS Epidemic Update 2001*

<sup>4</sup> UNDP, Human Development Indicators

The region has become crisis-prone and HIV/AIDS deadly grip is only another evidence of a more fundamental and complex situation. As such, overall poor performance of Sub-Saharan Africa on human improvements is reinforced, in this paper, by analyses of governance effectiveness. Although arguments favor intensive Government efforts to slow the spread of AIDS, policy formulation in view of the foregoing is uniquely challenging.<sup>5</sup>

Discussions now surround proposals to upscale interventions at the national level, drawing together civil society organizations and governments in the process. While much has been presented on the epidemiology of the disease from medical, and of late economic, perspectives, this policy research paper provides another perspective that links HIV/AIDS to the development process in its entirety. This paper argues that outside of a governance approach to addressing Africa's development challenges, efforts at mitigating the effects of HIV/AIDS would be unsustainable.

## **Methodology**

The conclusions and recommendations of this paper are made on the basis of an analysis of secondary data. By so doing, the author hopes to contribute to a greater appreciation of the real source of the HIV/AIDS pandemic and the solutions. No effort is made to verify nor to evaluate data, much of which are culled from UNAIDS, WHO, UNDP, World Bank sources, or directly from the bilateral funding sources reports.

This paper is informed by reviews of information in three categories. U.S. Bureau of Census data, Epidemiological Fact Sheets from the Working Group on Global Surveillance of HIV/AIDS and sexually-transmitted infections (STIs) of UNAIDS and WHO are examined along with programs of Inter-Governmental Organizations (IGOs) and the International Financial Institutions (IFIs). At another level, HIV/AIDS Action Plans of the Canadian International Development Agency (CIDA), the European Union (EU), and the United States are studied to identify the major thrusts, consistency, and impact of the lead bilaterals. The EU, in this context is considered as a harmonized policy perspective for its member states. Finally, national programs are reviewed in the context of six country cases—Botswana, Senegal, South Africa, Uganda, Zambia, Zimbabwe.

In selecting countries for case study, six indicators are used. These include Adult HIV prevalence, assessment of data on antenatal clinic attendees (ANC), Human Development Index rank, and estimated number of people living with HIV. Data used are for 1999. In 1999, UNAIDS and WHO worked closely with national governments and research institutions to recalculate estimates

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<sup>5</sup> Confronting AIDS; Public Priorities in A Global Epidemic

of people living with HIV/AIDS. Other indicators used in the selection process were the GNP 1996-1997 per capita annual growth rate; and for 2000, whether a National Strategic Plan on HIV/AIDS existed.

Data for thirteen countries were examined—Botswana, Burkina Faso, Ethiopia, Ghana, Kenya, Mauritius, Namibia, Senegal, South Africa, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe. The data were arrayed in terms of low-level, concentrated, and/or generalized prevalence from 0.08 (Mauritius) to 25 (Zimbabwe) percent. The six countries falling closest to the mid-point of each range were selected. Efforts were also made to ensure that all regions are covered while biasing the selection to those countries where significantly more data are available. Table 1 and Figure 1 illustrate the final count of the six countries selected for case study.

A closer examination of available data indicates that the most useful comparator is the adult HIV prevalence. Estimates from the selected countries range from as low as 1.77 percent for Senegal to as high as 35.80 percent in Botswana. Furthermore, estimates of the total number of persons living with HIV in 1999 as a proportion of the total population range from 0.85 in Senegal to 18.16 in Botswana; a consistent pattern with adult HIV prevalence. When the ANC data are used, however, Botswana falls into a different category—an inconsistent pattern.

While ANC provides a good context within which anonymous tests can be made, the age difference of women attending the clinics must be compared to the total population to ensure the sample is representative. Furthermore, locally-specific biases such as cultural preferences for use of medical facilities can influence the results.<sup>6</sup> This limits the utility of the ANC as a key comparator for this selection process.

For this paper, Senegal and Uganda are considered representatives of low-level prevalence (by WHO estimates Uganda would be high prevalence), while South Africa and Zambia and Botswana and Zimbabwe represent concentrated and generalized prevalence respectively. All the countries have National HIV/AIDS Action Plans. On HDI ranking the highest is South Africa at 101. Uganda is the lowest at 158 out of 172 countries included in the ranking.

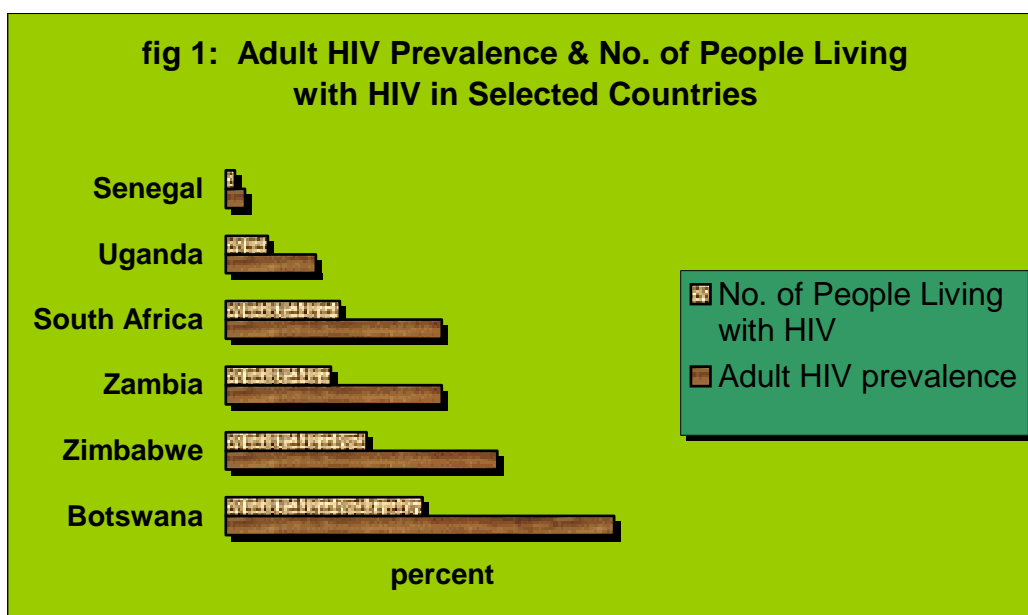
#### **Table 1: Key Country Indicators**

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<sup>6</sup> UNAIDS, *Trends in HIV Incidence and Prevalence: Natural Course of the Epidemic or Results of Behavioral Change?*; 1999

Country	Adult HIV prevalence (percent 1999)	ANC (1999 urban clinics)	GNP (1996-1997 per capita annual growth rate)	HDI RANK (1999)	Estimated No. of people living with HIV in 1999 (percent of population)	National Strategic Plan on HIV/AIDS ? (2000)	
						Yes	no
Senegal	1.77	0.2	2.5	153	0.85	X	
Uganda	8.30	5.5	3.0	158	3.88	X	
South Africa	19.94	16.0	-0.4	101	10.53	X	
Zambia	19.95	33.8	1.8	151	9.69	X	
Zimbabwe	25.06	47.4	0.1	130	13.01	X	
Botswana	35.80	34.0	3.0	122	18.16	X	

Source(s): UNAIDS Epidemiological Fact Sheets; UNDP Human Development Reports



Senegal and Uganda stand out among the few developing countries that have made meaningful inroads in mitigating the effects of the disease and controlling the spread. They provide an interesting contrast to South Africa and Zimbabwe where political commitment during the early phases of the epidemic could be characterized as “hostile” or denial. The situation in Botswana, on the other hand, challenges the assumption of the close linkages between human improvements, prevention and control of HIV/AIDS. A review of these country contrasts provides an interesting backdrop to our conclusions.

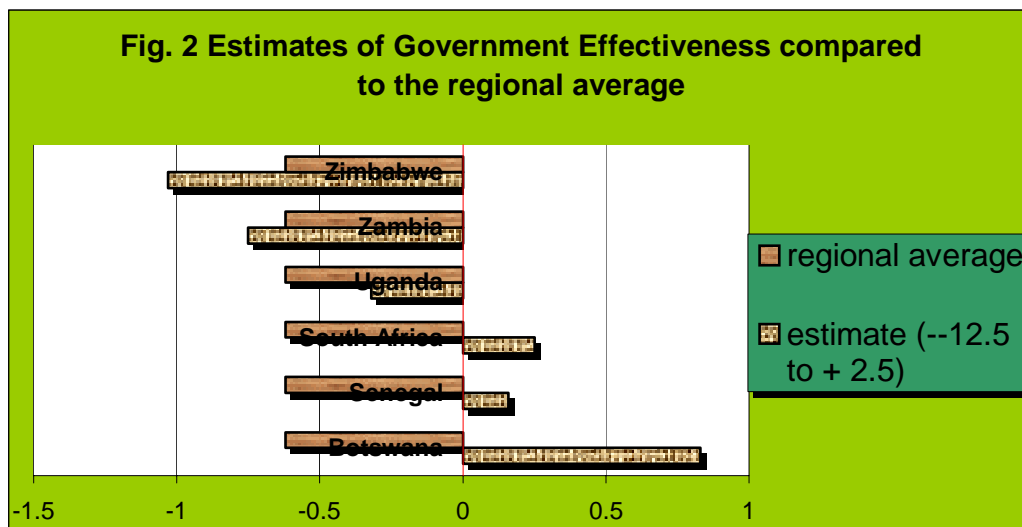
Furthermore, looking at 178 countries, assessments were made in 1997/98 and 2000/01 of six key composite indicators of governance—voice and accountability, political stability, government

effectiveness, regulatory quality, rule of law, and control of corruption.<sup>7</sup> On a scale of -2.5 to 2.5, with higher values corresponding to better outcomes, Governments of Sub-Saharan African countries (with a few notable exceptions) consistently demonstrate governance indicators in the negative.

## Government Effectiveness and HIV/AIDS in Africa

The ground-breaking work in this area was undertaken by Kaufman, Kraay, and Zoido with support from the World Bank<sup>8</sup>. The study is biased towards governance for economic development and the results, as used here, are subject to this limitation. Moreover, the datasets cover 1997 to 2001 and, therefore, does not adequately reflect changes in the governance arrangements over time and the effects on economic development

Nevertheless, of critical importance to the potential impact of HIV/AIDS programs is the cluster on government effectiveness; which combines perceptions of the quality of the public service provision, quality of the bureaucracy, competence of civil servants, independence of the civil servants from political pressures, and credibility of the government commitment to policies. Fig. 2 compares the scores of the six countries to the regional average for Sub-Sahara Africa. By these estimates, the Governments of Zimbabwe and Zambia are less effective than the regional average; while South Africa, Senegal, and Botswana show positive scores, Uganda's score is negative.



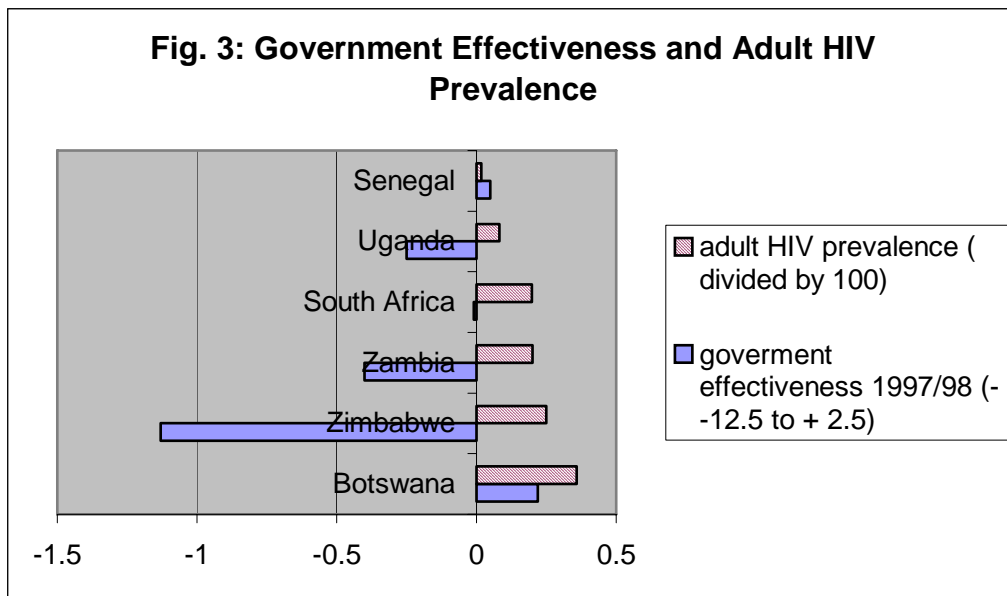
source: World Bank

<sup>7</sup> World Bank

<sup>8</sup> see Kaufman, Kraay, and Zoido (KKZ); *Aggregating Governance Indicators*; World Bank 1997

But how does this relate to HIV prevalence and “upcaling” of future interventions? In Fig. 3, the government effectiveness scores are compared to adult HIV prevalence (percentages adjusted by dividing by 100). The normal relationship should be an inverse. Higher levels of government effectiveness should result in lower levels of prevalence as seen in developed countries. Scores for 1997/98 are compared to adult HIV prevalence in 1999 and unexpected results emerge.

Senegal, South Africa, and Botswana have more effective governments but (except Senegal) HIV prevalence remains high. Whereas in Zimbabwe and Zambia, where the governments are the least effective (according to these scores), infection rates are lower than. What accounts for this result is discussed in the program review and case studies that follow.



source(s): World Bank, UNAIDS

## UNAIDS and the Global Response

The initial response to HIV/AIDS was largely sectoral, especially during the early stages of the epidemic in most affected countries. In the ground-breaking report in 1998, the world bank cited the reluctance of policymakers to intervene during the initial outbreak as a contributing factor to the spread of the disease.<sup>9</sup> Nevertheless, since national priorities in most Sub-Saharan countries are donor-driven aid partners are also associated with the decision-making processes. In 1985, WHO began aiding countries to develop plans for AIDS prevention and control.

<sup>9</sup> World Bank: *Confronting AIDS: Public Priorities in a Global Epidemic*; 1998

The WHO Global Programme on AIDS (GPA) prioritized the prevention, detection, and treatment of STDs, the prevention of sexual transmission of HIV, the prevention of transmission through blood supply, the reduction of transmission associated with substance abuse, the prevention of perinatal transmission, and the care and support of persons affected by HIV/AIDS/TB and STDs. This was to be accomplished by strengthening health care systems and the promotion of adequate and appropriate societal responses (UNAIDS). Most major aid sources did not begin integrating HIV/AIDS into their own policy framework until several years later. By 1996, only two bilateral ODA countries—Belgium and the United States, reported specific funding lines for HIV/AIDS interventions (UNAIDS).

Table 2 provides a matrix on current programmatic approaches of two bilaterals—CIDA and USAID and two multilaterals—EU and the World Bank, and for UNAIDS (joint program of 8 agencies). For the European Commission, HIV/AIDS assistance to Africa is within the context of the ACP Partnership Agreement, which is largely economic. The EC Programme of Action is designed to link country level actions aimed at increasing access to goods and services. Most of the HIV/AIDS funding provided under the 8<sup>th</sup> EDF is therefore for improving health systems, reorganization of services, and understanding the problems of the sector.

For the guiding principles of its current HIV/AIDS Action Plan, CIDA places emphasis on support for developing country governments to take a lead in responding to the epidemic. But, the activities and countries to be supported are spelled out to a high level of detail leaving little room for flexibility based on locally-defined needs; unlike DfID (not listed in Table 2) which allocates resources for local programming. In the WB framework, the major new funding source—MAP comes with conditionalities for access to the resources. And the WB inclination not to intervene in areas funded by other ODA agencies nor government further limits the utility of this window.

The WB also provides grants for HIV prevention and care, and administers grant programs for other funding organizations. Nevertheless, internal evaluations of WB-funded interventions since 1986 show poor implementation, little impact, and only few African countries drawing more than token resources. The prospect for the current shift to upscaling through these funding sources, therefore, is difficult to foresee.

USAID contributed nearly one-half of all HIV/AIDS ODA in 1996 (44%) and 1997 (48%). Like other ODA agencies, USAID is increasingly shifting from HIV/AIDS-specific activities to funding integrated programs and projects addressing wider development issues with HIV/AIDS as a component (UNAIDS). Other strategic shifts include channeling more resources through US-based non-governmental organizations and host country civil society.

**Table 2: Summary of Approaches of ODA Agencies**

Aid Agency	Guiding Principles Objectives	Current Approach	Success Factors Lessons Learned
Canadian International Development Agency	<ul style="list-style-type: none"> <li>• Support developing country governments to take the lead</li> <li>• Intersectoral strategies including potential impact of other development programs</li> <li>• Promoting linkages to education, human rights, good governance</li> <li>• Promoting gender equality and sensitivity</li> <li>• Supporting communities</li> <li>• Supporting partnerships</li> <li>• Promoting SHD</li> <li>• Prioritization for optimal impact</li> </ul>	<ul style="list-style-type: none"> <li>• IEC</li> <li>• Surveillance</li> <li>• Community capacity building</li> <li>• Health-system strengthening</li> <li>• Support national programs</li> <li>• STD treatment and control</li> <li>• Prevention of MTCT</li> <li>• Network building</li> <li>• Drugs and supplies</li> <li>• Training</li> <li>• Testing and counseling</li> <li>• Targeting women</li> <li>• Targeting youth</li> <li>• Targeting children</li> <li>• Targeting sex workers</li> </ul>	<p><i>Success areas</i></p> <ul style="list-style-type: none"> <li>• Links with national programs</li> <li>• Synergies with other donors</li> <li>• Condom use</li> <li>• Syndromic mngt. Of STDs</li> <li>• Local capacity building</li> <li>• Peer counseling</li> <li>• Training</li> </ul> <p><i>Problem areas</i></p> <ul style="list-style-type: none"> <li>• Gender power relations and social stigma</li> <li>• Exclusion of youth</li> <li>• Proper approaches to testing and counseling</li> <li>• Donor dependency</li> <li>• Flexibility to absorb new finding and approaches</li> <li>• Insufficient attention to sectoral integration</li> </ul>
European Commission	<ul style="list-style-type: none"> <li>• Foreign aid should be directed primarily at enhancing national efforts</li> <li>• National strategies involves a political commitment to respect rights</li> <li>• Assistance should relate primarily to the poorest countries</li> <li>• Social, economic, cultural, and ethical realities should be taken into account</li> <li>• Assistance should come within the broader framework of social policy</li> <li>• Preventive measures remains the chief priority</li> <li>• Assistance should be targeted and precedence given to most cost-effective actions</li> </ul>	<ul style="list-style-type: none"> <li>• Cost-effective targeted preventative interventions</li> <li>• Strengthen health care systems and refine essential drug policies</li> <li>• Create new solidarity mechanisms</li> <li>• Explore prospect of financing care including anti-retrovirals and developing vaccines and microbicides</li> <li>• Support countries in purchasing existing commodities</li> <li>• Leverage further investment by the private sector in developing vaccines and microbicides</li> <li>• Support UNAIDS in the management of new solidarity instruments while leaving major decisions to developing countries</li> </ul>	<p><i>Success areas</i></p> <ul style="list-style-type: none"> <li>• Addressing poverty reduction, communicable diseases, and the gender perspective effectively within the framework of country strategy papers</li> <li>• Providing technical and normative inputs to country HIV/AIDS programming and identification in collaboration with UNAIDS and WHO</li> </ul> <p><i>Problem areas</i></p> <ul style="list-style-type: none"> <li>• Need for more effective aid management processes and more rapid disbursement and resource transfers</li> </ul>
World Bank	<ul style="list-style-type: none"> <li>• There is a need to scale up proven and culturally adapted interventions to achieve nationwide coverage</li> <li>• Countries need to prepare to cope with unprecedented burdens related to HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Advocacy to position HIV/AIDS at the top of the development agenda</li> <li>• Increased resources and technical support to mainstream HIV/AIDS in all sectors</li> <li>• Prevention efforts and activities to enhance care, support, and treatment</li> <li>• Expanding the knowledge base to help countries design and manage comprehensive programs based on local circumstances and practices</li> </ul>	<p><i>Success areas</i></p> <ul style="list-style-type: none"> <li>• A total of 552 million committed to HIV/AIDS programs since 1986</li> <li>• MAP offers another 500 million to SS Africa</li> </ul> <p><i>Problem areas</i></p> <ul style="list-style-type: none"> <li>• HIV/AIDS not adequately reflected in CAS</li> <li>• Project interventions limited on how to reach “at risk” groups</li> <li>• Design and management problems have militated against positive impact of projects</li> </ul>

Aid Agency	Guiding Principles Objectives	Current Approach	Success Factors Lessons Learned
USAID	<ul style="list-style-type: none"> <li>• Reduce HIV prevalence by 50 percent among 15-24 year old in high prevalence countries</li> <li>• Maintain HIV prevalence below 1 percent among 15-49 year old in low prevalence countries</li> <li>• Ensure that at least 25 percent of HIV-infected mothers in high prevalence countries have access to interventions</li> <li>• Ensure that high prevalence countries can provide basic care and psychosocial support to at least 25 percent of affected children</li> </ul>	<ul style="list-style-type: none"> <li>• Prevent new infections committing about 70 percent of budget commitment</li> <li>• Provide care and treatment to individuals and communities for HIV/AIDS, tuberculosis, and other opportunistic infections</li> <li>• Address the needs of children affected by HIV/AIDS using community-based care</li> <li>• Increase national and international surveillance</li> <li>• Increase the capacity of developing country already overstretched health systems</li> <li>• Work in partnership with other international donors, national governments, and a range of host-country and U.S. based organizations</li> <li>• Provide technical leadership through research</li> <li>• Create an environment that supports HIV/AIDS prevention and care</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals will seek to learn their HIV status where care and treatment are available</li> <li>• Increasing levels of resources, scaling up of projects, and the development of new program areas make measuring progress and effective targeting more urgent</li> </ul>
UNAIDS	<ul style="list-style-type: none"> <li>• strengthen and support national capability to coordinate, plan, implement, monitor, and evaluate an expanded response</li> <li>• identify, develop, and advocate for HIV/AIDS principles, policies, strategies, and activities that are recognized to be technically, ethically, and strategically sound</li> </ul>	<ul style="list-style-type: none"> <li>• enhance collaboration and joint action on HIV/AIDS by the cosponsors and the UN system as a whole;</li> <li>• monitor and evaluate UN system action on HIV/AIDS;</li> <li>• provide and facilitate technical support for the national AIDS response, including various sectors, NGOs, networks of people living with HIV/AIDS and the cosponsoring agencies;</li> <li>• strengthen the capacity of national leadership to coordinate, manage, monitor and evaluate the response to HIV/AIDS;</li> <li>• advocate for political commitment, multisectoral involvement and the development of policies/ environments conducive to an expanded response to HIV/AIDS, particularly in relation to human rights and dignity, and effective country-appropriate action;</li> <li>• cooperate on resource mobilization efforts to increase the level and diversity of financial and technical contributions to the country's response, and improve their allocation and use;</li> <li>• promote and support linkages for collaborative work on issues that cut across boundaries.</li> <li>• collecting, analysing and disseminating research findings and experiences of sound policies, strategies</li> </ul>	

		and initiatives from around the world; <ul style="list-style-type: none"> <li>• identify gaps and needs in critical areas of prevention, care and impact alleviation;</li> <li>• promote and support research and development to fill these gaps;</li> <li>• involve partners in priority-setting, policy and strategy development, research and evaluation;</li> <li>• provide a forum for debate and consensus-building;</li> <li>• provide technical support to operationalize best practice</li> </ul>	
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In 2001 USAID developed an “expanded response” strategy to the HIV/AIDS pandemic. The key elements include: an increase in the number of priority countries, a new resource allocation plan that puts more resources (technical and financial) at the field level similar to DfiD, and an expanded monitoring and reporting system to track progress in priority countries.

Sub-Saharan Africa continues to receive the largest proportion of program resources. For 1996 and 1997, Tanzania, Uganda, and Zimbabwe were the largest single recipients (UNAIDS). But the overall trend is a decline in funding per HIV-positive person despite an overall increase in HIV/AIDS disbursements by major funding sources from 1987 to 1997.

A review of the program content of ODA agencies reveals critical differences in timing, priorities, and treatment of HIV/AIDS. Because of the shift away from multilateral channels to direct funding of national programs through bilateral agencies, program delivery is increasingly linked to the fiscal periods and interests of the donor agency. Consequently, there are large differences in coverage of HIV/AIDS activities among countries (UNAIDS). Moreover, whether HIV/AIDS is approached as a sectoral, cross-sectoral, or rights-based concern depends on the ODA agency perspective. Since program countries are wont to accept the position of the major funding source, national programs evolve based on the criteria and content prescribed by the donor.

The criteria reportedly used in allocating resources to HIV/AIDS programs and projects to specific countries includes, in order of priority: 1) political/historical ties, 2) geographical areas of interest, 3) sectoral interests, 4) strategic move to or from government funding, 5) epidemiology of the disease. In most cases more than one criterion is used but less than half of the donors considered the severity of the epidemic as criteria for allocating resources to HIV/AIDS activities.<sup>10</sup>

By 1996, 15 ODA agencies and the European Commission had committed funds for programs for HIV/AIDS.<sup>11</sup> While the number of ODA agencies and amounts contributed to programs increased steadily and in absolute terms between 1987 and 1996, the relative funds made available per HIV-

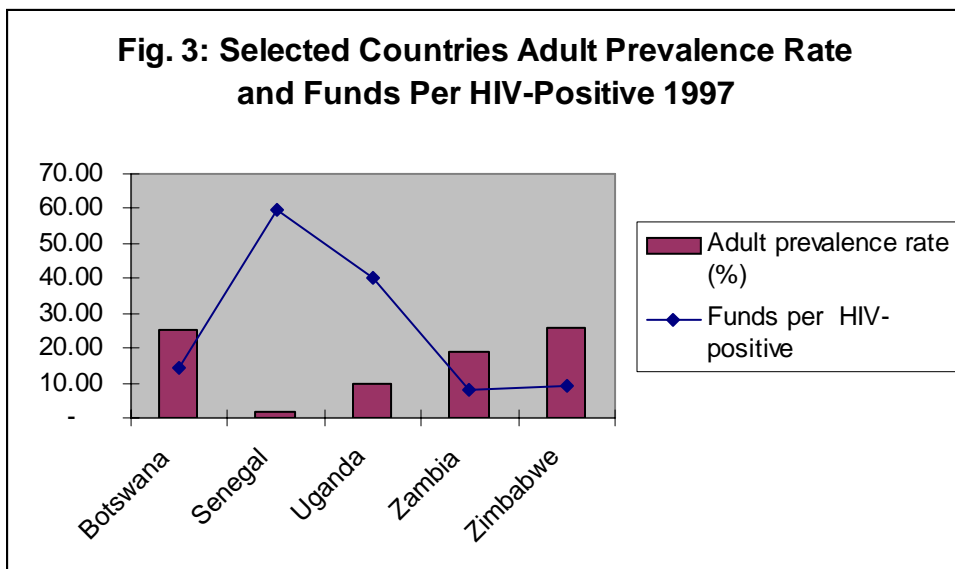
<sup>10</sup> UNAIDS; *level and Flow of National and International Resources for the Response to HIV/AIDS, 1996—1997*; 1998

<sup>11</sup> *ibid*

infected person more than halved from 1988 to 1997 (UNAIDS). Although UNAIDS and the IPAA have the most extensive program coverage, ODA channeled through multilateral sources dropped from 70 percent to 22 percent between 1987 and 1997.

This shift in funding channel reflects the trend in major ODA agencies to internalize HIV/AIDS into their own programs of assistance and build solidarity instruments with the multilaterals. Moreover, because significant portions of the programs are implemented by civil society organizations funded directly by bilaterals, it becomes difficult to trace and direct funds spent for care and support of people living with HIV/AIDS. This reinforces shortcomings in current capacity to monitor HIV/AIDS resource flows.

Figure 4 illustrates the relationship between HIV-prevalence and funds allocation per HIV-positive persons in five of our six select countries (data for South Africa was unavailable). The higher the resource flows the lower the levels of prevalence. In 1997, Senegal spent the highest per person amount (\$59.63) followed by Uganda (\$40.41). The lowest amounts were spent in the countries with the highest prevalence rates. The case of Botswana highlights the problem of associating gains made against the HIV epidemic entirely with availability of funding. Almost one and half times more was spent per person than Zimbabwe; yet both countries have the highest (and growing) adult prevalence rates.



source: UNAIDS

## Assessing Country Programs and Interventions

### *The Case for Botswana, Senegal, South Africa, Uganda, Zambia, and Zimbabwe*

There is no single solution or best practices for HIV/AIDS intervention given the social, cultural, and political diversity among countries (UNAIDS). Nevertheless, associations can be made between key development indicators and the level of success each country experiences in meeting all of its human development challenges. On the fight against the HIV/AIDS epidemic, the different outcomes in different regions of the world beg for a closer examination of those critical elements needed to succeed against the disease.

Data on HIV must be reviewed in light of intermediate determinants such as behavioral change, condom usage, and STDs. Understanding factors such as the phase of the epidemic, the dominant transmission modes, and the surveillance mechanisms are essential components of cross-country assessments. But also becoming increasingly important are situational variables such as poverty, gender empowerment, human development, and government effectiveness. In this respect, the data and the efficacy of the evaluation and analyses presented in this report are limited by the quality of data available on each country. Information here is culled largely from UNAIDS and the U.S. Bureau of Census sources. The discussion on country programs and interventions is not exhaustive, nor is it intended to be. It should, however, bring forth the broader perspective to Africa's newest crisis.

#### *Epidemiological Summary*

**Botswana** has the most severe HIV/AIDS epidemic in the world. Since 1985, when the first case was diagnosed, HIV/AIDS has emerged as a major human development concern of Botswana. Over the 1990s, HIV prevalence spread rapidly. National Sentinel Surveillance surveys have been conducted since 1992 and reveal exponential growth characteristics. In major urban areas, median HIV prevalence among ANC attendees increased from 6 to 43 percent from 1990 to 1998. Outside of major urban areas, median HIV prevalence increased to 30 percent in 1995 from zero in 1985-1987. HIV prevalence also increased from 22 percent in 1992 to 60 percent in 1998 among male patients with sexually transmitted infections in urban areas. Outside major urban areas, the prevalence increased to 53 percent over the same period. About 93 percent of all cases were by heterosexual transmission infecting largely those between the age categories of 20 to 40. Between 1998 and 1999, however, there was an encouraging decline among 15-24 year old pregnant women.

Whereas in **Senegal**, the epidemic is more concentrated and on a decline. Unlike most other countries in Sub-Saharan Africa, Senegal's case is of high-level HIV-2. In selected urban areas, HIV-1 prevalence among pregnant women ranged from 0.1 to 0.6 percent in 1997 and 1998. HIV-2 prevalence though stood at 0.6 percent. A 1995 study showed little differences among the rural population by sex. HIV-2 levels were 1.5 percent among males and 1.2 percent among females. HIV-1 infection was 0.1 percent and 0.4 percent among males and females, respectively. The highest levels of prevalence were found among urban prostitutes. HIV-1 prevalence ranged from 4 percent in 1990 to 13 percent in 1997—its highest level.

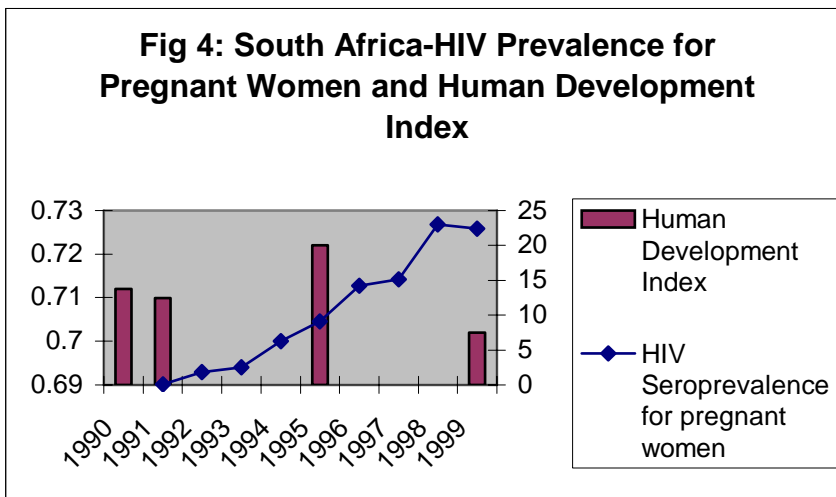
Over the 1990s, the HIV/AIDS epidemic exploded into a generalized state in **South Africa**. The country now faces one of the most serious infection rates at 19.9 percent of adults (1999). Unlike most Sub-Saharan countries, both urban and rural areas seem equally afflicted. Twenty-three percent of pregnant women were infected by 1998 and 22 percent in 1999. HIV prevalence rose among all age groups of pregnant women and studies point to a steadily worsening situation; and appears to be slightly higher among females than males. Among prostitutes, the rate increased by 21 percent between 1996 and 1998. Among STD patients, a steady increase from 1 to 20 percent is recorded from 1988 to 1994 in Johannesburg. Overall, 45 percent of female and 36 percent of male STD patients were infected in rural South Africa.

From a peak of 14 percent in the early 1990s, **Uganda** has been able to bring adult prevalence rates down to 8.3 percent by 1999. In urban areas, prevalence rates have declined by 50 percent since 1993. In urban clinics pregnant women 25-29 had the highest rates of between 17-21 percent, with steady increases over the period 1989-1992. Since 1992, however, reports show a decline and leveling off of infection levels. Prevalence among STD patients in Kampala also decreased every year from 1990 to 1998—from 44.6 to 29.4 percent.

There has been a notable decline in prevalence among 15-19 year old women in **Zambia**, though the epidemic state remains generalized. This is largely attributed to behavior change. Among all adult women, however, there is little sign of change in overall prevalence. In the capital, Lusaka, infection levels increased from 8 percent to 32 percent among pregnant women from 1985 to 1999. In general, rural areas had lower prevalence rates among pregnant women—ranging from 8 to 13 percent in 1998. Prevalence was much higher in younger women compared to males in the same age groups in 1999. Infection rate was as high as 69 percent among prostitutes in the large commercial, mining, and manufacturing areas in 1997-1998. Among STD patients, prevalence was no fewer than 33 percent and as high as 71 percent in various parts of the country.

The 1997 round of sentinel surveillance among pregnant women in **Zimbabwe** confirmed the seriousness of the epidemic in all geographic areas. In some rural areas, as much as 51 percent of pregnant women tested positive for HIV. The epidemic had become widespread and severe by 1990; with high levels not only amongst at-risk groups but also among the population at large. Urban and rural areas are equally affected. A 1994-1995 study of prostitutes in Harare reveals infection levels as high as 86 percent. Also for STD patients, infection level was 71 percent among male and 51 percent among female in 1995. Prevalence has increased steadily since 1990. Zimbabwe is in a generalized state of the epidemic.

Figure 4 shows the inverse relationship between the human development index and HIV prevalence for South Africa. As the indices of human improvement decline, HIV increased. This pattern is observed in all cases except Botswana where the impact of social and cultural factors provides empirical evidence for the importance of placing national responses within the local context.



### *Program Response and Results*

UNAIDS secretariat and its five IPAA constituencies broadened the international solidarity against the disease, improved technical cooperation in Africa, and strengthened national capacity. Working through task teams and working groups efforts have been made to harmonize policies, improve information and communications systems, and to reinforce the capacity of local institutions to provide training and advisory services. The formation of resource networks around specific themes has been accompanied by efforts to strengthen global and regional support. New solidarity mechanisms have also been established with DfID, GTZ, The Netherlands, U.S.,

Norway, Sweden, CIDA, and Belgium. The main outcome has been heightened global interest in the pandemic in Africa.

But at the country level results vary and discussions now surround intensified action and a scaling up of successful interventions to achieve national coverage. In some countries (**i.e. Zambia and Malawi**) National Strategic Plans have been completed, costed, with prioritized actions clearly identified. National Coordinating bodies, many established under the old framework of intervention with WHO, have been strengthened through added technical expertise and financial resource inflows. In **Uganda, Zambia, and Zimbabwe**, the response has been decentralized to the district levels to broaden community participation and mobilization.

Furthermore, in **Uganda and Zambia** HIV/AIDS issues have been “mainstreamed” and linked to on-going poverty reduction processes through the PRSP and debt relief initiatives. More importantly, monitoring indicators have been included in the national framework of development indicators and financial resource mobilization is achieving meaningful results both in terms of domestic reallocations and ODA inflows. Efforts are also being made to establish more appropriate resource transfer mechanisms to channel funds to communities with high prevalence levels.

At the global level, substantial progress have been made in highlighting the epidemic, reinforcing political commitment, collaboration and communication, and in mobilizing financial resources for intensified country-level actions.<sup>12</sup> It is progress on the country-level interventions, however, that will be the key determinant of progress against the disease.

**Senegal's** experience reveals the advantage of an early and immediate national response to the epidemic. After the first case was identified in 1986, a national aids prevention program was implemented with openness and honesty. By 1987 a blood transfusion screening system was established covering all regions of the country, political and religious leaders were enlisted to provide moral support to health authorities, and targeted interventions was established for young people and commercial sex workers. By 1998 cross-sectional surveys showed substantial knowledge build-up so that 96 percent of secondary school pupils and 99 percent of sex workers knew about HIV/AIDS and its prevention.<sup>13</sup> A strong research component, social marketing and a ten-fold increase in the supply of condoms, and efforts to rapidly develop the hospice infrastructure to increase care and support for persons living with HIV and AIDS were also critical

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<sup>12</sup> UNAIDS; *IPAA Progress Report 2000*; 2001

<sup>13</sup> Harvard AIDS Institute; *Africa Now! A Leadership Summit to Define African Priorities for HIV and AIDS*; 2001

elements of the Senegalese program. National infection rate has stabilized at less than 2 percent. STD levels are also on a decline.

**Uganda**, like Senegal, has made major inroads against the epidemic. Over the decade of the 1990s, adult prevalence declined from 14 to 8 percent. Early and sustained mobilization at the highest political level was a critical element of the national response. Seven other elements were essential to success in Uganda<sup>14</sup>. These include: 1) creative grassroots scheme in collaboration with The Aids Support Organization (TASO)—a civil society organizations; 2) awareness raising and community mobilization against HIV; 3) involvement of people living with HIV and AIDS; 4) a broad approach targeting young pregnant women in urban and rural areas; 5) research collaboration and implementation of evidence-based strategies; 6) HIV vaccine testing trials and short courses of antiretrovirals for MTCT prevention; and 7) effective resource mobilization and allocation decisions placing resources to support the most needed interventions.

**Botswana** presents an interesting case study of the right variables attaining the wrong or very little results. This needs more in-depth study beyond the scope of this paper. However, it is important to note that the first case was diagnosed in 1985, and by 1987 the institutional framework for a national response had been set into place. A one-year emergency program was formulated followed by the first five-year strategic plan. By the second five-year strategic plan it had become evident that HIV/AIDS was broader in scope than a health sector issue. A multi-sectoral approach coordinated through the National AIDS Council (supported by the National Aids Coordinating Agency as secretariat) was adapted with three key elements: 1) preventing transmission of HIV, 1) developing appropriate response on care for the infected, and 3) strengthening monitoring activities. Three socio-economic studies were commissioned to improve understanding of the impact of HIV. In collaboration with the UN HIV/AIDS Theme Group and other donors, a number of initiatives were launched to reduce the transmission, prolong life, and reduce morbidity.

However, policies and interventions aimed at reducing the HIV transmission were poorly targeted towards the most at-risk groups. Sentinel surveillance data from ANC was not adequately monitored and used in the forward planning processes. Even with growing evidence that sexual activity among the young was widespread, most health and educational institutions ignored their needs, resulting in unwanted pregnancies and rising levels of STD.<sup>15</sup> The government, though effective in making human improvements in other areas, did not feel ready to openly promote activities such as youth counseling. Moreover, heavy reliance on donors for funding the supply

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<sup>14</sup> IBID

<sup>15</sup> World Bank; *Botswana: Selected Development Impact of HIV/AIDS*; April 2001

of condoms restricted the availability and social marketing strategies were scarcely employed during the early stages.

In the case of **Zambia**, a new strategic framework (2001 to 2003) was launched focused on reducing transmission mainly through children, youth, and women; reducing the socioeconomic impact on individuals and families; and on mobilizing local and external resources. Within this context, support is selectively provided to high priority evidence-based and community-driven interventions. The funding approach is multisectoral. Funding mechanism for interventions by NGOs, religious organizations, or organizations of people living with HIV.

The Zambia framework also provides opportunity for supporting the more than 40,000 registered traditional healers who provide care to the bulk of the rural-based population. Their national association now forms a part of a technical committee on national remedies for HIV; though their practice is still seen as lacking scientific validity.

In **Zimbabwe**, HIV/AIDS is identified as one of three crisis areas.<sup>16</sup> An AIDS control program has been in effect for the past 15 years based largely on the old health sector approach through the Ministry of Health. A central feature of the “new” approach is the establishment of the National Aids Council by Act of Parliament. With a mandate to coordinate broad-based interventions, it reports to the Parliament but each agency is expected to use its comparative advantage to identify and implement interventions. Priority areas of the current national program include: social mobilization, IEC for specific target groups, condom promotion, and voluntary counseling and testing. Priority is also given to participatory approaches to behavior change and safe blood supply, care support and treatment, and training of health workers in clinic management, etc. Though extensive in its coverage and multisectoral in approach, the program seems highly externally-driven and tends to reinforce the ineffective model in place for more than a decade.

**Table 3: Priorities in Public Spending: Public Expenditure and Percent of GDP**

	Education		health		military		debt service	
	1985-1987	1995-1997	1990	1998	1990	1999	1990	1999
Botswana	7.3	8.6	1.7	2.5	4.2	3.4	2.8	1.4
Senegal	n.a	3.7	0.7	2.6	2.0	1.5	5.7	5.0
South Africa	6.1	7.6	3.1	3.3	3.8	1.3	n.a	3.7
Uganda	3.5	2.6	n.a	1.9	2.5	2.1	3.4	2.9
Zambia	3.1	2.2	2.6	3.6	3.7	1.0	6.2	13.9
Zimbabwe	7.7	7.1	3.1	n.a	4.5	3.4	5.4	11.6

Source: UNDP Human Development Report

<sup>16</sup> World Bank; *Zimbabwe National Response to HIV/AIDS 2000-2004*; 2000

Table 3 reflects the public spending priorities at the beginning and end of the decade of the 1990s. It reveals that even in the face of exponential growth in HIV/AIDS resource allocation for the health sector remained relatively low. In **South Africa, Zambia, and Zimbabwe** allocations did not exceed 3.6 percent annually over the decade; while expenditure on military and debt service took higher priority. More importantly, the initial reaction from the Governments did not create the environment for an early and effective response critical to checking the epidemic. With a full-blown HIV/AIDS epidemic well in evidence, economic difficulties over the past decade limit the options available to the governments in formulating and implementing broad-based interventions.

The case countries also demonstrate the importance of gender relations and the spread of HIV/AIDS. The plight of HIV-positive women and children is rarely adequately reflected in the national frameworks. Even in Senegal where openness and high-level commitment has characterized the effort to contain HIV/AIDS, prevalence level among women is higher. Legal discrimination against women is uncommon but social inequality is widespread and alters relationship between the sexes.<sup>17</sup> Young women in Senegal tend to begin sexual activity early and when financially dependent increasing their standards of vulnerability; also a common phenomenon in Zambia, Zimbabwe, and South Africa.

## Conclusions

In Senegal, HIV has infected a minute proportion of the population while in Uganda the situation is one of gradual but considerable progress in reversing the spread. In the other four countries reviewed in this paper, the virus has spread widely and few families are left unaffected. In Botswana and Zimbabwe, control programs have been in place for at least fifteen years. The results in each country have been different.

To be effective, public programs are expected to act as soon as possible and to prevent infection among those most likely to contract and spread HIV as the first line intervention. This was the case with Senegal but early action in Botswana did not achieve similar results. The increased flow of resources to HIV/AIDS programs also achieved mixed results. In Senegal and Uganda, high per capita expenditure seem to have contributed to the lowering of the prevalence; but this was not the case with Botswana.

To formulate and manage policies, government effectiveness is a critical factor to achieving meaningful results. Our analysis showed that in the case of HIV/AIDS, more effective

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<sup>17</sup> Sow Sidibe, Amsatou; *HIV/AIDS and Inequality in Senegal*; 2001

government may not necessarily make inroads against the epidemic. In the case of Botswana, considerable human improvements made by the government over the decade of the 1990s did not seem to slow the infection rate.

Large donor programs influence the decision-making process at the national level. But the epidemiology of the disease is not a priority of donors in resource allocation. Programs highly dependent on external funding, such as condom distribution in Botswana, suffer as a result. Furthermore, the shift towards bilateral as opposed to multilateral channels for financing HIV/AIDS interventions, will place further limits on the distribution and on countries ability to influence the flow of aid to recipients.

What accounts for these differences? Evidently the behavioral and social influences that underpin the HIV/AIDS epidemic need more research. Other determinants such as gender relations, poverty, human capability, and the attitude and effectiveness of the government also need to be taken into consideration in the development of more effective strategies for Africa's growth and development; as well as for HIV/AIDS interventions.

This requires significant high--level commitments to seek the welfare of African people that go beyond HIV/AIDS--to poverty, human rights and access to basic services, and empowerment of peoples in their communities to work for their own interests. In comparatively well-off countries, the level of local empowerment can be directly related to the level of human progress. The more people are empowered with knowledge and resources, and the right to decide, the greater impact can be made at local levels.

The HIV/AIDS pandemic must rightly be seen as one more symptom of a governance crisis in Africa. What is needed therefore in this struggle is a paradigm shift away from the sectoral approaches and from the so-called "upscaling" of donor-funded pilots to more substantive efforts to improve governance systems and arrangements. The experience of Senegal and Uganda shows that it can be done.