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Regional AIDS Strategy for the Sahel

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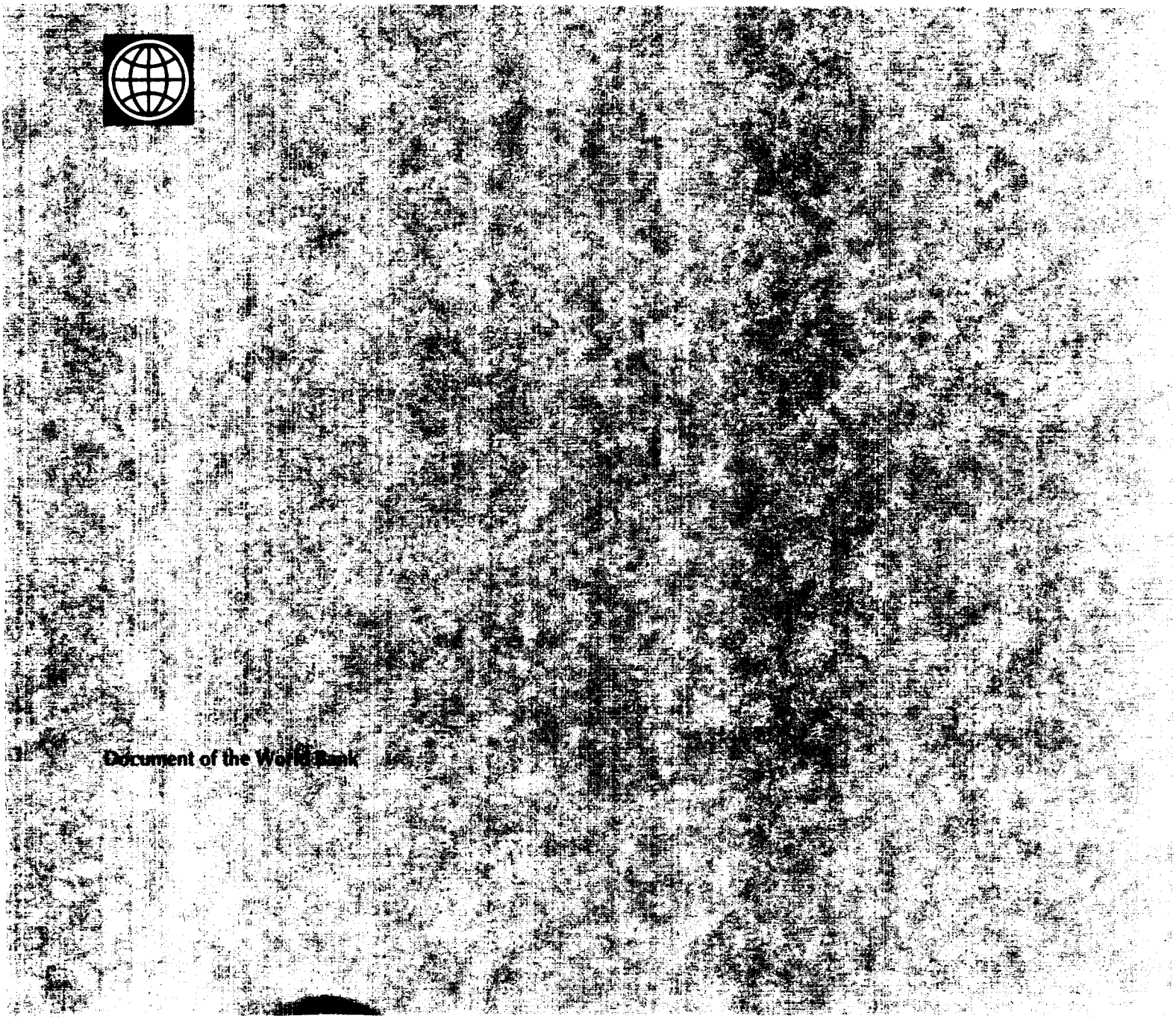
Western Africa Department
Population and Human Resources Division



This report was prepared by the AIDS core team in the Population and Human Resources Division of the World Bank's Western Africa Department (AF5PH) led by Edward Brown and comprising Roza Makonnen and Rejean Paradis. Bruce Benton (AF5PH) and Ernest Massiah of the Population, Health, and Nutrition Department (PHN) contributed to sections of the paper. Preparation of this paper was immensely aided by the contributions of participants in a number of consultations and review meetings. An inter-agency meeting bringing together about 10 multilateral and bilateral agencies, including NGOs, was organized in September 1993 to initiate the preparation process. Peer reviewers were Wendy Roseberry, Mead Over and Jean-Louis Lamboray. In addition, valuable contributions and advice were provided by the AF5PH Health and Population team and colleagues from other departments within the Bank. Many others outside the World Bank, including in particular the WHO/Global Program on AIDS, provided helpful comments and contributions. The paper was prepared under the general guidance of Ms. Katherine Marshall, the Western Africa Department Director, and Mr. Birger Fredriksen, the managing Division Chief, whose keen interest and support have helped shape the final product. Mr. François Laporte is the Lead Economist and Mr. Emmerich Schebeck is the Projects Advisor. Ms. Ghislaine Baghdadi provided support services, Mr. Ross Pfile and Ms. Lauren Ptito provided editorial assistance for the report.

LIST OF ACRONYMS

AF5PH	Western Africa Department - Population and Human Resources Division
AIDSCAP	AIDS Control and Prevention Project
AIDS	Acquired Immune Deficiency Syndrome
CAS	Country Assistance Strategy
CBOs	Community-Based Systems
CIDA	Canadian International Development Agency
ESS	Epidemiological Surveillance Systems
FAC	*Fonds d'Aide et de Coopération*
FAO	Food and Agricultural Organization (UN)
GPA	Global Program on AIDS
GUDs	Genital Ulcer Diseases
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IEC	Information, Education and Communication
KAP	Knowledge, Attitude and Practice
MCH	Maternal and Child Health
MTPs	Medium-Term Plans
NAPs	National AIDS Program
NGOs	Non-Governmental Organizations
PASE	*Projet d'Appui à la Surveillance Epidémiologique* (Epidemiological Surveillance Support Project)
PHN	Population, Health and Nutrition

SRI	Sahelian Regional Initiative
SSA	Sub-Saharan Africa
STDs	Sexually Transmitted Diseases
SWAA	Society for Women against AIDS in Africa
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

CONTENTS

EXECUTIVE SUMMARY

Introduction

1. The objective of this report is to define strategies for the World Bank ('the Bank') to effectively assist Sahelian countries in taking advantage of the window of opportunity that currently exists to carry the fight against the HIV/AIDS epidemic to a higher level. The report discusses the main issues and manifestations of the epidemic, identifies constraints to effective policy and program development and implementation, and proposes an agenda for action. It also spells out the key elements of donor collaboration and identifies areas and activities for Bank intervention. The report aims to enhance Bank staff's awareness and understanding of the dynamics of the epidemic in the Sahel and to help them engage in effective dialogue with government agencies, industry, NGOs, community organizations and donors.

2. The report argues that while the level of HIV seroprevalence and the number of AIDS cases in the Sahel are still relatively low in the *general population* compared to other regions of Sub-Saharan Africa (SSA), the rapidly rising trend and pattern of spread of the epidemic do not augur well for the future. The case is made that the late arrival of HIV/AIDS in Sahelian countries provides governments with a unique opportunity to draw upon the lessons learned about the disease and experience gained in combating it and to *take action now* and implement *cost-effective AIDS prevention interventions* before the epidemic takes hold in the general population.

3. **Epidemiology of the disease.** While available data are incomplete, current estimates suggest a *rapidly increasing* trend in the spread of the disease. Short-term projections indicate a tripling of the number of HIV-infected persons from about 782,000 in 1992 to approximately 2 million in 1997. The trend is even more alarming when the projected number of AIDS cases is considered. Based on estimated HIV seroprevalence, the cumulative number of AIDS cases is expected to rise from about 22,000 in 1992 to over 300,000 by 1997, a 15-fold increase in only 5 years. In addition, while HIV-2 infections are still predominant in countries such as Senegal, The Gambia and Guinea Bissau, HIV-1 infections are the most prevalent in the rest of the Sahel and are increasing at a much faster rate in all countries (the former is known to have a longer latency period and a lower pathogenicity than the latter). Thus, morbidity and consequent mortality rates are likely to rise rapidly over the next few years. Furthermore, there is evidence of a rapidly declining median age at infection, particularly among women, and there are as many women infected as men, suggesting higher proportions of heterosexual transmission.

4. **Consequences.** Although the demographic implications of the AIDS epidemic can be far-reaching, its effect on the rate of population growth in SSA and in the Sahel in particular is unlikely to be dramatic. It is estimated that even under the worst-case scenario, the Sahelian population will continue to grow at a rate higher than 2 percent per annum. However, the high morbidity and mortality impact of AIDS on the most economically active age group would have severe socio-economic consequences, leading to the disruption and disintegration of households and the creation of new poverty groups.

5. The rising trend in morbidity and mortality would also have a negative impact on all sectors, in particular on the provision and financing of health care. It is estimated that by 1997 deaths due to AIDS would account for no less than 30% of all adult mortality annually in the Sahel. In Burkina Faso, for example, about half of all beds in some wards at the National Hospital in Ouagadougou are already occupied by HIV/AIDS patients. Current direct lifetime costs of

AIDS in Burkina Faso are estimated at about 4% of total health expenditures, and could easily exceed 20% by 1997. Indirect lifetime costs (the value of healthy life years lost from the disease) is estimated to be about 17 times higher than the direct cost. The HIV/AIDS situation in Burkina Faso is increasingly resembling the situation found in Côte d'Ivoire, and presents a likely scenario for other Sahelian countries, in particular Mali, Chad, Niger and The Gambia, where the number of AIDS cases is increasing rapidly.

Main issues

6. Two broad categories of issues are discussed in the paper:

(a) **Factors affecting the spread of the disease,** which include: (i) limited understanding of the determinants and consequences of the disease among all segments of society (policy makers, opinion leaders, service providers, and the general population); (ii) high population mobility, particularly inter-country migration to the high endemic coastal countries such as Côte d'Ivoire, Ghana, Togo and Benin; and (iii) relatively higher vulnerability of women to STD/HIV infection due mainly to socio-cultural factors (such as early marriages, low levels of education, adverse cultural and religious practices, including in particular female circumcision) and poverty;

(b) **Impediments to effective program implementation,** which include: (i) limited political commitment, the absence of a multisectoral approach to program planning and implementation, limited involvement of NGOs and community organizations, and lack of funding; and (ii) program-related issues including the lack of effective information, education and communication (IEC) programs, limited initiatives on condom promotion, and weak epidemiological surveillance, laboratory capacity, STD clinical management and program management capacities.

Responses to the epidemic

7. National programs to combat the AIDS epidemic in the Sahel were initiated in 1987 with the development of emergency action programs and the establishment of National AIDS Committees (NACs) with assistance from the WHO/Global Program on AIDS (GPA). These led to the development of the first medium-term plans (MTPs, 1988-91) which focused primarily on health sector interventions. These plans and activities brought AIDS to the national agenda, but very little was achieved, due to the constraints outlined above. All Sahelian countries are now in the process of either initiating or implementing their second MTPs (1994-98). These plans emphasize: (a) the integration of HIV prevention activities into STD interventions; (b) an intersectoral approach and decentralized management of AIDS programs, giving greater responsibility to community health; and (c) an intensification of IEC interventions, particularly peer education programs and community mobilization efforts.

8. Donors, particularly WHO and UNICEF, have actively supported these initiatives. WHO/GPA has been instrumental in developing the medium-term plans and in providing technical assistance for the implementation of national programs. Major bilateral donors active in this area include USAID, the Dutch, the Germans, the French, the Canadians and the European Union.

9. . **The World Bank involvement.** The Bank's support for HIV/AIDS initiatives in the Sahel has been, until recently, very limited. This was due, in part, to the reluctance of governments to use Bank funds to support activities to combat a problem which was not considered to be a major concern, and for which there was apparently adequate bilateral grant funding. However, during the last two years, there has been a several-fold increase in Bank funding (under the soft loan facility of the Bank, the International Development Association (IDA)), as other donor funding has decreased while funding needs have increased.

10. Over the last three years, the Bank has focused attention on the following areas:

(a) **Improving the knowledge base to enhance the Bank's dialogue with the countries concerned**. This is being achieved by helping governments conduct Rapid Risk Assessment Surveys to build a strong data base for effective program planning and implementation. Within the Bank, AIDS-related issues are being given increased priority. Information meetings have led to greater staff awareness of the need for immediate action, task managers are placing more emphasis on such issues, and effective tools for dialogue and program development are being prepared.

(b) **Targeting key government officials to heighten their understanding of HIV/AIDS** and of the urgency of concerted national action on all fronts to prevent the epidemic from becoming a serious public health problem. The Bank will contact Heads of Government to express its concern regarding the need for countries to act quickly and its willingness to assist them in their fight against the disease. In addition, in the course of Bank/Government policy dialogues a concerted effort will be made to include specific actions to be taken to address the AIDS issue.

(c) **Providing support in Bank-funded operations for under-funded priority activities** under National AIDS Programs (NAPs), and integrating free-standing AIDS components into future IDA-financed projects in health (free-standing AIDS components were added to two Population Projects in the 1994 fiscal year (FY94) and other sectors such as Education and Agriculture. Proposed and ongoing IDA-funded activities are defined in detail in Section III of the report.

11. Local and international **non-governmental organizations** (NGOs) have become increasingly involved in activities dealing with women's reproductive health issues and AIDS. These organizations provide support for AIDS prevention and control activities, including the undertaking of research on cross-country issues such as migration and the spread of AIDS, the promotion of social marketing of condoms, and IEC programs. These include Care International, SIDALERTE, Society for Women Against AIDS in Africa (SWAA), Save the Children Fund (US and UK), ENDA Tiers Monde, Family Health International under AIDSCAP, and a number of independent local organizations.

12. **Lessons learned.** The main findings over the last decade in developing and implementing AIDS interventions in Africa and elsewhere are that: (a) behavioral change is difficult and slow; (b) comprehensive programs are essential; (c) IEC programs should attempt to disseminate more positive messages; (d) understanding gender issues is important in determining the degree of behavioral responses; (e) targeting youth is cost-effective; (f) involving NGOs, communities, and the private sector is critical for the success of programs; (g) local institutional capacity building is essential; (h) regional/ provincial approaches are important in expediting the process of program

impact; and (i) technical assistance is required to ensure effective program development and implementation.

Proposed Bank strategy and interventions

13. The Bank's proposed HIV/AIDS Prevention and Control Strategy for the Sahelian countries is aimed at promoting a full-scale, broad-based attack on the problem with the objective of helping Sahelian countries avoid a generalized epidemic and a major developmental setback. This strategy will use a two-pronged approach consisting of country-level activities supported through the lending program and regional activities supported through grant funding. These two approaches are summarized below and described in detail in Section IV of this report.

14. **Country-level activities supported through lending program.** Based on the perceived trend of the epidemic in the country, program quality and availability of funding, Sahelian countries have been ranked in order of priority for action. Burkina Faso, Mali, and Niger are ranked as high priority countries for Bank support, followed by Chad, The Gambia, and Mauritania, as medium priority, and Senegal and Cape Verde as low priority. Guinea Bissau and Sao Tome & Principe are not rated due to lack of relevant information.

15. For each of these countries the nature and level of Bank support would depend on the priorities already defined in the second MTPs and the extent of resources committed by the governments as well as other donors. However, the Bank's strategy for *country assistance programs* would cover activities in these key areas: (a) strengthening and expanding ongoing HIV/AIDS communication programs, targeting in particular decision-makers, opinion leaders, service providers, women and youth; (b) accelerating the establishment of social marketing programs to promote condom use, by strengthening and expanding existing public sector distribution networks and encouraging the development of private retail outlets; (c) expanding clinical management and care of STDs/HIV, and strengthening epidemiological surveillance and laboratory capacity, with particular emphasis on the integration of STD/HIV case detection and counseling into primary health care and family planning programs, and enhancing clinical capacity to enable screening and diagnosis of STDs/HIV, particularly among women; (d) increasing assistance to community, NGO and private sector initiatives; (e) encouraging multisectoral interventions; and (f) improving collaboration and coordination with other donors.

16. **Regional program supported through grants.** The focus of the Bank's work program for FY95-97 will be on developing integrated strategies and fostering cooperation at the regional level to increase the effectiveness of HIV/AIDS interventions. The thrust of the proposed regional program will be to: (a) establish a full-scale information, education and communication (IEC) program, using a variety of communication channels, to widely disseminate information on the disease and its prevention; and (b) foster regional cooperation and explore innovative approaches to controlling the spread of the epidemic. Such extensive, high impact programs are difficult to launch and implement through country lending programs, which lack the synergistic advantages and economies of scale of a regional approach. A regional program could recruit the best program/technical specialists, often unavailable at the country level, to develop a wide-based campaign having the maximum regional impact in the shortest period of time. Specific attention would be given to the following activities:

(a) Mobilizing political and opinion leaders and organizations throughout the region to address HIV/AIDS issues at the highest level. Regional workshops, seminars, study tours and other kinds of group initiatives would be organized to exchange ideas and build a regional consensus at the highest level. Semiannual consultations would be conducted to evaluate progress and identify areas for further action;

(b) Identifying and working with national figures/local heroes (political, religious and sports personalities) with regional appeal to develop strong advocacy roles and mount aggressive education and information campaigns;

(c) Supporting pilot projects to test innovative ideas, particularly those relating to cross-border issues, such as migration (developing sub-projects around border towns and areas of affinity), condom promotion, etc.;

(d) Promoting studies and research of regional significance by universities and research centers in the region, establishing collaborative arrangements with research centers, developing research networks, and providing opportunities for research results to be incorporated into programs at the national level; and

(e) Providing technical support and training to NAPs to improve their capacity to manage multisectoral national programs and upgrading the quality of the response to the national HIV/AIDS issue.

17. Support will be provided for the development of effective mechanisms/structures to coordinate and facilitate the implementation of the regional activities. The nature and form of the mechanisms/structures were discussed during a regional technical planning workshop held in Ouagadougou, Burkina Faso from September 11-15, 1994. The workshop brought together 61 participants including NAP managers and observers from UNDP, UNICEF, AIDSCAP, CARE International, SIDALERTE, and Save the Children Fund (US and UK), as well as representatives of local NGOs. Participants identified priority problem areas at the regional level and selected specific interventions to address these priority areas. Constraints to program development and execution were identified and complementary interventions required to ensure effective implementation were discussed.

18. The total budget for this program is estimated at US$6.0 million, over a 3-year period --FY95-97--(US$2.0 million per year), of which US$1.2 million is expected to be provided through the Special Grant Program (SGP) as the World Bank's contribution. The SGP has approved funding (US$300,000) for the first year (FY95) of this program. The remaining US$1.6 million for FY95 would be funded from external sources yet to be determined. It is anticipated, however, that the complementary donor financing would be readily forthcoming since such a program is widely seen as a high priority in the Sahel.

I. INTRODUCTION AND OVERVIEW

A. INTRODUCTION

1. The Sahel[1] is perhaps the last frontier in Sub-Saharan Africa (SSA) in the spread of the AIDS epidemic. Although available data are inadequate, they suggest that the overall prevalence of the human immunodeficiency virus (HIV, the causal agent of AIDS) is still very low in the Sahel. The devastating economic and social effects of this disease, which could negate achievements in all sectors, can still be averted if countries act vigorously to prevent HIV transmission. The relatively late arrival of HIV in the Sahel presents governments with an opportunity not enjoyed in other parts of Africa, where the caseload of HIV-induced illness and AIDS was already high by the time the presence of the virus was recognized. Governments in the region are in a position to draw from the body of knowledge and experience already accumulated about the epidemic both to prepare, at the earliest opportunity, to meet its consequences, and to take urgent action to control its spread. In the absence of a vaccine against HIV and affordable, widely applicable therapies for AIDS, at present the only means of preventing HIV transmission is to encourage people to adopt self-protective measures. Even if effective vaccines and treatment regimes become available in the foreseeable future, however, prevention would still be the first and foremost priority.

2. The objective of this report is to define strategies and actions to assist Sahelian countries in taking advantage of this window of opportunity and carry the fight against the epidemic to a higher level. The report discusses the main issues and manifestations of the epidemic, identifies constraints and impediments to effective policy and program development and implementation, and proposes an agenda for action. It also spells out the key elements of donor collaboration and identifies areas for Bank intervention. The report draws on lessons learned in other regions, particularly the experience gained in those regions where the disease is now endemic. It is intended to enhance Bank staff's awareness and understanding of the dynamics of the epidemic in the Sahel and to assist them engage in effective dialogue with government agencies, industry, NGOs, and community organizations.

B. EPIDEMIOLOGY OF THE DISEASE

General

3. The epidemiology of HIV infections is becoming more and more complex as it spreads without recognizing any geographical, political, social, economic or religious boundaries. In SSA, the pandemic is characterized by its variability and unpredictability, with each population group having its own dynamics and patterns of transmission. As elsewhere, but even more predominant in SSA, heterosexual transmission is by far the most important mode of acquiring HIV, accounting for 80% to 90% of all infections. In addition, numerous studies indicate the predominant role of sexually transmitted diseases (STDs) as biological cofactors in the transmission and virulence of HIV. This association is strongest with genital ulcer diseases (GUDs) such as syphilis, chancroid, and genital herpes, the first two being highly prevalent in SSA. This relationship has been demonstrated in both directions; first GUDs foster HIV transmission (median risk estimate of approximately 10 times), and second, HIV causes more severe clinical manifestations of GUDs.

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[1] The Sahel refers to Burkina Faso, Cape Verde, Chad, The Gambia, Guinea Bissau, Mali, Mauritania, Niger, Senegal, and Sao Tome & Principe.

Other studies have shown that gonococcal and chlamydial infections increase the risk of HIV transmission by 3-5 times. This is a major concern considering the very high prevalence of these infections among pregnant women in Africa, where gonococcal infections are 10-15 times higher, chlamydial infections 2-3 times higher, and syphilis more than 10 times higher, compared with similar groups in developed countries (Wasserheit and Holmes, 1992).

4. The progression of HIV infection to clinical onset of symptoms of AIDS appears to be different between African and industrialized countries, with African HIV-infected patients progressing more quickly to AIDS than patients in industrialized nations. Although more research is still needed to understand the specific reasons for this difference, it appears that differences in clinical management of opportunistic pathologies and individual health-seeking behavior may play a role in the spread of HIV infection. For example, over the last ten years, a dramatic increase of some pathologies such as tuberculosis has been noted in Africa, exacerbating the already high morbidity and mortality levels in the region. It has also been documented that poor nutritional status has an adverse effect on the clinical manifestation of HIV-related diseases.

Nature of the data

5. Estimates of HIV-infected persons and AIDS cases in the Sahel rely almost entirely on two sources: (a) various small-scale HIV prevalence surveys conducted beginning in 1985-86; and (b) data gathered from sentinel surveillance systems among specific population groups. With the exception of Senegal, and to a lesser extent The Gambia and Burkina Faso, most countries do not have reliable data on the levels and trends of HIV infection and even less so with regard to STDs. Moreover, AIDS case reporting is known to be highly incomplete, varying from 10% to 30% of the actual level in any country. This lack of reliable data on STDs, HIV, and AIDS is principally due to the weak and inadequate health information systems existing in these countries, and the absence of adequate epidemiological surveillance systems and poor laboratory capacity (paras 41, 43). In addition, there has been considerable reluctance to report AIDS cases, particularly in the early years of the epidemic (para. 19). Although data collection and analysis have improved markedly in recent years, many biases still remain and estimates should be interpreted cautiously, particularly for more "conventional" STDs. A proven rule of thumb, however, is that in areas where HIV infection rates are still low, the prevalence rates of other STDs, as well as the incidence of tuberculosis, are good indicators of the potential spread of HIV infection.

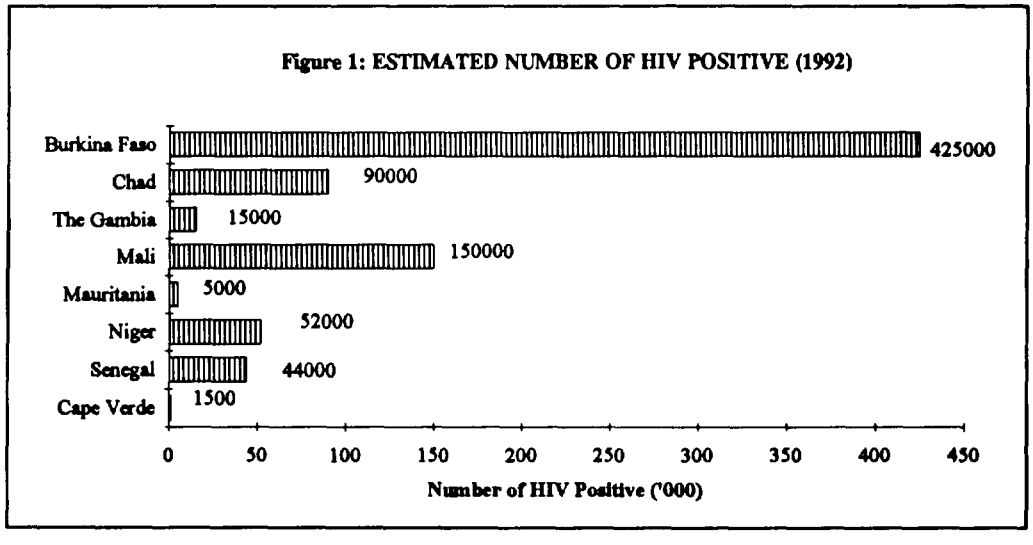
Levels, trends, and patterns

6. The Sahel can generally be characterized as having relatively *low levels* of HIV seroprevalence when compared with other sub-regions in SSA. However, current estimates based on surveys and reported cases, suggest a *rapidly increasing* spread of the disease. And while HIV-2 infections are still predominant in countries such as Senegal, The Gambia and Guinea Bissau, HIV-1 infections are the most prevalent in the rest of the Sahel and are increasing at a much faster rate in all countries (the former is known to have a longer latency period and a lower pathogenicity than the latter). Thus, morbidity and consequent mortality rates are likely to rise rapidly over the next few years. Furthermore, although the *age pattern* of the spread of the disease suggests higher levels of infection among populations over 30 years of age,[2] there

[2] Evidence from a 1991 study of prostitutes in Ouagadougou indicated that by age, HIV-1 levels ranged from 1% to 4.3%, with those over 50 years of age most infected. HIV-2 levels range from 9.8% to 41.6% with a maximum at ages 40-49.

is evidence of a rapidly declining median age at infection, particularly among women. There is no conclusive evidence regarding the gender differentials in the rate of infection in the Sahel, however, estimates from elsewhere in SSA suggest a narrowing gender gap (almost a 1:1 ratio).

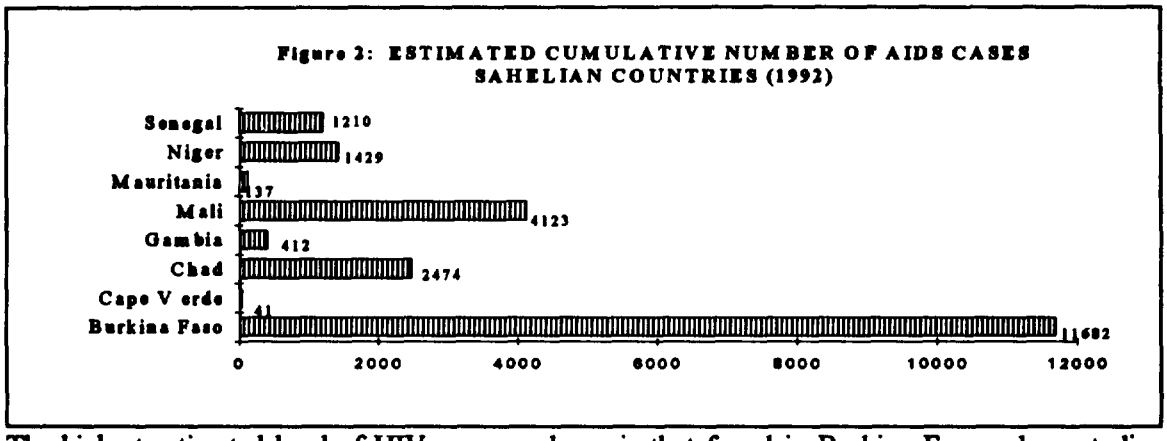
7. **Levels.** For the whole of the Sahel, as of December 1992, there were about three quarters of a million individuals (782,500) estimated to be already infected with HIV. Burkina Faso is estimated to have over 50% (425,000) of those infected, followed by Mali and Chad respectively (Figure 1).[3] The cumulative number of *declared AIDS cases* for the region as of December 1992, was only 6,047.[4] This figure, however, grossly underestimates the actual number of AIDS cases by a factor of about 3-5. Estimates based on the level of HIV seroprevalence suggest that there were about 4 times more AIDS cases (21,508) than were actually declared, of which 50% (11,682) was accounted for by Burkina Faso. Mali, Chad, Niger, and Senegal, all had over 1,000 cases of AIDS during this period (Figure 2).



8. Compared with other sub-regions in SSA, however, levels of HIV seroprevalence are much lower in the Sahel. Current estimates of HIV seroprevalence for the general urban population in the Sahel are less than 5%, compared to over 10% in coastal West Africa, and between 15% and 20% in certain central and eastern African cities. Estimates of HIV infection among pregnant women attending maternal and child health (MCH) clinics (considered representative of the general population) are much lower, currently in the neighborhood of 1% to 3%, although in some "pockets" in a few countries (e.g., Sikasso in Mali, Gaoua in Burkina Faso and Moundou in Chad) prevalence rates have already exceeded 5%. Much higher levels of HIV seroprevalence (over 20%) have been estimated among selected groups engaged in high-risk sexual behavior (such as commercial sex workers and STD patients); these levels are comparable to those in other parts of SSA (Table 1).

[3] Estimates are derived from surveys and sentinel data undertaken during the early 1990s.

[4] These are cases reported to WHO and they exclude Guinea Bissau and Sao Tome and Principe.



The highest estimated level of HIV seroprevalence is that found in Burkina Faso, where studies among commercial sex workers in Ouagadougou in 1989 and Bobo-Dioulasso in 1991 showed HIV-2 levels of 41.6% and 45%, respectively. In addition, the level of other STDs is very high, about 20% (WHO, 1991). Annex 1 describes, in detail, the epidemiological situation in eight of the BANK countries.

Table 1: HIV SEROPREVALENCE AMONG COMMERCIAL SEX WORKERS IN SELECTED AFRICAN COUNTRIES, 1992

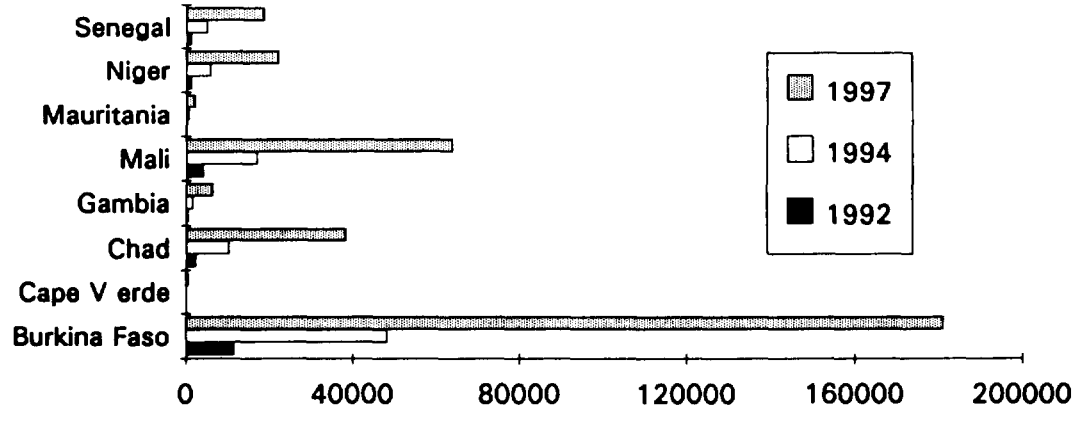
LEVEL	COUNTRY	
HIGH (Above 20%)	BURKINA FASO	CAR
	CONGO	COTE d'IVOIRE
	ETHIOPIA	THE GAMBIA
	GUINEA BISSAU	MALAWI
	MALI	RWANDA
	SENEGAL	TANZANIA
	UGANDA	ZIMBABWE
	ZAMBIA	
MEDIUM (5%-20%)	BENIN	NIGER
	CAMEROON	SUDAN (SOUTH)
	GHANA	
	NIGERIA	
	TANZANIA (EXCEPT WEST)	
LOW (Below 5%)	DJIBOUTI	
	LIBERIA	
	MADAGASCAR	
	SOMALIA	
UNKNOWN	ANGOLA	BOTSWANA
	BURUNDI	CAPE VERDE
	CHAD	COMOROS
	EQUATORIAL GUINEA	GABON
	GUINEA	LESOTHO
	MAURITANIA	MAURITIUS
	MOZAMBIQUE	NAMIBIA
	SAO TOME & PRINCIPE	SEYCHELLES
	SIERRA LEONE	SUDAN
	SWAZILAND	TOGO

Source: US Bureau of the Census.(1992).

9. **Trends.** Since the first few hundred cases of AIDS were reported in the Sahel in the mid-1980s, the level of HIV infection and number of AIDS cases have been increasing and spreading rapidly among all groups. Short-term projections (1992-97)[5] so far attempted for the Sahel indicate that by 1997 there will be almost 2 million individuals infected with HIV, almost tripling the estimated number of infections in 1992 (782,500). HIV seroprevalence among the general population, while still modest when compared to other subregions (para. 8), is expected to increase from about 2% to 4% during this period. Among the countries, the most striking case is Burkina Faso, where the estimated level of HIV seroprevalence is projected to increase from its current level of 7% to 10% by 1997, with over 1 million individuals infected with the virus (Annex 2).

10. The trend is even more alarming when the current estimates and projected number of AIDS cases are considered. Given the five- to seven-year lag between infection and manifestation of AIDS, there is tremendous momentum for the rapid increase in the number of AIDS cases in the Sahel over the next five years. Based on HIV seroprevalence data, in 1994 there are about 89,000 AIDS cases in the Sahel; a four-fold increase from 1992. This figure is expected to rise to over 300,000 by 1997 (Figure 3). Thus, in only five years (1992-97) the total cumulative number of AIDS cases is expected to increase more than 15-fold. The likely consequences of this rapidly increasing trend in HIV/AIDS are discussed in the next section.

Figure 3: PROJECTED CUMULATIVE NUMBER OF AIDS CASES IN THE SAHEL (1992-97)



11. **Patterns.** The pattern of the spread of HIV infection in the Sahel mirrors that in the rest of Africa, where predominately older cohorts of men and younger cohorts of women are infected, reflecting the early marital age for girls. While the evidence is not conclusive regarding gender differentials in the rate and level of infection,[6] the importance of male seasonal out-migration to the highly endemic coastal countries of Côte d'Ivoire, Ghana, Togo, and Benin suggests relatively higher levels of infection among men than women. There is, however, evidence of a rapidly

[5] The projections are based on the WHO/GPA Epi Model.

[6] Most surveys and studies have focused on women as the unit of analysis, and thus only limited estimates of seroprevalence among men are available, except for particular high risk groups, such as STD patients and to a lesser extent those in certain occupational groups, such as the military and truck drivers.

increasing rate of infection, particularly among younger women. There is also growing evidence of an increasing rate of mother-to-child transmission, particularly of HIV-1, with an estimated transmission rate of 35% to 40%. This rate is about twice that estimated for developed countries for the same strain of virus. Four hypotheses have been postulated to explain this marked variation: (a) more virulent strains in Africa; (b) increased viral load; (c) high prevalence of other STDs; and (d) breastfeeding (although it is still, and will remain, one of the major public health measures to encourage even in HIV hyper-endemic areas).

C. CONSEQUENCES

12. The rapidly increasing trend in HIV infection and the number of AIDS cases do not augur well for the future in the Sahel. The limited analytical work undertaken so far in selected countries (Burkina Faso in particular) demonstrates that the socio-economic consequences of the epidemic would be devastating, exacerbating the already fragile economies in the sub-region.[7]

13. **Direct demographic effects**. Population projections incorporating the effects of AIDS prepared for selected Sub-Saharan African countries indicate that even in the worst case scenario, the long-term direct demographic effect of AIDS would be a reduction of about 1% or less per annum in the rate of population growth (Bulatao and Bos, 1992). In the Sahel, given the high rate of population growth (about 3% per annum), even without the slowing of HIV infections, the population will continue to grow rapidly - over 2 % annually - and will more than double in size during the next 25 years.

14. **Mortality and morbidity effects**. The most obvious and direct impact of the epidemic is on the health status of the population. Given the recent nature of the epidemic in the Sahel, the mortality effects of the epidemic are still very modest. About 10,000 deaths were attributable to AIDS in 1992, accounting for less than 2% of the total crude death rate. This figure is expected to more than triple this year to about 34,000 and would increase to 92,000 by 1997, by which time almost 10% of total deaths in the sub-region each year would be attributable to AIDS. When adult mortality is examined, it becomes even more evident that the mortality implications of the AIDS epidemic during the next 3 years would be far more devastating than that of any single illness, in particular due to the resurgence of pulmonary infections such as tuberculosis. By 1997, deaths due to AIDS would account annually for no less than 30% of all adult mortality in the Sahel.

15. **The burden of the disease.** The rapidly rising trend in long-term morbidity and mortality would have a serious negative impact on the provision and financing of health care, "crowding out" other health services. A recent rapid assessment of the economic impact of HIV conducted in Burkina Faso estimated that nearly half of the beds in some wards at the National Hospital in Ouagadougou are now occupied by HIV/AIDS patients. The situation in Burkina Faso is reaching alarming proportions, very much reflecting the situation in Côte d'Ivoire. Based on the estimated total lifetime average cost of AIDS care per patient of US$416[8] (derived from the Burkina Faso

[7] The analysis below is based on short-term projections made using the Epi Model and recent work on rapid economic impact analysis done in Burkina Faso conducted by Ms. Logan Brenzel (January, 1994, see Biblio.).

[8] This figure compares favorably with those derived from other studies in Eastern Africa, where more in-depth analytical work has been conducted.

study), the estimated total direct cost of HIV/AIDS was US$446,000 in 1992.[9] While this amount may appear modest, it already represents approximately 4.1% of the total expenditures (recurrent and investment) of the Ministry of Health in 1992. But this is a very conservative cost estimate as it is based on the total number of *reported* AIDS cases in 1992, which clearly understates the actual number of AIDS cases by a factor of about five. Thus, the direct lifetime cost of AIDS in Burkina Faso could already exceed 20% of the total health budget. This percentage is likely to increase rapidly during the next few years as the number of AIDS cases rises (Figure 3). In addition, estimates of the indirect cost of AIDS (the value of healthy life years lost from the disease) derived from the study (by calculating the discounted healthy years of life lost) is about US$8 million in 1993, based on 1,073 reported AIDS cases. A more plausible estimate of the indirect cost based on the estimated number of new AIDS cases would be about US$60 million.

16. These figures are substantial and predict the likely scenario in other Sahelian countries, particularly, Mali, Chad, Niger, and The Gambia, where the number of AIDS cases is rapidly increasing. However, this analysis represents only one aspect of the global burden of the disease, namely the impact on the health sector. The epidemic would have severe negative effects on household welfare and productivity, increase costs to firms, and affect major economic sectors, including education and agriculture. One major social consequence of the growing number of AIDS deaths is the rapid increase in the number of orphans. Estimates from the short-term projections cited above, indicate that by the end of 1994, for the Sahel as a whole, there would be almost 70,000 cumulative AIDS deaths. This figure would more than triple to over a quarter of a million (282,000) by 1997, resulting in over 1.7 million orphans.[10] In addition, with a relatively higher percentage of mother-to-child transmission observed in Africa, the number of pediatric AIDS cases would increase significantly over the next three years, creating even greater pressure on already limited public health resources. At the household level there would be tremendous disruption of families as household resources are diverted to care for the growing pediatric AIDS cases, prolonged morbidity among the adult members, and the growing number of AIDS orphans.

17. Without effective intervention to mitigate the spread of HIV/AIDS, the epidemic, as currently observed in many Eastern African communities, would create new poverty groups, exacerbate the already difficult economic situation and pose a considerable challenge in coping with the situation. Moreover, it would alter the distribution of income, thwart efforts to develop sectors that rely on skilled or scarce manpower, and will likely reduce the growth rate of per capita income below levels that would have been feasible without AIDS. For the Sahel, further analytical work is urgently required to identify and measure quantitatively the distribution of the economic burden of the disease, particularly the potential impact on individuals, households, firms and sectors, in order to identify policies to mitigate the impact and implement cost-effective prevention programs in sectors most sensitive to HIV infection.

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[9] The cost is estimated by multiplying the 1,073 reported AIDS cases in 1992 by the average lifetime cost of AIDS care per patient of US$416.

[10] Estimates of orphans are derived indirectly by multiplying the total cumulative deaths due to AIDS by the average number of children a Sahelian woman at age 35 would have had (5 children), 35 years being the average age at death of AIDS patients.

II. MAIN ISSUES

A. FACTORS AFFECTING THE SPREAD OF THE DISEASE

18. **Limited understanding of the determinants and consequences of the disease.** One of the most important problems confronting the National AIDS Programs (NAPs) in the Sahel is the continuing *denial* and, at best, *latent acceptance* of the existence and the potential gravity of the AIDS epidemic. This denial is pervasive at all levels of society. Among *key policy and decision makers* it has resulted in a reluctance to respond quickly and effectively to combat the disease. The almost casual reference to and dismissal of AIDS as a foreign problem, contracted only by selected groups such as commercial sex workers, underscores the levity with which the disease is treated in official circles. Few policy makers comprehend the socio-economic determinants of the disease. Fewer still appreciate the macro- and micro-level impact of the AIDS epidemic and the need for an expeditious and effective response to prevent a looming disaster.

19. The lack of awareness at the official level is compounded by the fact that the *general population* lacks an understanding of the nature of the disease and its modes of transmission.[11] Among individuals and communities, the initial reaction of denial during the first stages of the disease has changed to a sense of fear and victimization as the fatality of the disease becomes known. While risk factors for HIV/AIDS depend on country-specific behavior patterns, the main risk factors are directly related to patterns and modes of sexual behavior. These include unprotected sexual intercourse, multiple sex partners, prior history of STDs, and infrequent use of contraceptives, particularly condoms. Limiting the spread of the epidemic, therefore, requires changes in sexual behavior. However, several obstacles exist, requiring concerted efforts at both the policy and program levels. Cultural and religious norms prevent an open discussion of HIV/AIDS and other issues such as sexuality, making efforts to increase awareness of high-risk behavior among the general population difficult. Misconceptions regarding the transmission of HIV persist and rumors and myths abound about traditional cures for AIDS, creating false hope and security among individuals and thwarting any efforts aimed at fostering behavioral changes that would enable the prevention of the transmission of HIV.

20. Low levels of knowledge are not observed exclusively among the 'general public'. Misinformation and myths about the disease are also prevalent among *health and social workers*. The main threat this poses is not to the workers' own health, but to client-provider interaction.[12] A survey of health personnel and social workers in Burkina Faso found that 60% had never attended a meeting in which AIDS was discussed, only 10% had received any formal training on AIDS, and 30% did not know the etiology of AIDS and its clinical characteristics. Adequate knowledge of HIV, STDs, AIDS and the contexts in which sexual activities occur are needed when interacting with STD patients, individuals who are HIV positive or have AIDS, and the families of those with the disease. Clinic-based service providers lack the interpersonal skills necessary to interact with

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[11] In the Sahel most people have heard of AIDS either through friends or the mass media. In the 1993 Burkina Faso Demographic and Health Survey, 84% of women and 94% of men had heard of AIDS, though strong regional differences were noted. Among secondary school students a high level of knowledge was noted but precise questions were less familiar, only 33% knew what seroprevalence meant and 22% felt the information on AIDS was exaggerated (see Sicard et al., Biblio.). Among commercial sex workers in Mali 85% had heard of AIDS, but only 17% could name its symptoms.

[12] The occupational risks to health workers are low; the risk of health workers contracting HIV relates more to their sexual behavior patterns.

and counsel their clients. Frequently, service providers lack an understanding of their clients' cultural and social beliefs and their expectations of the provider-client interaction.[13]

21. The lack of awareness concerning AIDS can also be found in *formal sector employment*, where oftentimes employees who are known to have or believed to have HIV/AIDS face the risk of stigmatization or loss of employment. This is further complicated by the fact that regulations ensuring confidentiality do not exist and employees do not have legal recourse if they lose their jobs. Misconceptions and fears about the transmission modes of HIV make efforts to protect infected individuals against such problems difficult. Employers have not been capable or willing to implement cohesive policies and regulations concerning AIDS in the workplace. This is partly due to their limited understanding of the potential negative impact on profitability and productivity resulting from a loss of functional and productive employees from the workforce. It is therefore in the best interests of industry to protect all of its productive employees and promote the creation of working environments that foster the integration of functional individuals within a society that cares for members infected by HIV.

22. All of these factors create an environment in which few believe that the situation could reach an alarming level, worsening the already existing crisis in the countries. Consequently, there is clearly a lack of sense of urgency and, to date, no country has launched a vigorous program to combat the epidemic. Behavioral changes that would enable individuals to prevent the transmission of the virus have not been fostered. This situation is extremely worrisome and calls for massive campaigns to sensitize key officials, the general population, and health personnel to the need for immediate and vigorous action to limit the further spread of the epidemic and to minimize its impact.

23. **High population mobility.** Seasonal in-country and inter-country migration have been identified as potential factors in the spread of HIV/AIDS in the Sahel. This phenomenon is perhaps more critical in the Sahel than in any other SSA subregion. The migration factor is complex and multidimensional, incorporating economic, social, and behavioral dimensions. Economic activity within the region brings about the frequent and continual mobility not only of resources, but people as well, who bring their cultural habits and sexual norms and networks across borders. The movement of workers *within* countries from predominantly rural areas to economically active areas, such as mining and border towns, and the proliferation of commercial sex activity in these mobile communities, have dramatically increased the risk of the spread of HIV/AIDS. In addition, the potential spread of AIDS through inter-country mobility of workers and prostitutes has also increased, as the primary destination of most Sahelian migrants is one of the highly endemic coastal countries such as Côte d'Ivoire, Benin and Togo. In Niger, for example, 80% of AIDS cases are linked to migrants from Côte d'Ivoire. In The Gambia, the incidence of STDs and AIDS is higher in small towns along the Trans-Gambia highway than in rural areas, and in Burkina Faso, the incidence of STDs reflects the seasonal patterns of migratory movements, with peaks observed during the harvest time when young men return. The risk of the spread of HIV/AIDS in home countries is also increased as migrants in the Sahel tend to return to rural

[13] In Burkina Faso, an ethnographic study of health service utilization revealed that the low levels of clinic attendance were related to the widespread use of traditional medicine. The reasons for this high utilization of traditional medicine were: (i) traditional medicines were believed to be more efficacious for certain diseases; (ii) there was easy access to reputable traditional healers; (iii) traditional remedies were available at lower costs, and there was a "sense of ease" when dealing with traditional healers; and (iv) clinic staff were perceived as "authoritarian, patronizing, and/or arrogant" and the overall quality of health care was rated as unsatisfactory.

areas, where health and other infrastructure (including communication services) are worse than those in urban areas.

24. The low levels of education, differing language skills, and status of migrants limit their access to information and services that may reduce their risk of contracting the HIV virus. A study in Abidjan revealed that 17% of all immigrants and 38% of female immigrants did not understand French and were not receiving information on AIDS prevention (Yelibi, Valenti, Volpe, et al., 1992). Among Malian and Nigerien migrants to Côte d'Ivoire, it was observed that all had heard of AIDS, often via the radio, but that knowledge of its modes of transmission was limited and condom use infrequent.

25. **Relatively higher vulnerability of women to STD/HIV infections**. Evidence from various studies indicates that overall, more women than men are being infected with HIV at significantly younger ages (5-10 years younger than men).[14] Among females, those in their teens and early 20s are being infected more than those in any other age group. Biological, socio-cultural, and economic factors contribute to make women more vulnerable than men to HIV infection. Biologically, the transmission of HIV is more likely from an infected man to a woman than from an infected woman to a man. Sexually transmitted infections disproportionately affect the health of women. In the initial stages of STDs, less than 50% are symptomatic in women and therefore not immediately obvious or visible; as a consequence women are less likely to seek treatment when they contract STDs. Women are also less able to prevent exposure to STDs/HIV than men as they lack preventive methods which they control. Further, their subordinate decision-making role in sexual relationships limits their ability to negotiate, particularly as it relates to a partner's fidelity and condom use. Constantly traumatized genitals from infections, inadequate treatment, and poor hygiene are contributing factors which increase women's risk of contracting HIV/AIDS.

26. Among the socio-cultural factors, marriage at an early age and early initiation to sex increase young girls' risk of exposure to HIV. Due to the immature genitalia of younger women, non-STD related lesions and genital ulcers are common owing to the traumatic sexual experience and girls are thus exposed to a higher risk of HIV infection.[15] In addition to initiating sexual activity at an early age, the practice of polygamy, visiting relations, and high levels of partner exchange increase the transmission of STDs. In Niger, 30% of unmarried women were in sexual unions with two or more men and 36% of all women were in polygamous marriages. A condom acceptability study which followed 136 men in Mali over a period of one month, noted that each man had, on average, 9.4 sexual partners.

27. Moreover, other harmful cultural practices such as female infibulation and circumcision, which cause scarring and infections, as well as non-infectious genital inflammation caused by high fertility, contribute to increased risk of HIV infection among women. Female circumcision is still widely practiced in Chad, Mali, Niger, Senegal and The Gambia. Culturally, circumcision is associated with notions of female hygiene, modesty and social status and is seen by some women as a means of reducing promiscuity. The conditions under which circumcisions are performed increase the likelihood of female morbidity and mortality. They are generally performed by

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[14] See UNDP - Young Women: Silence, Susceptibility and the HIV Epidemic.

[15] In Niger 50% of women of reproductive age reported that their first sexual intercourse was at age 15 (Niger DHS 1993), and among students in Burkina Faso it was 15.6 years for males and 17.0 years for females (See Sicard et al. 1992).

traditional birth attendants, female elders, and in some cases by spouses, with the majority of these procedures being done at home. The sequelae of circumcisions include a higher frequency of major postpartum hemorrhage and urinary tract infections causing pain at micturition, dribbling urine incontinence and poor urinary flow.

28. Cultural and religious norms ensure that women's subordination is maintained in society and this is manifested by their subordinate role in decision-making, particularly as it relates to their sexuality and reproductive health. Further, cultural and societal norms discourage open discussions about sexuality, STDs, AIDS, and reproductive health issues. Women have little control over the behavior of their partners and little choice as to the circumstances under which they have sexual intercourse, thus placing them and their partners at risk. Low literacy rates and educational levels contribute to the fact that women in general do not have an adequate understanding of reproductive health issues and have limited access to information concerning STDs and AIDS. Further, women's reproductive responsibilities and their key role in maintaining household health, as well as their productive responsibilities, place severe constraints on their time and resources. As a consequence, women do not have the time, money, or means to seek medical treatment as often as they should.

29. Economic necessity and a lack of alternatives for financial independence force women to be highly dependent on spouses or male partners. This financial dependence places women in a weak position, restricting their decision-making role (particularly as it relates to their partner's sexual behavior) and limits their ability to request fidelity and/or use of condoms. For those women who do not have spouses or partners and who lack the skills to seek gainful employment elsewhere, prostitution often becomes an economic necessity. The sexual practices of commercial sex workers, such as frequent, unprotected sex with multiple partners, greatly increase their risk of HIV infection.

B. IMPEDIMENTS TO EFFECTIVE PROGRAM IMPLEMENTATION

Policy and institutional constraints

30. **Absence of a multisectoral approach.** The dynamic and complex nature of the AIDS epidemic underscores the importance of *multi-sector/multi-level approaches* for addressing the AIDS problem. However, this approach has yet to be effectively developed in the Sahel. National AIDS Programs (NAPs) have been managed almost exclusively by the Ministries of Health, with little or no inputs from the other sectoral ministries such as education, agriculture, and commerce. In addition, the central planning ministries are, for the most part, not involved in making decisions relating to funding and coordination. Thus, NAPs are very weak and lack the capacity and authority to enact broad-based social policies and to coordinate activities outside the health domain. Although the second generation Medium-Term Plans (MTPs), propose an intersectoral program approach, no clear strategies spell out how this will be implemented. This pattern cannot continue if AIDS programs are to achieve meaningful impact.

31. During an interagency meeting held at the Bank to discuss AIDS prevention and control in the Sahel,[16] the difficulty of developing comprehensive, multisectoral STD/AIDS strategies was

[16] The meeting, which was held on September 16, 1993, brought together about 20 individuals representing key multilateral and bilateral agencies and representatives of a few NGOs supporting AIDS initiatives in the Sahel and elsewhere. (See summary of meeting dated October 5, 1993).

recognized. The need to increase awareness, at the senior government level, that the AIDS issue is not specific to the domain of health and to make it relevant to other non-health sectors by clearly explaining the non-health impact of AIDS, i.e. relating it to Agriculture, Industry, Education, etc. was stressed. In Uganda, for example, an NGO presented this message to senior-level government officials, including the President, explaining the multidimensional impact of the AIDS epidemic and thus enabling the Government to see AIDS as a multisectoral issue. A practical solution suggested was to adopt a "bottom up" approach, first identifying specific local initiatives (ongoing or proposed) and later developing institutional and sectoral linkages.

32. **Limited NGO and community involvement.** At present, the involvement of community-based organizations (CBOs) and NGOs in the design and implementation of HIV/AIDS interventions is limited. Very little has been done to harness the capacities of industry, NGOs, communities, and individuals in the prevention and control of the AIDS epidemic. CBOs and NGOs, in certain instances, interact with a segment of the general population that governments neither have the capacity nor the willingness to reach and therefore may serve as liaisons between governments and communities. In addition, their smaller size, moderate resource needs, and different orientation provide these organizations with a flexibility that the public sector may not have and which is essential for implementing HIV/AIDS interventions.

33. Experience in eastern and southern Africa has shown that the most effective responses to the epidemic are those involving industry, NGOs, community groups and individuals who have been affected directly or indirectly by the disease. The challenge is to find the "right" type of institutional structure, i.e. community groups including NGOs and industry leaders, in an effort to build a network of front-line initiatives and to avoid creating new structures.

34. **Inadequate funding**. Funding has become a question of growing concern for AIDS programs in the Sahel. While the MTPs produced at the inception of the national programs were apparently fully funded by way of pledges, actual funds made available fell far short of required resources. Domestic resource mobilization has also been limited as governments have been constrained due to the multitude of demands/priorities placed on public resources. In addition, the expectation that donors would come through with their commitments delayed efforts to seek other sources of funds, including funding from IDA. For example, in Burkina Faso, The Gambia and Niger, only 20% of the funds required to implement FY91 and FY92 activities were made available. Private sector involvement, while increasing, has also been limited. Thus, while good progress has been achieved in many program areas, the lack of adequate resources has been a major constraint in the effort to accelerate implementation of AIDS prevention and control programs in most of these countries.

Program-related issues

35. The failure to adopt safe behavior may be indicative not only of a lack of knowledge, but of the poor quality of and limited access to services that restrict the individual's ability to realize behavioral intentions. For example, the lack of condoms or inappropriate clinic hours may explain the dichotomy between low levels of condom use and high levels of awareness of their importance in preventing the transmission of STDs and AIDS. The matrix below (Table 2) provides a qualitative assessment of the NAPs in eight Bank countries. A maximum *country score* of 20

points is given for an effective program, with each program component rated on a scale of 1 to 4.[17] Five of the countries scored below average (10 points). Chad has the weakest program with a score of 5 points, followed by Mauritania and Niger with 7 points each. For the sub-region as a whole, the weakest program component is IEC, followed by clinical management and laboratory capacity. An important program element which is partially subsumed under the IEC component in the matrix is condom promotion, which is very weak in all countries except Burkina Faso. The issues relating to these program elements are discussed below.

TABLE 2: QUALITATIVE ASSESSMENTS OF NATIONAL AIDS PROGRAMS

Program Components / Country	EPI. SURV.	IEC	CLIN. STD MNGT	LAB. SUP./ BLOOD SAFETY	PROG. MGMT	TOTAL
BURKINA FASO	1	2	1	1	2	7/20
CAPE VERDE	3	2	3	3	3	14/20
CHAD	2	1	1	1	1	5/20
GAMBIA	2	2	3	3	2	12/20
MALI	2	2	1	1	2	8/20
MAURITANIA	1	1	2	1	2	7/20
NIGER	2	1	1	1	2	7/20
SENEGAL	3	2	2	3	3	13/20
TOTAL	16/32	13/32	14/32	14/32	17/32	

Scale: 4: Good- adequate program input (human, financial, and logistical support). Well-conceived to achieve defined objectives;
3: Fair- some limitations in program input, but functioning adequate to achieve defined objectives;
2: Weak- major limitations;
1: Very weak- program practically non-existent.

36. **Weak Information, Education and Communication (IEC) programs.** The IEC elements of the NAPs have been, to date, very limited in scope and intensity, and extremely timid in the nature of the messages conveyed. This has been due in part to the continuing problem of denial of the existence of the epidemic, the absence of strong political commitment, and the limited understanding of the determinants and consequences of the disease (para. 18). In addition, there has been considerable reluctance on the part of governments to admit that they do not have the required capacity to develop effective IEC programs, which has led to limited use of well-qualified, non-government expertise. As a consequence, the first MTPs had very limited support for IEC activities, and most of the efforts were characterized by their:

(a) emphasis on medical issues, particularly on cognitive information to raise knowledge levels, while failing to adequately examine the social and cultural contexts in which sexual behaviors occur;
(b) *ad hoc* nature and limited duration;
(c) materials, which were targeted at specific populations and not at specific behaviors;
(d) messages, which were essentially negative and were designed to generate fear;
(e) focus on increasing demand for services without attention to the adequacy and quality of supply, namely the limited technical/managerial skill mix needed to develop AIDS prevention activities; and
(f) inadequate behavioral impact evaluations.

[17] The above ratings are based on an evaluation undertaken by AF5PH of program quality and impact of the strengths and weaknesses of the National AIDS Program in eight Sahelian countries.

37. There has been a *heavy reliance on a narrow range of communication mediums and strategies.* A recent review of IEC in a number of Sahelian countries[18] noted the near-exclusive use of group talks as a communication strategy. These talks tended to be didactic and targeted at a small audience. While print materials were visible, they were more frequently found in administrative centers and not in the field. Materials, in particular pamphlets, were used more as decorations rather than as tools for facilitating dialogue with clients. The use of electronic media was almost entirely limited to a few intermittent emissions of messages focusing on the health consequences of the disease. Messages were poorly designed and were primarily targeted at groups considered to be engaged in high-risk behavior (commercial sex workers, single women, truck drivers, STD patients, etc.). Program managers tended to regard these groups as pools of infection rather than as human beings with their own needs and rights. The emphasis has been on containing the spread of HIV infection into the community rather than on providing support services and information for the individuals concerned. This approach has tended to reinforce the impression that AIDS is a condition remote from the daily lives of the majority of the population.

38. Surprisingly, in a sub-region with low literacy levels, indigenous oral communication mediums such as music and drama have not been enthusiastically embraced. Little attention has been paid to *interpersonal communication* as a way of improving communication between clients and providers. The token attempts at *community participation* have been non-participatory and have reflected a limited knowledge of community structure and dynamics. Harnessing the potential of existing NGOs (paras 32-33) to mobilize community action, use of religious networks and peer education is only beginning to occur and should be encouraged.

39. Another weak element of the IEC program is the limited attention to female reproductive health issues (paras 25-29) and their *linkage to family planning*. The limited understanding of the determinants of the disease and its implication for family welfare and economic well-being has led to strong resistance, even among service providers, to addressing these multidimensional elements of the program, and has, in turn, reinforced stereotypes and misinformation. The role of IEC programs in fostering the natural linkages between activities to prevent and control HIV/AIDS and all other sectoral interventions cannot be overemphasized.

40. **Limited condom promotion initiatives.** Availability of and access to condoms is very limited in most Sahelian countries. The distribution and sale of condoms are carried out mainly in public health facilities and a few pharmaceutical depots, covering less than 40% of the population in most countries. Because of their "formal" nature, these distribution networks do not offer access to the majority of the population, particularly the youth, men, and single women. The sale and advertising of condoms through informal networks of retailers (*social marketing*) has proven effective in educating the general population about STD/HIV infections and in promoting condom use. In the Sahel, Burkina Faso is the only country with a well-established social marketing program for the sale of condoms, and has, to date, achieved higher levels of condom sales than the combined distribution and sales of the other countries in the sub-region. In Senegal, Mali, and Niger, while efforts to initiate social marketing of condoms have been under discussion for many years, only limited progress has been made so far, due in part to objections from certain segments

[18] A review of the use of educational materials by health agents was undertaken in Mali, Senegal, Niger, and Mauritania by Management Sciences for Health in 1990.

of the society and reticence on the part of decision makers to permit mass media advertising of condom use for AIDS prevention.

41. **Weak Epidemiological Surveillance Systems (ESS).** Despite its demonstrated importance, in general, epidemiological surveillance is very poorly developed in SSA, and in Sahelian countries in particular. In these countries, ESS is characterized by: (a) a lack of reliable data on levels, trends, and patterns of STDs/HIV to monitor and forecast the epidemic; (b) the limited use of existing data for decision making; (c) an inadequate number of personnel trained in data collection, analysis and dissemination of needed information for prevention and control activities; and (d) a lack of regional cooperation between countries to address common problems. The central role of data and information for effective planning and implementation of NAPs underscores the need to quickly address these impediments and constraints. Efforts will have to be geared towards building a strong human resource base to strengthen the existing systems.

42. **Weak clinical management.** Clinical management has to be considered at two levels; *first*, the provision of appropriate diagnosis, treatment, and counseling for STDs; and *second*, the provision of effective medical treatment and counseling to HIV-infected people with or without AIDS. Unfortunately, in the Sahel, not only are STDs believed to be very prevalent, as in other SSA countries, but there is also a very limited capacity for STD clinical management demonstrated by: (a) the non-existence of STD clinics in most Sahelian countries; (b) the lack of medical supplies and antibiotics for diagnosis and treatment; and (c) the lack of adequately trained health personnel for STD management. Actions needed to address these limitations must focus primarily on the provision of adequate training for health personnel in STD management, adequate supply of STD drugs and medical supplies, minimal laboratory capacities at the central and regional levels, and support for better diagnosis and treatment. Providing adequate medical treatment and counseling to STD/HIV-infected people helps to alleviate physical and psychological suffering from diseases associated with HIV infection, and prevent transmission to non-infected people.

43. **Limited laboratory capacity.** Limited laboratory capacity has two major implications, namely the effects on: (a) the safety of blood transfusion; and (b) clinical management of STDs. Although the transmission of HIV and other blood-borne diseases such as hepatitis B by way of blood transfusion is currently practically fully prevented in industrialized countries, in SSA and in the Sahel in particular, transfusion is still responsible for significant numbers of these infections (at least 10% of cases of HIV infection are still transmitted through blood). This sad reality is indicative of the weakness of the laboratory systems in the sub-region. The situation in the Sahel is characterized by a *severe lack of human resources, laboratory equipment, materials and supplies.* Even where minimal equipment is available, frequent ruptures in stocks of test kits, reagents, etc. make them as inoperative as those without equipment. All these factors have a severe negative impact on the capacities of the laboratories to support curative and preventive activities. The lack of adequate laboratory support is hampering effective clinical management of infectious and communicable diseases in the Sahel, particularly opportunistic infections and traditional STDs. Lack of appropriate facilities for precise and accurate diagnosis leading to improper management of STDs has resulted, in many areas, in a resistance to antibiotics and an increasing practice of auto-medication. This phenomenon has become a major public health problem in the region, with increasing evidence of more severe morbidity and complications from STDs, thus facilitating the spread of STD/HIV infections.

44. **Weak managerial capacity.** The management of NAPs in the Sahel is characterized by inadequate and poorly trained personnel, and in most countries by an institutional dichotomy in the

management of STD and HIV/AIDS, usually represented by a coordinator for each program. In addition, the location of the NAPs in the Ministries of Health exposes them to all the weaknesses of the public health systems in these countries. National AIDS coordinators are often clinicians with limited or no public health and management experience and thus lack the capacity to facilitate broad-based intersectoral programs. The tendency has been to create highly centralized management structures with limited integration of AIDS activities into existing health delivery systems, thus narrowing the scope of interventions even in the health sector. To improve capacity for program implementation, NAPs must be managed as multi-sectoral programs (para. 30) by adequately trained program managers at all levels (central, regional, and local) and in the various sectors (health, education, agriculture, and industry).

III. CURRENT RESPONSES TO THE EPIDEMIC

A. ONGOING GOVERNMENT INTERVENTIONS

45. The first cases of AIDS in the Sahel were reported as early as 1985-86. However, it was not until late 1987 that national programs to combat the disease were officially initiated. National AIDS Committees (NACs) were established to help prepare emergency action programs. These programs led to the development of the first three-year MTPs (1988-91) which focused primarily on health sector interventions: training of health personnel, enhancing diagnostic techniques, disseminating information (public awareness), conducting small-scale epidemiological surveys (usually in major cities), and providing a limited supply of STD medication and equipment. In Burkina Faso condoms were also promoted and distributed.

46. Although these plans and activities brought AIDS issues on to the national agenda, very little was achieved during the first phase because of the constraints described in Section II. There has evolved, however, a greater recognition of the need to develop a more aggressive information, education, and communication (IEC) strategy and to broaden the scope of interventions to deal with multi-sectoral/multi-level dimensions of the problem. The second-generation MTPs (1994-98) were designed to respond to these concerns. The plans emphasize: (a) integration of HIV with STD interventions; (b) an intersectoral approach and decentralized management of AIDS programs, giving greater emphasis to community health; and (c) intensification of IEC interventions, particularly peer education programs and community mobilization efforts.

B. DONOR AND BANK SUPPORT

47. Donors, particularly WHO and UNICEF, have actively supported these initiatives. The WHO/ Global Program on AIDS (GPA) has been instrumental in the development of the MTPs, and in the provision of technical assistance to implement national programs. As mentioned earlier, NAPs are facing increasing funding gaps, particularly since the early 1990s. IEC activities, and to a lesser extent epidemiological surveillance, have been more attractive to multilateral and bilateral agencies such as the Dutch and German governments for interventions mostly in rural areas, USAID with condom promotion and distribution, and CIDA for epidemiological surveillance in selected countries. Other donors, namely the French and the European Union, have provided support mainly for STD clinical management and laboratory equipment and supplies in major cities. Recently, however, some principal donors, in particular USAID, are beginning to concentrate their efforts at the regional level, and to disengage from "lower priority" countries.

48. **The World Bank Involvement.** The Bank's support for AIDS initiatives in the Sahel has been, until recently, very limited. This was due, in part, to the reluctance on the part of officials to use Bank funds to support activities to combat a problem which was not considered to be a major concern, and for which there was apparently adequate bilateral grant funding. This orientation has, however, changed over the last two years as other donor funding has decreased while funding needs have increased. There has, in fact, been a several-fold increase in IDA support during the last two years for AIDS initiatives in the Sahel. The Bank's interventions to date have been at two levels: *within the Bank*, to promote the inclusion of AIDS issues in sector activities in all countries and to develop a comprehensive AIDS strategy for the Sahel; and at the *country level*, to assist Sahelian countries launch vigorous action programs to prevent AIDS from becoming a major health problem.

49. Over the last three years, the Bank has focused attention on the following areas:

(a) **Improving the knowledge base to enhance the Bank's dialogue with the countries concerned.** This is being achieved by helping governments conduct Rapid Risk Assessment Surveys to build a strong data base for effective program planning and implementation (see Annex 3). This effort is aimed at better understanding the AIDS situation within countries and increasing awareness of the disease among policy makers and the population as a whole[19]. Within the Bank, AIDS-related issues are being given increased priority. Information meetings have led to greater staff awareness of the need for immediate action, task managers are placing more emphasis on such issues, and effective tools for dialogue and program development are being prepared.

(b) **Targeting key government officials to heighten their understanding of HIV/AIDS** and of the urgency of concerted national action on all fronts to prevent the epidemic from becoming a serious public health problem. At the 1993 Annual Meetings, the need for urgent attention to AIDS prevention figured prominently among the issues discussed with national delegations. The Bank will also contact Heads of Government to express its concern regarding the need for countries to act quickly and its willingness to assist them in their fight against the disease. In the course of Bank/Government policy dialogues a concerted effort will be made to include specific actions to be taken to address the AIDS issue.

(c) **Providing support in Bank-funded operations for under-funded priority activities under NAPs.** During the last two years, upon request from national authorities and in response to further analysis of national programs, the Bank has substantially increased its support for AIDS initiatives in all countries (except Sao Tome & Principe and Cape Verde). This support has primarily been in the form of health sector interventions, particularly through ongoing and newly-approved IDA-funded Health and Population projects. The following provides a brief description of the ongoing and proposed country-level activities.

(i) **Burkina Faso.** The Bank recognizes the critical nature of the AIDS situation in this country and has, over the last two years, undertaken vigorous action at both the policy and program levels in support of the National AIDS Program. Under the ongoing Health Project, a total of US$750,000 was allocated to finance priority activities planned during the first two years of the Second MTP (1993-1997). These include support for epidemiological surveillance (in particular conducting STD/HIV Rapid Risk Assessment Survey), laboratory equipment and training. In addition, when the Population and AIDS Project becomes effective in the next few months, the IDA credit will constitute the largest single source of external funds (US$10.6 million) for AIDS prevention activities in the country (see Box 1 below).

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[19] The data will also assist in improving dialogue with governments and better targetting of AIDS interventions. For example the Niger survey, which was completed in June 1993, provided the needed data for the in-country workshop to develop the second MTP organized in October 1993. By the end of 1994, surveys were completed in 5 countries where they have been identified as a priority (see Annex 2)

Box 1: BURKINA FASO: Population and AIDS Control Project

This project will be the first IDA-funded project in the Sahel to include a full-fledged AIDS component. The AIDS control component aims at slowing down the spread of HIV/AIDS by promoting behavioral change, through increasing *public awareness* of HIV/AIDS. Particular emphasis would be placed on strengthening management capacity at the national and community levels, and on increasing the involvement of the private sector and NGOs in project activities. Specific activities include:

(a) Social marketing and public sector distribution of condoms;
(b) Establishment of a Fund to provide grant financing for projects in the areas of population, family planning, and AIDS prevention and control activities undertaken largely by NGOs;
(c) IEC campaigns using various media channels such as radio spots, serial dramas, dance and singing groups, folk theater, etc. to raise awareness of HIV/AIDS and other STDs and to promote behavioral changes; and
(d) Institutional strengthening of clinical management and community care capacities within the country.

(ii) **Cape Verde.** So far there has been no direct Bank support for the AIDS Program, which is fairly well advanced and apparently well-funded. However, some support is being considered for preventive activities, particularly for IEC under the proposed Education Project (FY96). In addition the Government has expressed interest in being actively involved in the proposed Sahelian Regional Initiative (see Section IV).

(iii) **Chad.** Although to date only limited Bank support has been provided to the National AIDS Program, preparation is underway for major support under the proposed Population and AIDS project planned for FY95. Meanwhile, support is being provided under the Project Preparation Facility [20](PPF) for the proposed project to undertake a STD/HIV Rapid Risk Assessment Survey to be followed by a KAP survey in early 1995. In addition, support was provided by the Bank for the preparation of the Second Multisectoral MTP in May 1994. The Chad National AIDS Program has encountered some funding difficulties in the past, and it is hoped that the support to be provided by the Bank under the proposed Population and Health Project will fill a major gap in funding needs and help achieve the objectives of the National AIDS Program.

(iv) **The Gambia.** Funding is being provided under the ongoing National Health Development Project for IEC activities, epidemiological surveillance, STD materials and supplies, and technical assistance for strengthening laboratory capacity. Approximately US$200,000 has been provided to date, including funding costs for conducting the STD/HIV Prevalence Survey beginning in mid-May 1994. Although The Gambia is one country in the Sahel where valid information on epidemiology of STD/HIV infections has been available since the

[20] Although project preparation is the Government's responsibility, advances to finance project preparation activities are made by the Bank when there is a strong probability that a Bank loan will be made for the project.

mid- and late-1980s, the planned 1994 survey is likely to provide more recent and updated data for most of the country. Additional funding for AIDS activities will be considered under the proposed Health and Population Project (FY96).

(v) **Guinea-Bissau.** Support for the National Blood Donor Bank, provision of drugs for AIDS-related diseases, and AIDS prevention activities is being provided under the health component of the ongoing Social Sector Project. In addition, preparation efforts have been initiated for a Population and AIDS Project planned for FY96. This project will provide substantial funding for activities planned under the Second MTP (1994-1998).

(vi) **Mali.** Priority activities are being supported under the ongoing Health, Population and Rural Water Supply Project. A total of US$1.4 million has been allocated under the project in support of the last two years of the first MTP. This includes support for IEC, epidemiological surveillance (including STD/HIV Rapid Risk Assessment Survey), STD clinic management and laboratory facilities to strengthen sentinel surveillance in six selected sites, training of health personnel in clinical and laboratory procedures at district hospitals, program management and monitoring, and technical assistance for the development of the Second MTP (1994-98). Given the rapidly rising HIV/AIDS trend in Mali, further Bank support would be required to meet the program needs under the Second MTP currently under preparation.

(vii) **Mauritania.** Under the ongoing Second MTP (1994-1998), financial support for high priority activities is being provided through the ongoing Health and Population Project. A total of US$0.9 million has been allocated under the IDA credit to support the program during the next 3 years (1994-97). The funds include substantial support for IEC, training, and epidemiological surveillance (including a small-scale STD/HIV prevalence survey among pregnant women in Nouadhibou).

(viii) **Niger.** The first Bank support for AIDS in the Sahel was provided in 1987 under the ongoing Health Project for the procurement of laboratory equipment to ensure blood safety. Since then, considerable support has been provided through both the Health Project and the new Population Project. Funding has focused primarily on IEC initiatives, epidemiological surveillance, procurement of STD and anti-tuberculosis drugs, and strengthening laboratory capabilities at the national and selected regional hospitals, particularly to ensure safe blood transfusions. Total Bank support under the two credits is US$1.3 million. Following Senegal, Niger is the second country in the Sahel to benefit from Bank support in conducting a STD/HIV Rapid Risk Assessment Survey, which was completed in June 1993. The survey has significantly improved the knowledge about the prevalence of major STDs in the agglomeration of Niamey, and therefore provides valid data for strengthening the National STD and AIDS Program (see Annex 1, item 6, for further details). It is also envisaged that the new Health Project (FY96), currently under preparation, will provide substantial support for AIDS prevention activities.

(ix) **Senegal.** Direct financial support to the National AIDS Program has not yet been provided, although an official request is expected for support of planned activities during the 1994-1998 five-year Strategic Plan. However, support is being provided for IEC activities for youth through the Family Life Education program financed under the ongoing Human Resource Development Project. Total Bank support for AIDS prevention activities is estimated at US$600,000.

C. SUPPORT FROM THE NON-GOVERNMENTAL SECTOR

50. Over the past few years the changing political situation has given rise to the creation of a number of local NGOs either as local affiliates of international NGOs, such as SIDALERTE, Society for Women Against AIDS in Africa (SWAA), Save the Children Fund (US and UK), and ENDA Tiers Monde, or as independent local organizations venturing into community activities dealing with women's reproductive health issues and AIDS. There is also a number of well-established international NGOs doing interesting work on AIDS prevention. Notable among these are Care International, focusing primarily on migration issues, and Population Services International and the Futures Group, both promoting social marketing of condoms. Family Health International, through its AIDSCAP programs, is also targeting specific groups for AIDS prevention activities. These international NGOs are primarily funded through USAID. In addition, considerable support for epidemiological surveillance is being provided in four countries through CIDA under the PASE project (*Projet d'Appui à la Surveillance Epidémiologique*).

D. LESSONS LEARNED

51. Over the last 10 years a series of programs in communicable disease prevention, family planning, and, more recently, AIDS has been developed in the Sahelian region. The success of these interventions has varied. While some small-scale interventions have been notably successful, few state-organized national level interventions have demonstrated similar results. The varying impacts are illustrative of the difficulty faced in changing one of the most complex social behaviors - sex - and accepted norms of sexuality, are intimately linked to gender relations and religious norms, and are shrouded by social taboos that limit public discussion. AIDS forces discussion of sex and its relationship to disease, death, and life. Some of the main lessons learned over the last decade in developing AIDS interventions in Africa and elsewhere are:

(a) **Behavioral change is difficult and slow.** There is a need to address the *non-cognitive determinants of behavior*. In the earlier stages of the global response to AIDS, the exhortation to provide information in an attempt to halt its spread led to a profusion of biomedical jargon directed at the public. This strategy increased recall of the name of the disease but it did not increase knowledge of the causes, symptoms, and treatment options available for the opportunistic infections associated with AIDS. More importantly, recall of the disease did not produce the desired behavioral responses. Changing sexual behaviors requires research on the non-cognitive aspects of these behaviors, and the belief systems that exist about death, sickness, disease, and sexual practices. Effective AIDS education initiatives must be based on an understanding of the socio-cultural dynamics and the nexus between treatment options, service delivery modes, gender relations, and the belief systems mentioned above. It is necessary to convince policy makers to have more realistic expectations for behavioral change.

(b) **Comprehensive programs are essential.** While the demand for condoms should be addressed at the early stage of programs, supply side issues must also be addressed very early in program development. Communication is frequently associated with the production of materials and diffusion of information that stimulates the demand for services. Demand-side approaches to communication fail to address service delivery concerns. Stimulating demand for services that do not exist, or that cannot adequately serve the population, reduces the credibility of the source of information and prejudices the target audience's attentiveness to future messages. Attention must also be paid to the quality of the services provided. One of the main reasons for low levels of service utilization in the Sahel is that the client's negative perceptions or experiences are communicated within the social networks. To improve the utilization of services, clients must be provided with quality services; quality being defined from both cultural and technological perspectives. Strategies for stimulating demand and providing quantitative and qualitative inputs into the supply for services must be incorporated within a comprehensive AIDS communication plan. Attempts at coordination between supply- and demand-side approaches are difficult when communication strategies have been developed independently, or in an *ad hoc* manner.

(c) **Local institutional capacity building is essential.** Response to the AIDS epidemic comes spontaneously from within. It is necessary to relate to what is happening at the country level and build upon these efforts. Decentralization of decision-making should be encouraged. Multiple actions with significant amounts of funding (i.e. dosage effect) can be effective. However, donor agencies need to be careful not to thwart community-level institutional infrastructure through the creation of new organizational structures and/or through overfunding. In some instances, the best strategy might be to leave communities alone.

(d) **The importance of targeting youth**. Interventions targeting youth constitute an important cost-effective means of preventing and mitigating the spread of STD/HIV. However, perceptions that sex education and teaching about reproductive health may encourage early sexual activity among youth represent highly negative barriers to the implementation of effective prevention programs for young people. Various studies, however, have shown no evidence of increased sexual promiscuity and precocious sexual activity among youth receiving sex education.[21] In addition, some of these studies (6 out of 19) concluded that "sex education either delays the onset of sexual activity or decreases the level of sexual activity." In many of the studies (10 out of 19), it was found that sex education has increased adoption of safer practices by sexually active youth. Therefore, there is strong evidence that effective school-based sex education programs may serve as effective mechanisms for promoting changes in sexual behavior.

(e) **The importance of provincial/regional approaches.** The ethnic and social variations in the sub-region necessitate a mosaic of communication approaches within a country. These approaches have a greater appeal to the intended audience and are cost-effective. National boundaries are not indicative of cultural differences and strategies can be tailored to the linguistic and cultural diversity of the region. Programs developed in one

[21] This follows a detailed review of 19 studies that evaluated the sexual behavior of students receiving sex education. The reviews were undertaken by WHO/GPA in collaboration with research groups at Macquarie University in Sydney, Australia; the University of Exeter, U.K., and The Bowling Green State University in Ohio, U.S.A.

country may be relevant to populations residing in another country when the socio-economic as well as infrastructure realities within countries are taken into account. Innovation is key; it is therefore important to learn from others.

(f) **The important role of technical assistance.** Specialists' assistance is often required in project development, implementation, and evaluation given the relative inexperience and limited manpower capabilities of local implementing agencies. Technical assistance must be planned to build institutional capacity and reduce the reliance on external assistance.

IV. PROPOSED BANK STRATEGY AND INTERVENTIONS

52. The issues discussed above and the lessons learned underscore the need for broad-based intersectoral, multilevel strategies, focusing principally on preventive measures to mitigate the spread of the epidemic as well as to cope with the burden of the disease. In a sub-region where the disease is principally transmitted through heterosexual intercourse, the challenge of changing sexual behavior is daunting. Low literacy levels, low status of women, religious and social taboos, and a limited human resource base constitute major impediments to efforts to combat the epidemic. The Bank is well-placed to help these countries take advantage of the window of opportunity that still exists to mitigate the rapid spread of the epidemic in the region. Its comparative advantage in policy dialogue at the highest level can ensure greater visibility and effective integration of HIV/AIDS issues into macroeconomic dialogue and country assistance strategies. Its interventions in almost all sectors of the economy can facilitate effective interaction among the various actors in the field; and its funding capacity can help meet major gaps in the resource needs as other funding sources dwindle.

53. Only an immediate full-scale, broad-based attack on the problem can prevent a generalized epidemic and major developmental set-back for the Sahelian countries. To this end, the Bank would support a two-pronged strategy. First will be country-level activities supported through lending operations and sector work. This support will focus on *medium- to long-term* strategies to develop sustainable policies, programs and institutions to deal with the epidemic. Second will be support for a short-term (3 years, FY 95-97) high-impact interventions at the *regional level.* This program will complement national programs by helping to build a regional coalition, increase the level of political commitment at the national level, and achieve maximum impact in the shortest time possible. These two strategies are summarized below and described in more detail in Section IV of this report.

A. COUNTRY-LEVEL ACTIVITIES SUPPORTED THROUGH LENDING AND SECTOR WORK

54. While efforts will be made to support AIDS initiatives in all countries in the sub-region, there is a need to focus on countries with the greatest needs in order to achieve maximum impact. An attempt has therefore been made to rank the countries in order of priority for IDA support. This ranking is based on the current assessment of: (a) the perceived trend in the spread of the epidemic (scope and earlier occurrence of the epidemic, population size, migration patterns and geographic proximity to hyper-endemic countries); (b) program quality (section II, para. 35-44); and (c) the adequacy of funding. Burkina Faso, Mali, and Niger are ranked as high-priority countries, followed by Chad, The Gambia, and Mauritania as medium-priority countries, and Senegal and Cape Verde as low-priority countries. Guinea Bissau and Sao Tome & Principe are not rated due to lack of relevant information.

55. For each of these countries the nature and level of Bank support would depend on the priorities already defined in the second MTPs and the extent of resources committed by the governments as well as other donors. However, the Bank's strategy for *country assistance programs* would cover activities in these key areas: (a) strengthening and expanding ongoing HIV/AIDS communication programs at the country level; (b) accelerating the establishment of social marketing programs to promote condom use; (c) expanding clinical management and care of

STD/HIV-infected persons, epidemiological surveillance, and laboratory capacity; (d) increasing assistance for community/NGO and private sector initiatives, particularly in support of programs in the work place and home care of HIV-infected persons and those with AIDS; (e) promoting of broad-based policy analysis, program coordination, research, monitoring and evaluation; and (f) improving collaboration and coordination with key donors in the region. Attention would be given to *inter-country* and *inter-regional* dimensions of the problem while taking into consideration specific national concerns.

56. **Strengthen and expand ongoing HIV/AIDS communication programs.** While the approach to communication program development does not represent a break with previous approaches to health communication in the sub-region, its inadequacy is magnified in the case of STD/AIDS prevention (paras 36-39). Changing sexual behavior requires an in-depth understanding of socio-cultural norms and behaviors regarding sex, sexuality, gender relations, and the public discussion of these subjects. In this regard, the Bank's AIDS communication strategy would focus primarily on assisting the NAPs in broadening the range of channels currently being used and will: (a) involve beneficiary participation in all stages of program design and implementation; (b) be research-driven and adhere to a systematic approach to communication program development; and (c) pay particular attention to the evaluation of the cognitive, attitudinal, and behavioral impact of communication interventions.

57. The objectives of the Bank's AIDS communication strategy will be to: (a) increase knowledge about STDs/AIDS as well as the perceived sense of the risk of contraction among specific target populations (decision makers, opinion leaders, service providers, women, and youth) as well as the general population; (b) promote safe health and sexual practices; (c) promote the utilization of health services for treatment of STDs and care of HIV/AIDS cases; and (d) contribute towards the development of local manpower with expertise in communication, particularly to strengthen the capacity of health communication personnel to design, manage, implement, and evaluate multi-channel behavior change interventions; and support the integration of communication skills in the curricula of tertiary-level institutions that train public health personnel. Support would be provided in the following five critical areas: (i) mass media production and dissemination of information; (ii) interpersonal communication and peer education, particularly for youth both in and out of school; (iii) consultative meetings and seminars to build a strong political commitment at the highest level to address the problem; (iv) training; and (v) research and evaluation to improve the quality of data on the social, cultural and economic determinants of sexual behavior patterns, the utilization of treatment facilities, and the impact of communication interventions.

58. **Condom promotion.** With the exception of Burkina Faso, no country has yet launched a nationwide condom promotion program for STD/HIV prevention, using all possible channels of delivery. Critical elements of the Bank's strategy will be to: (a) assist the countries in the region to develop nationwide condom social marketing programs; and (b) strengthen and expand the existing public sector distribution network, through procurement of condoms, training, and logistic support. With regard to condom social marketing, efforts are underway in Niger under a USAID-funded initiative and, in The Gambia, the Government has requested IDA-funding for a similar program. Senegal, Mali, Mauritania, Chad, Guinea Bissau, and Sao Tome & Principe, are yet to come on stream and efforts will be made to assist these countries to initiate similar programs. To accelerate the process of implementing such a program, preparatory work would be supported under the proposed centrally-funded regional program (para. 65).

59. **Expanding clinical management of STD/HIV, epidemiological surveillance and laboratory capacity.** The Bank's strategy will be to support the integration of STD/HIV services, namely case management, care and counseling at all levels of the public health system, and to build capacity for referral at the secondary and tertiary levels. In particular, emphasis will be placed on: (a) integrating STD/HIV case detection and counseling in the primary health care and family planning programs; (b) enhancing clinical capacity to enable screening and diagnosis of STD/HIV, particularly among women, and providing opportunities for youth to seek help through non-formal networking; (c) developing a robust epidemiological data base through improved data collection at the peripheral level, and laboratory confirmation of most frequent syndromes at the regional and central levels; (d) training of the various levels of health personnel, social workers, laboratory technicians, data analysts in appropriate cognitive skills (counseling, referrals, testing, and data recording and management); (e) developing protocol/clinical algorithms to improve diagnosis, treatment and follow-up of STD patients and treatment for tuberculosis; (f) developing the capacity for blood screening and precise guidelines for blood transfusion to avoid unnecessary transfusions; and (g) providing essential drugs and laboratory supplies.

60. **Support for NGO/community/private sector initiatives.** To ensure effectiveness of AIDS initiatives, it is essential to foster ownership of activities by involving, from the outset, individuals and communities who are directly or indirectly affected by HIV/AIDS. In addition, involvement of CBOs, including various youth and women's associations, NGOs and industry (including various workers' associations) in activities in which they are more efficient, such as targeted information dissemination, counseling, and peer education programs, would be supported under the Bank's strategy. Moreover, during the next three to five years, the growing number of AIDS patients and orphans of AIDS (paras 14-16) would necessitate support for community and home care of AIDS patients and their families. As experience for Eastern Africa demonstrates, NGOs would be actively encouraged, under the Bank's strategy, to support home and community care initiatives. Where needed, technical and financial assistance would be given to CBOs, NGOs and the private sector to enhance their institutional capacities. Also, recognizing the important role of traditional healers as a source of care, the Bank's strategy would be to encourage the exploration of mechanisms to integrate them into the system of care. In addition, effective coordination and communication would be encouraged among all actors to avoid duplication of efforts and misuse of resources.

61. **Support for multisectoral interventions**. In addition to support for NGO/community initiatives and health sector interventions, the Bank, through its lending program, would encourage the inclusion of AIDS prevention activities in other sector-specific investment lending, especially in education, agriculture, industry, and urban development. Programs in these sectors affect the masses of the population and are thus effective vehicles for reaching the most vulnerable groups. In addition, efforts will continue to strengthen the poverty and gender focus of Bank interventions to provide the enabling environment for effective actions in all sectors. In the education sector, beyond the conventional in-school health education programs through which AIDS education activities are being promoted, a more comprehensive program to address AIDS within the sector needs to be developed. Already, the Bank has initiated a major step to increase enrollment of girls in primary and secondary schools, a critical factor in reducing the social and economic vulnerability of women (paras 25-29). Task managers would be encouraged to collaborate with UNESCO, which is in the process of developing a program on AIDS, to address policy and institutional concerns in the education sector. Similarly, the Agriculture and Environment Division would be encouraged to link up with FAO, which is currently assessing the implications of the AIDS epidemic in the agricultural sector. Task Managers in all sectors would be sensitized to the

issues, and encouraged to take the lead in policy dialogue relating to appropriate actions in their sectors. At the country operations level, country officers and economists would be encouraged to discuss AIDS issues at the highest level of government in their macroeconomic dialogue, and to include these issues in documents such as Country Assistance Strategies (CASs) and Policy Framework Papers (PFPs), etc. To enhance their capacities to deal with these issues at the macro level, they would be encouraged to undertake country-specific analyses of the economic impact of AIDS, drawing on the various sectoral analyses to be undertaken by the various sector operation divisions (para. 63).

62. **Program management and coordination**. The multisectoral nature of interventions necessitates a strong and effective coordination mechanism in order to avoid duplication of efforts and conflicting objectives. The Bank's strategy would be to provide support to strengthen coordination of activities at all levels, encourage decentralization of program management to the local level, and support management training. National AIDS Committees would be given support to: (a) increase their capacities to collect and make available relevant baseline data for decision making by those participating in the planning and implementation process; (b) facilitate the identification of the unique roles of the various sectors, NGOs and other actors; (c) ensure the political commitment at the highest level, including, in particular, the active participation and leadership by the Ministry of Finance and Plan; (d) take active leadership in the planning process to ensure maximum ownership of the plans; and (e) ensure that AIDS planning is synchronized with overall health and development planning.

63. **Policy analysis, research, monitoring and evaluation**. As the epidemic advances in the Sahel, there is an ever-increasing need to understand its determinants and consequences in order to adopt appropriate policy changes, and continuously refine program planning and implementation strategies. Building strong political commitment for effective action will depend primarily on understanding the burden of the disease on society as a whole. To this end, in-depth analytical research is required. A specific research agenda will be collaboratively developed at both national and regional levels. The ongoing Bank support for the collection of epidemiological data in all AF5 countries (Annex 2) will be complemented by a more comprehensive research agenda directed at the following areas:

(a) **Socio-cultural and behavioral dimensions of AIDS.** Considerable analytical work has already been conducted in most of the countries regarding gender issues and development.[22] These studies would be complemented by formative research focusing primarily on: (i) analysis of the social and cultural determinants of sexual behavior, sexual preferences, and cultural practices such as circumcision, bloodletting, etc., and their link to HIV transmission and assessment of the appropriate channels and mediums for the diffusion of AIDS education and information messages; (ii) evaluation of the behavioral and attitudinal impact of communication programs, a very much neglected area; and (iii) evaluation of the cost-effectiveness of interventions; and

(b) **Economic analysis.** Although the channels through which AIDS will have an economic impact is clear (paras 13-17), the magnitude of the impact is still not well documented both due to a dearth of studies measuring current impacts and in the case of the Sahel, because of the uncertainties concerning the future spread of the disease. The

[22] WID and poverty assessments have been undertaken in all Sahelian countries.

proposed research agenda would include: (i) analysis of the economic and demographic burden of the disease; (ii) its public expenditure implications; (iii) current and future costs to households; and (iv) implications for employment and productivity, GDP growth and GDP per capita.

64. The Bank's role, through investment lending, sector work, and dialogue with governments, would be to assist policy makers in defining policies, undertaking legislative reforms, and providing guidelines regarding such issues as AIDS in the workplace, confidentiality, empowerment of women (reproductive health issues, economic and social status), and youth and AIDS.

B. REGIONAL ADVOCACY AND CAPACITY-BUILDING PROGRAM

65. **Rationale**. A key element of the Bank work program on AIDS for FY95-97 will be the development of a *regional advocacy and capacity-building program* to complement the ongoing and proposed national programs. The economic and social linkages and the scarcity of technical and financial resources call for the development of integrated regional strategies and collaboration to increase the effectiveness of HIV/AIDS interventions at the country level. A regional program with high visibility and substantial grant financing from the donor community can bring the necessary urgency to bear on the problem. There are also important regional factors, notably inter-country migration, which are accelerating transmission and which cannot be adequately addressed through a country-by-country approach. There is also much to be gained through cross-fertilization of ideas, "peer pressure" among decision-makers, and program planning in a sub-region where social/sexual behavior and political sensitivities to the problem are relatively uniform. Moreover a broad regional coalition backed by sizable funding from the donor community would be more effective in taking the bold actions required in overcoming denial and inertia at the national level. Such a regional program would also have the advantage of ensuring collaboration among the major international agencies concerned (UNDP, WHO, UNICEF, and the Bank) and drawing upon their comparative advantages.

66. **Proposed activities.** The thrust of the proposed regional program will be to: (a) establish a full-scale Information, Education and Communication (IEC) program to widely disseminate information on the disease and its prevention; and (b) foster regional cooperation and explore innovative approaches to controlling the spread of the epidemic. Such extensive, high-impact programs are difficult to launch and implement through country lending programs, which lack the synergistic advantages and economies of scale of a regional approach. A regional program could recruit the best program specialists, often unavailable at the country level, and develop a broad-based campaign aimed at having the maximum regional impact in the shortest period of time. These efforts would entail:

(a) Mobilizing political and opinion leaders and organizations throughout the region to address HIV/AIDS issues at the highest level. Regional workshops, seminars, study tours and other kinds of group initiatives would be organized to exchange ideas and build a regional consensus at the highest level. Quarterly consultations would be conducted to evaluate progress and identify areas for further action;

(b) Identifying and working with national figures/local heroes (political, religious and sports personalities) with regional appeal to develop strong advocacy roles and mount aggressive education and information campaigns;

(c) Supporting pilot projects to test innovative ideas, particularly those relating to cross-border issues, such as migration (developing sub-projects around border towns and areas of affinity), condom promotion, etc.;

(d) Promoting studies and research of regional significance by universities and research centers in the region, establishing collaborative arrangements with research centers, developing research networks, and providing opportunities for research results to be incorporated into programs at the national level; and

(e) Providing technical support and training to NAPs to improve their capacity to manage multisectoral national programs and upgrading the quality of the response to the national HIV/AIDS issue.

67. A variety of communication channels would be utilized to reach certain audiences with specially designed messages regarding information on HIV/AIDS, prevention interventions and appropriate health seeking behavior. Cultural and language differences as well as points of optimal access to target groups would be given extensive consideration and attention. These activities would be coordinated with bilateral donor financing and in-country Bank projects that strengthen health services, in particular STD clinical management and counseling, family planning, and condom distribution. Support will be given for the development of effective mechanisms/ structures to coordinate and facilitate the implementation of the regional activities. The nature and form of the mechanisms/structures were discussed during a regional technical planning workshop held in Ouagadougou, Burkina Faso from September 11-15, 1994. The workshop brought together 61 participants including NAP managers and observers from UNDP, UNICEF, AIDSCAP, CARE International, SIDALERTE, and Save the Children Fund (US and UK), as well as representatives of local NGOs. Participants identified priority problem areas at the regional level and selected specific interventions to address these priority areas. Constraints to program development and execution were identified and complementary interventions required to ensure effective implementation were discussed.

68. The total budget for this program is estimated at US$6.0 million over a 3-year (FY95-97) period, or US$2.0 million per year, of which US$1.2 million is expected to be provided through the Special Grant Program (SGP) as the Bank's contribution. The SGP has approved funding (US$300,000) for the first year (FY95) of this program. In addition, the Bank will allocate the equivalent of one staff position to manage the program. The remaining US$1.6 million for FY95 would be funded from external sources yet to be determined. It is anticipated, however, that the complementary donor financing would be readily forthcoming since such a program is widely seen as a high priority in the Sahel. The estimated cost breakdown by activity is shown in Annex 5.

C. IMPROVING COLLABORATION AND COORDINATION WITH DONORS.

69. The activities defined above can only achieve effective results if there is true partnership and collaboration among the key donors actively seeking to assist national and local authorities in the Sahel in combating the epidemic. The importance of this issue was clearly recognized by donors who attended the Inter-Agency Meeting on AIDS held by the Sahel Department in September 1993. Although the partnership issue is complex and often difficult to resolve, the will is there and resloution is possible. Bank management recently made a commitment to support and actively participate in the UN co-sponsored program. The Bank will work within the broad

framework of this program and actively collaborate with key agencies (WHO/GPA, UNICEF, UNDP, and UNFPA). Constructive dialogue and partnership will be developed with the major bilateral agencies (such as USAID, FAC, the Nordic governments, Germany, and Canada) as well as with NGOs, all of which are actively supporting initiatives in AIDS prevention in the Sahel.

BIBLIOGRAPHY

Ainsworth, M. and Over, M., *The Economic Impact of AIDS: Shocks, Responses, and Outcomes*. World Bank Technical Working Paper, no. 1. Washington, D.C.: World Bank, 1992.

Amat-Rose, J. et al., (1990) "La géographie de l'infection par les virus de l'immunodeficience humaine en Afrique noire: Mise en évidence de facteurs d'epidémisation et de régionalisation," *Bulletin de la Société de Pathologie Exotique et de ses Filiales* 83(2): 137-148.

Benor, D. et al., *Agricultural Extension: The Training and Visitation System*, Washington, D.C.: World Bank, 1984.

Brenzel, Logan,(1994) "The Economic Impact of AIDS in Burkina Faso". Report submitted to the AF5PH division, World Bank, under the preparation of the Population and AIDS Project (FY94).

Bulatao, R. and Bos, E., *Projecting the Demographic Impact of AIDS*. World Bank Staff Working Paper, no. 941. Washington, D.C.: World Bank, 1992.

Caldwell, J., Caldwell, P., and Quiggin, P., (1989) "The Social Context of AIDS in Sub-Saharan Africa," *Population and Development Review* 15(2): 185-234.

Damiba, A., Vermund, S., Kelley, K., (1990) "Rising Trend of Gonorrhea and Urethritis Incidence in Burkina Faso from 1978 to 1983", *Transactions of the Royal Society for Tropical Medicine and Hygiene* 84(1): 132-135.

Dayal, R., "Social and Gender Dimensions of the AIDS Epidemic in Asia" (draft). World Bank, Asia Technical Department, April 23, 1993.

de Bruyn, M., "Women and AIDS in Developing Countries," *Social Science and Medicine* 34(3): 249-262.

Demographic and Health Surveys: Burkina Faso - Preliminary Report (1993).

Demographic and Health Surveys: Niger (1992).

Demographic and Health Surveys: Senegal (1987).

Foster, S., Lucas, S., (1991) "Socioeconomic Aspects of HIV and AIDS in Developing Countries: A Review and Annotated Bibliography," Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.

Harrison, L.H. et al., (1991) "Risk Factors for HIV-2 Infection in Guinea-Bissau," *Journal of Acquired Immune Deficiency Syndromes* 4(11): 1155-60.

Hunt, C., (1989) "Migrant Labour and Sexually Transmitted Diseases: AIDS in Africa," *Journal of Health and Social Behavior* 30(4): 353-373.

Jancloes, M., "Balancing Community and Government Financial Responsibilities for Urban Primary Health Care: Pikine-Senegal, 1975-1981." In *Primary Health Care: The Africa Experience*, edited by R. Carlow, R., and W. Ward. Oakland, CA: Third Party, 1988.

Kennedy, E., *Successful Nutrition Programs in Africa: What Makes them Work?* World Bank Population and Human Resources Department Working Paper, no. 706. Washington, D.C.: World Bank, 1991.

Koumare, B., Ba, M., Jesencky, K., and Nichols, D., (1990) "A Pilot Intervention to Slow the Spread of AIDS in a High-risk Group in Bamako, Mali", unpublished.

Lamboray, J. and Elmendorf, E., *Combating AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank Agenda for Action*, World Bank Discussion Paper, no. 181, Africa Technical Department Series. Washington, D.C.: World Bank, 1992.

Kim, Young-Mi, et al., (1992) "Improving the Quality of Services Delivery in Nigeria," *Studies in Family Planning* 23(2): 118-127.

Lindan, C., Allen S., et. al., *Knowledge, Attitudes, and Perceived Risk of AIDS Among Urban Rwandan Women: Relationship to HIV Infection and Behavior Change.* Current Science Ltd, December 1990.

Over, M., *The Macroeconomic Impact of AIDS in Sub-Saharan Africa.* World Bank Technical Working Paper, no. 3. Washington, D.C.: World Bank, 1992.

Reid, E., (1992) *The Challenge of the HIV Epidemic.* Paper presented to the Royal Australian College of Medical Administrators, Brisbane, Australia, April 22, 1992.

Reid, E., (1992) "Why Women and HIV? It Takes Two to Tango, Safely," *AIDS Health Promotion Exchange* no. 3, Royal Tropical Institute (Netherlands).

Sicard, J., Kanon, S., Quedraogo, L. and Chiron, J.P., (1992) "Evaluation du comportement sexuel et des connaissances sur le SIDA en milieu scolaire au Burkina Faso: Enquête connaissances, attitudes, crayons et de pratiques (CACP) à Banfora sur 474 adolescents de 14 à 25 ans." *Annales de la Societé Belge de Médecine Tropicale* 72(1): 63-72.

Summary of the Meeting on AIDS Prevention and Control in the Sahel, Washington, D.C. October 5, 1993.

U.S. Agency for International Development, "HIV/AIDS Strategic Action Plan for Asia" (Draft). Washington, D.C., 1993.

U.S. Bureau of the Census, AIDS/HIV Surveillance Database, Center for International Research, Washington, D.C., 1992.

United Nations Development Programme, *Young Women: Silence and Susceptibility and the HIV Epidemic*, n.d.

Wasserhelt, J.N., and Holmes, K.K., (1992), "RTIs: Challenges for International Health Policy, Programs and Research." In *Reproductive Tract Infections: Global Impact and Priorities for Women's Health, edited by* Germain, A., Holmes K.K. Piot, P., Wasserheit, J.N. New York: Plenum Press, 1992.

World Bank, (1992) "Tanzania: AIDS Assessment and Planning Study." Population and Human Resources Division, Southern Africa Department, Report No. 9825-TA. Washington, D.C., June 1992.

World Bank, (1992) "Women and AIDS in Sub-Saharan Africa." Women in Development Unit, Poverty and Social Policy Division, Technical Department Information Note, September 1992.

World Bank, (1993) Brazil, AIDS and STD Control Project Staff Appraisal Report, Human Resources Division, Country Department I, Report No. 11734-BR. Washington, D.C., October 8, 1993.

World Bank, (1993) Burkina Faso: Proposed Population and AIDS Control Project, Staff Appraisal Report (Draft). Washington, D.C., November 1993.

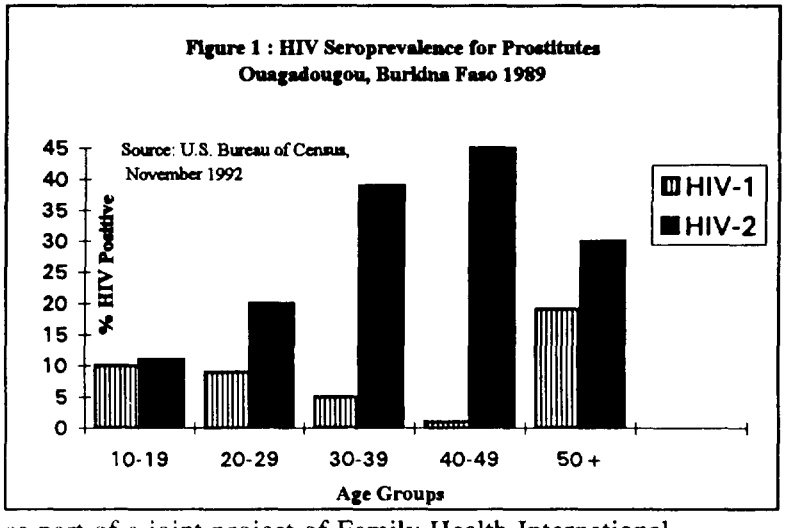
World Bank, (1993) Zimbabwe: Sexually Transmitted Infections Prevention and Care Project, Staff Appraisal Report, Southern Africa Department, Population and Human Resources Operations Division, Report No. 11730-ZIM. Washington, D.C., May 28, 1993.

Yelbi, S., Valenti, P., Volpe, C., et al. (1992) *Assessing Health Education Needs for AIDS among immigrants in an Urban Context: Côte d'Ivoire*. Paper presented at the International Conference on AIDS, 1992.

Brief Country Profiles

1. BURKINA FASO

As of December 31, 1992, 2,886 cumulative AIDS cases have been reported in *Burkina Faso*, with 1,073 cases reported for 1992 alone (although the actual number of cases is most likely much higher).[1] A 1989 study among prostitutes in Ouagadougou showed HIV-1 levels ranging from 0 to 14.3% and HIV-2 from 9.8% to as high as 41.6%, with a peak in the 40-49 age group (see Figure 1). A more recent study conducted in December 1991 among 182 prostitutes in Bobo-Dioulasso, as part of a joint project of Family Health International (AIDSCAP) and the *Centre Muraz*, showed that 45% of women screened were HIV positive. Prevalence rates among STD patients were estimated at 15.6% and 19.2% in two studies conducted in Ouagadougou (1985-86) and Bobo-Dioulasso (1990-91) respectively, with approximately one out of four TB patients found HIV positive. Infection rates among pregnant women increased significantly from 1.7% in 1985-87 to 4.9% in 1990 and 7.2% in 1991 (HIV-1). A recent survey supported by GTZ in Gaoua, Province of Poni (near Côte d'Ivoire) in 1992, showed a staggering HIV prevalence rate of 14.5% among a similar group, approaching prevalence rates encountered in urban areas of neighboring hyperendemic countries (Côte d'Ivoire, Ghana). These last figures are of particular concern for a population of supposedly low risk, and therefore call for vigorous intervention programs.



A seroprevalence survey among 197 truck drivers in Ouagadougou in April-May 1993 showed, on the other hand, prevalence levels of over 13%, which again confirms the steady increase of HIV infections (mostly HIV-1 and dual HIV-1/2) in various population groups in recent years. Concerns about increased risk of STD/HIV transmission among occupational groups such as truck drivers and particularly among miners (reflecting the importance of the gold mining industry in the country) underscore the importance of further investigating the social-behavioral aspects of transmission of the disease to assist in the design of appropriate interventions. Although data are routinely collected in all health centers with regard to more "traditional" STDs such as syphilis and gonococcal infections, prevalence of these infections has been estimated at approximately 2-3 and 7-9 cases per 1,000 STD consultations in 1987-1988. This information should be interpreted very cautiously given the unavailability of efficient laboratory facilities for diagnostic confirmation, except for the *Centre Muraz* in Bobo-Dioulasso. Results obtained from the STD/HIV prevalence survey conducted in 1991 among prostitutes in Bobo-Dioulasso are the only reliable information on prevalence of few STDs

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1 Source: Lankoande, S., *Protocole d'étude de prévalence des maladies sexuellement transmissibles et des infections VIH au Burkina Faso*. Comité National de Lutte contre le SIDA, June 1993.

such as syphilis and chlamydial infections (approximately 10%) and gonococcal infections (5.5%).

These fragmentary data make it difficult to provide reliable estimates of HIV prevalence at the country level, although it could be estimated that between 300,000 and 425,00 inhabitants are actually HIV positive, assuming a prevalence of between 7-8% in the adult population (15-49 years of age). These figures are estimated from information derived from surveys and sentinel surveillance programs addressing pregnant women seen on consultation in selected antenatal clinics, and occupational groups such as truck drivers. These estimates should again be interpreted with great caution based on important variations in prevalence rates between higher endemic regions (Southern and Western Provinces closest to Côte d'Ivoire, Ghana and Togo) and regions with relatively low endemicity (Eastern and Northern Provinces), and urban (prevalence rates among adult population estimated between 7 to 9% in Ouagadougou and Bobo-Dioulasso) vs. rural areas. However, the epidemiological situation in Burkina Faso seems to have reached a dramatic and rapidly worsening proportion.

2. CHAD

In *Chad*, only 59 cases of AIDS were reported in 1990. However, by December 31, 1992, the cumulative total of AIDS cases reported had increased to 899, and as of June 30, 1993, to a total of 1,131. Although these numbers indicate a rapid increase in the number of AIDS cases, the lack of adequate and reliable seroprevalence data makes it difficult to assess the extent of HIV infection in the country. A survey conducted in 1989 among the adult population in four sentinel surveillance sites showed levels varying from 0 to 1.6% for HIV-1 infections, with an estimated rate of 1.1% for the city of N'Djaména.

In 1992, data from a small-scale study indicated much higher levels of HIV infection among pregnant women (3.1%), blood donors (4.3%), and tuberculosis patients (8.8%). Most recent data obtained from five selected sentinel surveillance sites (January-October 1993) showed a significant increase among pregnant women in N'Djaména (3.8%) and Moundou (7.6%), while in other cities the rates varied between 2% and 3.1%. Information on prevalence of STDs is very limited.

3. THE GAMBIA

In *The Gambia*, where more relevant and updated data on various STDs are available, a cumulative total of 240 AIDS cases was reported as of mid-June 1993, with HIV-2 infections representing about 55% of all cases. National seroprevalence surveys conducted in 1988 and 1991 respectively revealed an increase in HIV from 1.7% to 2.2% among the general population, with a predominance of HIV-2 (over 75% of all positive cases). A study among commercial sex workers (CSWs) showed an overall prevalence of 30% in selected urban areas. Two studies conducted among STD patients in 1989 and 1990 estimated prevalence rates varying from 4.9% to 6.7%, while data from sentinel surveillance systems found infection levels for pregnant women to be 1.4% in 1990. However, a study conducted in 1985 among

attendants of antenatal clinics showed that between 22% and 27% were positive for N.gonorrhoeae and 35% for C.trachomatis infections, which is of particular concern for the further spread of HIV.

Preliminary results from the recently launched MRC/GOG longitudinal study on the perinatal transmission of HIV infection[2] among all women attending eight (8) antenatal clinics throughout the country showed a relative stability of HIV-2 (about 1.0%) but a significant rise in HIV-1 prevalence (at 0.6%) compared to previous surveys. According to the same study, an estimated 4.2% of women had serological confirmation of active syphilis.

This high prevalence of syphilis, combined with the observed upward trend of HIV-1 infection, constitute a major cause for concern. There is also evidence of particular patterns of STD/HIV transmission among specific ethnic groups, such as a high prevalence of syphilis among the Jola women in younger age groups and presence of HIV-1 infection among the Serahuli group in the Upper River Division. These preliminary results show the need for specific control program interventions in the very near future.

4. MALI

A total of 460 AIDS cases were reported in *Mali* during 1992, compared with 377 and 242 cases in 1991 and 1990, respectively. This represents an almost twofold increase during this 3-year interval, with a cumulative total of 1,479 cases reported as of March 1993. However, these reported cases were derived exclusively from the two main hospitals in Bamako, and this clearly underestimates the actual number of AIDS cases in the country. Results from a study of prostitutes in Bamako in 1987 showed that nearly one-quarter (23%) were infected by HIV-1, while an even larger proportion (27.4%) was HIV-2 seropositive. A study among pregnant women in Bamako also showed the presence of both infections in 1987, with rates of 0.4% for HIV-1 and 1.4% for HIV-2. Seroprevalence among blood donors in 1987 and 1988 has more than doubled, increasing from 1.7% to 4.1%.

Preliminary results from a national prevalence survey conducted among the general population from the eight regions (sample size of 4,892 participants) during 1992 and early 1993 indicate a significant increase in HIV infections, varying from 2% in Gao and Tombouctou to levels of 4% to 6% in Kayes, Ségou, Bamako, and even higher (over 6%) in Sikasso, which is closer to Côte d'Ivoire. The overall national prevalence was estimated at 5.3%, with 3.4% prevalence for HIV-1, 0.9% for HIV-2 and 1.0% for dual HIV-1/2 infections.

While these results should be interpreted with caution due to biases in the selection criteria of studied population groups, they seem to indicate a rapid increase in HIV infections, particularly HIV-1. No reliable data are available on other STDs.

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2 Preliminary Progress Note, July 1993.

5. MAURITANIA

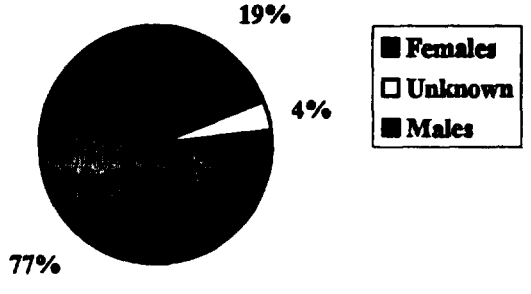
In *Mauritania*,[3] a cumulative total of 40 AIDS cases have been reported as of December 31, 1992. However national authorities acknowledge that this represents an under-estimation of the real number of cases in the country, mainly due to a lack of awareness and training of health professionals, as well as weaknesses in laboratory support for case confirmation. Studies conducted in 1986 among pregnant women, STD patients, and prostitutes showed HIV prevalence varying from 0% to 0.6%. The prevalence still remains at 0% among a representative sample of 200 pregnant women according to a survey conducted in Nouakchott in 1992. Data collected from blood donors during 1987-1989 gave an estimated HIV prevalence between 0.3% to 0.5%, while the prevalence among similar groups in 1992 had reached 0.71%. Results from a survey conducted in 1989-90 suggest that HIV seroprevalence still remains low among STD patients (1.41% in Nouakchott and 1.73% in Nouadhibou), while prevalence has reached 14.2% among hospitalized TB patients in 1991 compared to 5.71% the previous year.

It appears that the AIDS epidemic in Mauritania is lagging a few years behind neighboring countries, with an estimated HIV prevalence of 0.5% among the general adult population in the main cities, and a two- to three-fold increase among STD patients. Data obtained from 1,689 blood donors during the first trimester of 1993 show that 11.7% of them were positive for syphilis; however prevalence of gonococcal and chlamydial infections for the country is unknown.

6. NIGER

In *Niger*, 809 cumulative AIDS cases had been reported as of December 31, 1992 (see Figure 2). A study conducted during 1987-1989 among prostitutes in Niamey showed moderately high levels of HIV-1 (4.9%) and HIV-2 (7.6%) infections, with an overall increase of 50% in 1989 (11.2%) compared to the first two years. In the same study, HIV seroprevalence among pregnant women varied from 0.1% (HIV-1 and HIV-2) and 0.3% for dual infection. On the other hand, a 1988 study in the northern mining town of Arlit showed a prevalence of

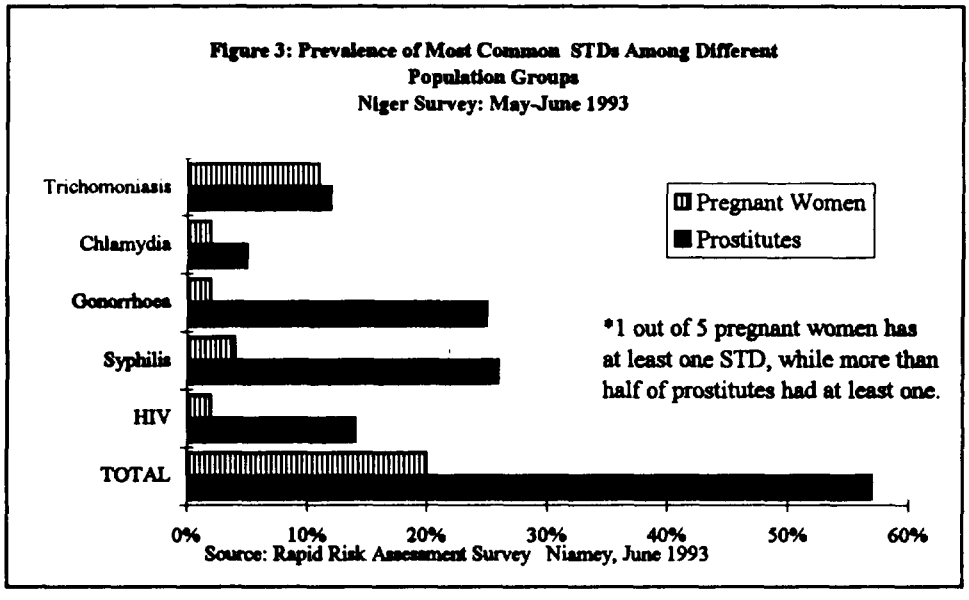
Figure 2: Cumulative Number of AIDS Cases by Sex in Niger: 1987-1992 (Total: 809)



Source: Programme National de Lutte contre le SIDA, Niger

3 Programme National de Lutte contre le SIDA et les MST - Revue externe du premier Plan à Moyen Terme 1991/1993. Nouakchott: Ministry of Health and Social Affairs/WHO, August 1993.

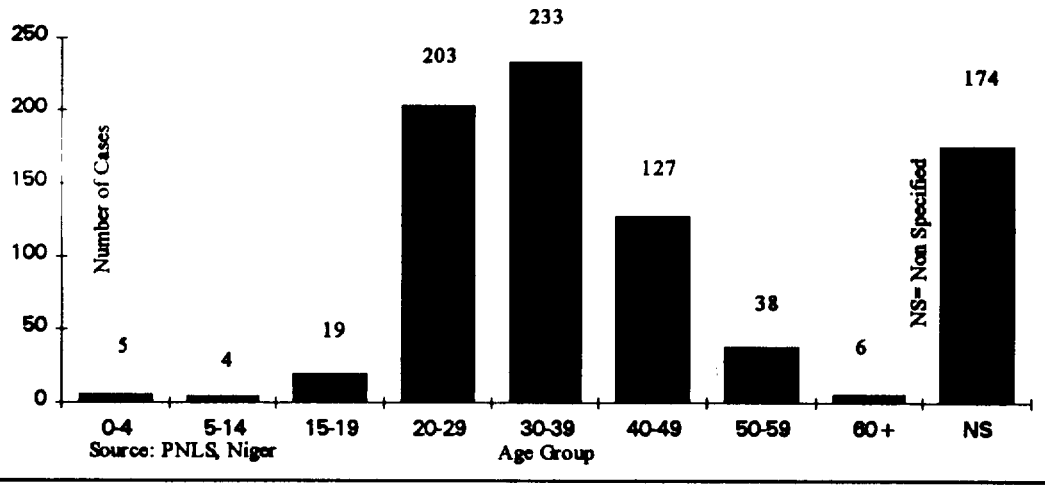
4.3% among prostitutes. More recent sentinel surveys among pregnant women in Zinder, Tahoua, Maradi, and Niamey (1991-1992) showed a slight increase of HIV prevalence, ranging from 0.3% to 1.3%, while prevalence among prostitutes was estimated at between 5% and 7%.



Preliminary analysis of data from the recent rapid risk assessment survey carried out from May 24 to June 28, 1993 among specific population groups in the urban agglomeration of Niamey (including Dosso for truck drivers) shows overall HIV prevalence of 1.3% among pregnant women (5/400), 15.4% among prostitutes (39/254) and 3% among truck drivers (8/263), which seems to indicate a significant rise in recent years. Among various other STDs studied, the prevalence of syphilis was relatively high in pregnant women (4%), and N. gonorrhoeae infections relatively low (1.5%) (Figure 3). As expected, syphilis (26.8%) and gonorrhoea (28.7%) rates were much higher among prostitutes. These data provide the first valid estimates on the most prevalent STDs for the country as well as related social and behavioral factors, although analysis has been undertaken for Niamey only. The results of the survey were presented and discussed at a National Consensus Seminar in October 1993 as part of the preparation of the Second Medium-Term Plan (1994-1998), and should be used for planning and evaluation of future interventions.

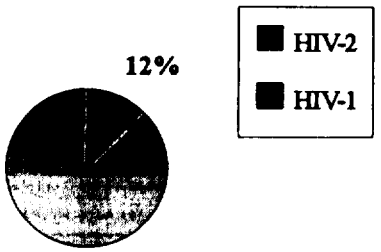
The following figures present the cumulative AIDS cases by age groups for the period 1987-92 (Figure 4), the proportion of HIV-1 (88%) and HIV-2 (12%) strains among confirmed AIDS cases (Figure 5), and the projection of AIDS cases for the 5-year period 1993-1998, using the WHO/GPA Epimodel (Figure 6).

Figure 4: Cumulative AIDS Cases by Age Group
Niger (1987-1992)



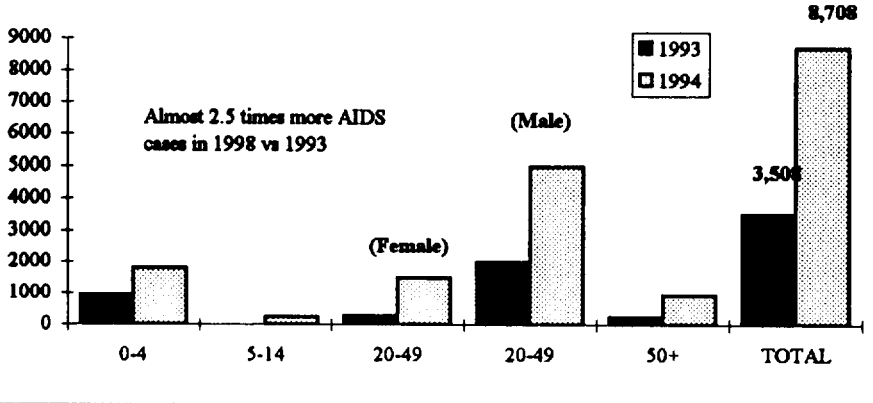
Source: PNLS, Niger

Figure 5: HIV Strains Among Confirmed AIDS Cases
Niger (1987-1992)



Source: Programme National de Lutte contre le SIDA, Niger

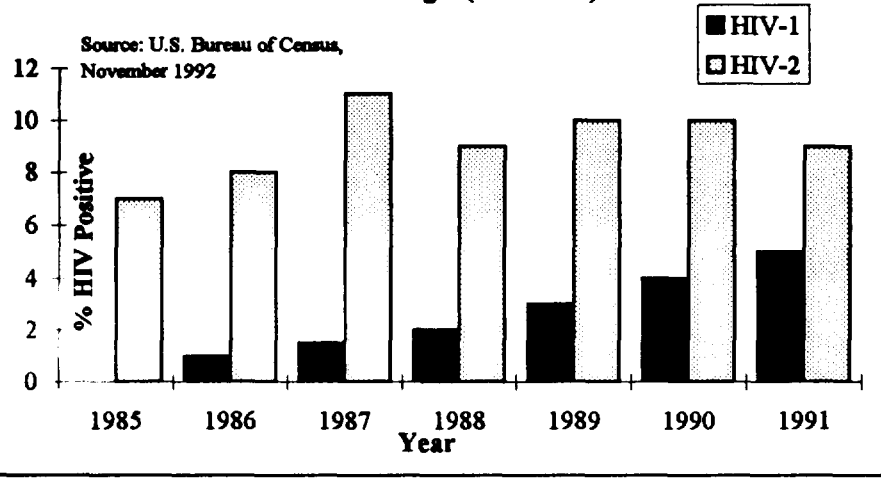
Figure 6: AIDS Cases Estimates in Niger 1993/1998
WHO/GPA Epimodel



7. SENEGAL

As a result of successive surveys conducted among different population groups since 1985, *Senegal* is the only country in the Sahel where valid and detailed data on most common STDs and HIV/AIDS exist. Follow-up studies on registered prostitutes in Dakar during the 1985-1992 period have shown an increase in HIV-1 infections from 0% to 3.9%, with HIV-2 infections increasing from 7% to 9% over the same period (Figure 7). A similar pattern of infection rates has also been noted among the same population group in other cities. HIV prevalence for STD patients has remained more or less constant over the years, varying between 0.5% and 1.5% for HIV-1, HIV-2 and mixed infections, with a gradual spread of HIV-1 to different regions.

Figure 7: HIV Seroprevalence for Registered Prostitutes Dakar - Senegal (1985-1991)



Studies among pregnant women showed variations in infection rates between regions, with HIV-2 being more predominant in all regions except Saint-Louis, with levels varying between 0.2%-0.4% and 0.9%-1.6%. HIV seroprevalence among blood donors was measured at 0.8% and 0.5% for HIV-1 and HIV-2 respectively, with a steady decline of HIV-2 during 1987-1990. With regard to other STDs, a 1991 study determined the prevalence of the following diseases among antenatal and Ob/Gyn clinic attenders, respectively, as follows: a prevalence of N. gonorrhoeae of 1.1% and 1.6%, a prevalence of C. trachomatis of 11.3% and 13.3%; and of syphilis of 5.4% and 15.9%. In a third group (male STD patients), a prevalence of as high as 47% was detected for gonococcal infections. Another study, conducted in 1991 among commercial sex workers (CSWs), found the prevalences of these three infections to be: N. gonorrhoeae- 15.3%; C. trachomatis- 19.9%; and syphilis- 26.8%. This pattern clearly demonstrates the risk of the potential further spread of HIV infections in Senegal with significant increase in major STDs, even if actual figures seem to present only a relatively slight increase of HIV during a 7-year interval.[4]

4 Source: idem. Information available on five countries: Burkina Faso, Chad, Mali, Niger and Senegal.

8. CAPE VERDE

In *Cape Verde*, various HIV seroprevalence surveys were conducted, including one in April 1986 (Praia and Sal), one in February 1987 (Praia, Fogo and Sao Vicente), and a national survey among the general population (over 5,000 subjects in the 9 inhabited islands) in 1988-1989. This last survey showed an overall 0.47% HIV prevalence, with a clear predominance of HIV-2 infection. Data routinely collected through a sentinel surveillance system among attendants at prenatal clinics indicate a relatively low level of infection, varying between 1.0% and 2.5 % in Praia in 1992, and less than 1.0% in Mindelo; in the capital, the prevalence among 146 STD patients varied between 2.0% and 7.5% for the same year. Since 1989, an average of 10 to 15 AIDS cases are registered every year, with a total number of 65 cases reported as of December 1992. Although published data are not available on most common STDs, according to health authorities prevalence is estimated to be relatively low.

It is believed that the control of STD/HIV transmission in recent years has been relatively successful, with particular emphasis on the IEC component of the NAP, and that both STDs/AIDS programs are well integrated. An AF5PH mission appraised the respective strengths of the epidemiological surveillance component, as well as the laboratory capabilities and clinical management in July 1993.

PROJECTIONS OF AIDS AND HIV INFECTIONS

BURKINA FASO

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	607	22762	53809	89341	122225	147938	164550	172049	171589	164869	153707
HIV Cum	0	607	23369	77178	166519	288744	436682	601232	773281	944870	1109739	1263446
HIV Curr	0	607	23366	77046	165972	284543	425000	575530	724961	883710	984459	1082306
AIDS New	0	0	3	129	875	3194	7481	14020	22618	32840	44121	55860
AIDS Cum	0	0	3	132	1007	4201	11682	25702	48320	81160	125280	181140
AIDS Curr	0	0	2	64	437	1597	3741	7010	11309	16420	22060	27930
DEATH New	0	0	2	66	502	2034	5338	10751	18319	27729	38480	49990
DEATH Cum	0	0	2	68	569	2604	7941	18692	37011	64740	103220	153210
DEATH Curr	0	0	2	68	569	2604	7941	18692	37011	64740	103220	153210

CAPE VERDE

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	2	80	190	315	432	522	581	608	606	582	543
HIV Cum	0	2	82	272	587	1019	1541	2122	2730	3336	3918	4461
HIV Curr	0	2	82	272	583	1004	1500	2031	2560	3050	3478	3822
AIDS New	0	0	0	0	3	11	26	49	80	116	156	197
AIDS Cum	0	0	0	0	4	15	41	91	170	286	442	639
AIDS Curr	0	0	0	0	2	6	13	25	40	58	78	99
DEATH New	0	0	0	0	2	7	19	36	65	96	136	176
DEATH Cum	0	0	0	0	2	9	28	66	131	228	364	541
DEATH Curr	0	0	0	0	2	9	28	66	131	228	364	541

CHAD

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	128	4820	11395	18919	25883	31328	34846	36434	36337	34914	32550
HIV Cum	0	128	4948	16343	35262	61145	92473	127319	163753	200090	235004	267554
HIV Curr	0	128	4947	16315	35049	60256	89099	121676	153521	182904	208474	229195
AIDS New	0	0	1	27	186	676	1584	2969	4790	6954	9343	11829
AIDS Cum	0	0	1	28	213	889	2474	5443	10232	17186	26530	38359
AIDS Curr	0	0	0	14	83	338	792	1484	2395	3477	4672	5915
DEATH New	0	0	0	14	108	431	1130	2277	3879	5872	8149	10586
DEATH Cum	0	0	0	14	121	551	1682	3958	7837	13709	21858	32444
DEATH Curr	0	0	0	14	121	551	1682	3958	7837	13709	21858	32444

GAMBIA

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	21	803	1899	3153	4314	5222	5806	6073	6056	5818	5425
HIV Cum	0	21	824	2723	5876	10190	15412	21220	27293	33349	39168	44593
HIV Curr	0	21	824	2718	5841	10042	15000	20313	25588	30485	34747	38200
AIDS New	0	0	0	5	31	113	264	495	798	1159	1557	1972
AIDS Cum	0	0	0	5	35	148	412	907	1705	2864	4421	6393
AIDS Curr	0	0	0	2	15	56	132	247	399	580	779	986
DEATH New	0	0	0	2	18	72	188	379	646	979	1358	1764
DEATH Cum	0	0	0	2	20	92	280	660	1306	2285	3643	5407
DEATH Curr	0	0	0	2	20	92	280	660	1306	2285	3643	5407

MALI

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	214	6034	18892	31532	43136	52214	58077	60724	60861	58188	54280
HIV Cum	0	214	6248	27140	58772	101910	154124	212201	272925	333486	391675	445925
HIV Curr	0	214	6247	27193	58417	100427	150001	203130	255671	304841	347468	381993
AIDS New	0	0	1	46	309	1127	2841	4946	7863	11891	15572	18715
AIDS Cum	0	0	1	47	356	1483	4123	9071	17054	28945	44217	62932
AIDS Curr	0	0	1	23	154	564	1320	2474	3891	5786	7799	9868
DEATH New	0	0	1	23	177	718	1884	3794	6488	9787	13681	17844
DEATH Cum	0	0	1	24	201	919	2803	6597	13083	22880	36431	54075
DEATH Curr	0	0	1	24	201	919	2803	6597	13083	22880	36431	54075

MAURITANIA

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	7	268	633	1061	1436	1740	1939	2094	2016	1939	1806
HIV Cum	0	7	275	908	1969	3387	5137	7073	9087	11115	13054	14862
HIV Curr	0	7	275	908	1947	3346	5000	6771	8539	10180	11580	12731
AIDS New	0	0	0	2	10	36	86	166	266	366	518	667
AIDS Cum	0	0	0	2	12	48	137	302	568	935	1474	2131
AIDS Curr	0	0	0	1	5	19	44	88	133	193	280	329
DEATH New	0	0	0	1	6	24	63	128	216	336	483	596
DEATH Cum	0	0	0	1	7	31	93	220	436	762	1214	1802
DEATH Curr	0	0	0	1	7	31	93	220	436	762	1214	1802

NIGER

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	74	2766	6884	10991	14884	18101	20139	21081	20884	20172	18808
HIV Cum	0	74	2888	9443	20374	35338	53439	73692	94813	115807	135779	154688
HIV Curr	0	74	2889	9457	20881	34914	53000	70417	89701	108877	128481	139422
AIDS New	0	0	0	16	107	291	915	1715	2767	4018	5388	6835
AIDS Cum	0	0	0	16	123	514	1489	3146	5912	9930	15388	22183
AIDS Curr	0	0	0	8	58	186	488	988	1384	2008	2889	3417
DEATH New	0	0	0	6	61	249	685	1315	2241	3888	4708	6116
DEATH Cum	0	0	0	6	70	319	872	2287	4688	7661	12869	18746
DEATH Curr	0	0	0	6	70	319	872	2287	4688	7661	12869	18746

SENEGAL

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	83	2887	8871	8849	12884	15318	17099	17812	17788	17099	15813
HIV Cum	0	83	2420	7891	17340	29884	45210	62248	80088	97883	114982	130805
HIV Curr	0	83	2469	7877	17128	29469	44000	59886	78086	89420	101922	112081
AIDS New	0	0	0	13	91	331	775	1463	2342	3400	4569	5783
AIDS Cum	0	0	0	14	104	436	1210	2691	5008	8409	12970	18754
AIDS Curr	0	0	0	7	48	186	387	728	1171	1700	2284	2882
DEATH New	0	0	0	7	62	211	583	1113	1887	2871	3884	5175
DEATH Cum	0	0	0	7	69	270	852	1966	3832	6703	10887	16862
DEATH Curr	0	0	0	7	69	270	852	1966	3832	6703	10887	16862

SAHEL

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV New	0	1117	41908	99072	164488	228087	272381	302887	316773	315885	303883	283008
HIV Cum	0	1117	43085	143087	308880	531827	804008	1106978	1423748	1739873	2043228	2326228
HIV Curr	0	1117	43019	141884	304737	523883	782900	1086883	1334783	1660844	1812883	1992719
AIDS New	0	0	0	397	1810	5881	13774	25813	41843	60484	81234	103847
AIDS Cum	0	0	0	343	1853	7734	21508	47322	89088	149439	230883	333510
AIDS Curr	0	0	3	118	605	2840	8887	12807	20821	30232	40817	51424
DEATH New	0	0	3	122	694	3746	9628	19784	33728	51084	70849	92041
DEATH Cum	0	0	3	124	1048	4784	14421	34415	68143	119187	190048	282087
DEATH Curr	0	0	3	124	1048	4784	14421	34415	68143	119187	190048	282087

RAPID RISK ASSESSMENT SURVEYS

Introduction

1. Despite its demonstrated importance, epidemiological surveillance is generally very poorly developed in Sub-Saharan Africa, particularly in Sahelian countries. Most Sahelian countries have weak Epidemiological Surveillance Systems (ESSs) characterized by:

(a) a lack of reliable data on levels, trends, and patterns of HIV/STDs to monitor and forecast the epidemic;

(b) a limited use of existing data for decision making;

(c) an inadequate number of personnel trained in data collection, analysis and dissemination of needed information for prevention and control activities; and

(d) a lack of regional cooperation between countries to address common problems.

2. The central role of data and information for the effective planning and implementation of National AIDS Programs (NAPs) underscores the need to quickly address these impediments and constraints.

Design and carrying out of STD/HIV prevalence surveys

3. In order to alleviate these problems, the Population and Human Resources Division of the Sahel Department (AF5PH) undertook *Rapid Risk Assessment Surveys* in most AF5 countries in order to improve country-specific data on HIV/STD prevalence. This effort is aimed at better understanding the AIDS situation within countries and increasing awareness of the disease among policy-makers and the population as a whole. The data will also assist in improving dialogue with governments and in the better targeting of AIDS interventions.

4. Although most of the costs of these surveys will be supported under existing Bank-financed health and population projects, except for Chad where an external grant is expected, additional costs such as consultancy fees (field epidemiologist and microbiologist) as well as travel-related costs (airfare, per diems) for all surveys must be borne by external trust funds. These costs are estimated at approximately 26% of the total survey costs for Mali, Burkina Faso and The Gambia.

Conclusion

5. Although the implementation of the surveys has fallen slightly behind the original timetable in the case of Mali and Burkina Faso, it is expected that by the end of FY95 they will all have been completed, except for countries where such an approach is not essential, namely Senegal, Cape Verde, Mauritania, Guinea-Bissau and Sao Tomé & Principe. For some countries (Senegal, Cape Verde) this information is already available, while for others (Mauritania, Guinea-Bissau), results from recently conducted STD surveys are available. Therefore, most countries in the Sahel will benefit from an updated and reliable database, particularly for the most prevalent STDs. This information will be essential for the planning and evaluation of appropriate interventions for STD and AIDS control activities.

6. As a complement to these epidemiological surveys, a more detailed protocol will be developed in FY95 in order to assess the various social and behavioral aspects of STDs and HIV/AIDS transmission, particularly regional and inter-country issues such as migration and AIDS. Such a multi-country survey is planned for Niger, Mali, Burkina Faso and Chad, and a second survey is envisioned for late FY95 for Mauritania, Senegal, The Gambia and Guinea-Bissau. A budget of approximately US$120,000 each will be necessary for the planning and conduct of these socio-behavioral surveys.

7. National seminars are planned in each country as part of results diffusion and launching of appropriate interventions for prevention and control of STDs/HIV infections in the Sahel, both at the country and regional levels.

DEVELOPMENT OF RESEARCH PROTOCOLS

1. Objectives

1.1 To assess, by conducting rapid prevalence surveys, the existing situation in Sahelian countries with regard to HIV prevalence and the more important STD infections, such as: syphilis, gonococcal and chlamydial infections, genital ulcers (chancroid), trichomoniasis and candidosis (in women), among different population groups (e.g. pregnant women, prostitutes, truck drivers, military); and

1.2 To study risk factors related to STDs, including behavioral and socio-demographic characteristics.

2. Methodological Aspects:

2.1 Standardized questionnaires were developed and criteria were used to select representative samples from the general population (e.g. pregnant women) and specific high-risk groups (e.g. prostitutes, STD clients, migrant workers);

2.2 Development of indicators and laboratory procedures (training of laboratory technicians, procurement of materials and supplies), follow-up of positive cases and contact tracing, ethical considerations;

2.3 Procedures were developed for data collection, analysis, and dissemination of results (national and/or regional seminars, etc.).

3. Expected Outcomes

3.1 Increased knowledge of prevalence of STD/HIV infections.

3.2 Increased capacities to develop immediate and long-term interventions.

Outline for Proposed AIDS Prevention Interventions

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Limited awareness of gravity of AIDS situation	A) Policy-making level				
	Denial and/or latent acceptance of the existence and potential gravity of epidemic at senior government level, particularly outside of the health sector.	Sensitize key officials to the gravity of the AIDS epidemic.	Limited knowledge of macro- and micro-level impact of AIDS.	Undertake research on macro- and micro-level impact of AIDS and disseminate results.	Political commitment to combat the AIDS epidemic manifested by Government's expressed declaration of its concern and commitment through allocation of resources to AIDS interventions.
	Attitudes persist whereby AIDS is seen primarily as a "foreign problem" contracted by marginal groups such as prostitutes.	Increase awareness/ understanding of socio-economic determinants and consequence of the disease.	Political resistance to change as policy-makers are not convinced of gravity of situation and therefore may not respond quickly.	Hold national and regional level workshops/seminars targeted towards senior level government officials to sensitize them about HIV/AIDS and its macro-economic impacts, through various tools such as the AIDS Impact Model (AIMS).	Effective marketing by donors and opinion leaders to encourage participation of target audience.
	Policy-makers are not fully aware of interventions to be undertaken to prevent and/or control the spread of AIDS.	Increase policy-makers' awareness of effective AIDS interventions.	Lack of information on effective interventions being being designed/implemented in other regions and countries.	Hold workshops/seminars to increase policy-makers' knowledge of possible HIV/AIDS interventions.	
				Plan policy and study tours to highly endemic countries such as Uganda, Côte d'Ivoire, Indonesia etc., targeted at senior government officials	Tour participants must be individuals within Government and local opinion leaders, who can and will effectively internalize messages and attempt to bring about change.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Limited awareness of gravity of AIDS situation (cont.)	B) General Population General population has limited knowledge and understanding of the nature of the disease and modes of transmission. Behavioral changes that would enable individuals to prevent transmission of infection have not been fostered.	Improve knowledge of sexual behavior/patterns of various groups to assist in the development of IEC and education programs. Increase general population's awareness of disease and its transmission modes by disseminating information on STDs and HIV/AIDS through different communication channels.	Cultural, religious norms prevent open discussion of sexuality, AIDS. Class and gender differences make generalization of messages difficult. Population's limited access to information. Misinformation and myths abound about the disease and possible preventive measures. Societal norms and behavioral habits that encourage multiple partners are difficult to change.	Undertake qualitative research to better understand socio-behavioral aspects of HIV/AIDS including factors that influence sexual decisions and practices and perceptions. Strengthen IEC campaigns through various media forms, including radio, TV, newspapers and other channels including workshops, seminars, pamphlets, posters etc. at community centers, youth clubs, women's associations, savings clubs, religions networks as well as schools and at workplaces. Promote interpersonal communication such as counseling, information exchange and peer education in specific sites for target groups. Identify and use individuals that are perceived as local "heroes" or "heroines" to serve as advocates for HIV/AIDS prevention.	Availability of research capacity and resources for IEC campaigns with culturally sensitive and linguistically differentiated backgrounds. Use of media channels that have outreach capacity to general population. Use of appropriate media channels that take into account educational levels of target groups, accessibility to media etc. Use of appropriate language that is readily understood by target groups. Frequency, intensity and timing of message transmissions should take into account constraints faced by target audience. "Heroes" or "heroines" will need to have credibility and trust of community.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Limited awareness of gravity of AIDS situation (cont.)	C) Health Personnel, Social Service and Providers				
	Health personnel have limited capacity for case management, counseling and educating public about HIV/AIDS.	Increase training for health and social service providers to improve clinical capacity and counseling services as well as their overall concept of quality of care.		Provide training in case management, and AIDS counseling and education for AIDS patients and family.	Messages must be internalized by health personnel and social workers for them as advocates for change.
	Limited awareness and understanding of perceptions and behavior of general population by health personnel and social service providers.	Sensitize health personnel and social workers to perceptions, beliefs, myths, practices of general population to HIV/AIDS.		Hold training workshops/ seminars aimed at sensitizing personnel who are involved in HIV/AIDS activities.	Messages and approaches must be differentiated by age, gender, socio-economic status and status within families.
	Limited understanding of the role that traditional medicine and its practitioners play in the fight against the AIDS epidemic.	Better understand traditional medical care and integrate it into HIV/AIDS intervention to foster behavior changes.	Limited knowledge of traditional medicine practice and its practitioners.	Undertake qualitative research to better understand the activities undertaken by traditional practitioners and their role in the fight against AIDS.	Make effort to create partnerships with traditional practitioners rather than "educating" them.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Increased risk of the spread of HIV/AIDS due to migration of workers to endemic countries	Lack of awareness among policy-makers of the migration factor in the spread of HIV/AIDS. Sex trade and prostitution at migrant destination sites is seen primarily as "foreign problem".	Sensitize policy-makers to the socio- economic implications of migration in the Sahel and behavior of migrants and CSW at destination.	Policy-makers do not fully comprehend the relationship between migration and the spread of HIV/AIDS in the Sahel. Complexity and multidimensional aspect of the migration issue.	Use country-specific data to demonstrate the impact of migration on the spread of HIV/AIDS. Conduct national and regional workshops/seminars targeted towards senior-level policy-makers to increase awareness of behavior patterns of migrants and to educate them of impact of migration on the spread of HIV/AIDS both in country of origin and country of immigration.	Recognition of the urgency of the issue and political commitment to address it. Commitment by governments to seek and enforce national and regional solutions to the issue.
	Seasonal internal and external mobility of workers (mainly male) to hyper - endemic countries, e.g. Côte d'Ivoire, Benin, Togo. Movement of CSWs to economically active areas both within countries and across borders such as mining areas, border towns, fishing villages etc.	Educate migrants and CSW about risks of HIV infection and foster behavioral change in sexual activities.	Lack of understanding of behavior patterns of migrant workers, CSW, truck drivers at destination sites. Difficulty in identifying target population, i.e. migrant workers, CSW, truck drivers, as they are extremely mobile. Difficulty in identifying appropriate mechanisms for intervention due to mobility of target groups. Language barriers that arise due to influx of migrants from different countries.	Undertake qualitative research to better understand behavior patterns of migrant workers, CSW, truckers etc. to assist in development of strategies that are cognizant of different behavior patterns. Identify appropriate channels for information dissemination, i.e. extension workers for migrant farm workers, etc. Launch IEC, counseling, and peer education programs and social marketing of condoms at national borders targeted at migrants, truckers and CSWs to foster behavioral change.	Accessibility and appropriateness of channels used for dissemination of information on HIV/AIDS. Appropriateness of languages used in education and information dissemination interventions and media choice.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Increased risk of the spread of HIV/AIDS due to migration of workers to endemic countries (cont.)	Individual countries do not see migration issue as their specific concern.	Develop a regional strategy to address inter-country migration and AIDS in the Sahel.	Difficulty in mobilizing resources for regional strategies and activities. Poor regional institutional capacity.	Hold regional-level seminars/ workshops addressing the migration factor in the spread of HIV/AIDS in the Sahel. Develop inter-country programs by earmarking resources for specific interventions.	Cooperation among countries to address this as a regional issue and develop and enforce regional strategies.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Relatively higher vulnerability of women to HIV/AIDS infection	Lack of political commitment to address women's issues.	Increase awareness of low status of women in society at the policy level	Difficulty in mobilizing political leadership on this issue.	Utilize community networks to increase awareness of social/religious constraints on women and mobilize support.	Constituency lobbying within the countries.
	Cultural, religious and legal constraints exist which ensure the subordination of women in society.	Foster cultural reforms and enact legislative changes that would promote the empowerment of women.	Strong and entrenched cultural norms that place women in subordinate position.	Promote legislative reforms that address constraints placed an women, such as legislation to increase age at marriage.	Political commitment to reform and change. Constitutency lobbying within countries.
	Biological factors lead to women having greater risk of infection for STD/HIV and these factors are exacerbated by social factors such as early age at marriage and initiation to sex. STD/HIV transmission rates are higher for women than for men. STDs are often asymptomatic and therefore not always immediately visible or obvious in women, leading to delays in seeking medical assistance.	Enhance clinical capacity to enable screening and diagnosing of and affordable treatment for STD/HIV for women.	Women have limited access to OB/GYN and STD services. STD detection and diagnosis are not routine elements of MCH/FP services provided. Medications are difficult to find and return treatments often required, placing further constraints on women's time and resources.	Include STD detection and diagnosis as integral part of MCH/FP service provision. Use traditional medicine channels to refer patients to STD related care.	Health care providers increase their awareness of the costs of care and treatment to women and concept of "invisibility" of STDs. Target audience must have ability to fit new concepts of sexuality, reproductive health issues etc. into existing conceptual framework about sexuality, illness and contagion.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Relatively higher vulnerability of women to HIV/AIDS infection (cont.)	Women have limited understanding of reproductive health issues and control over their sexual life.	Increase women's awareness of their rights in their sexual life and their understanding of reproductive health concerns. Increase women's awareness of HIV/AIDS. Design interventions and reorient outreach toward women.	Women have limited access to information on HIV/AIDS and therefore are not fully aware of risks. Low socio-economic status of women manifested by low literacy and their subordinate role in decision-making, particularly regarding issues of sexuality. Women face severe constraints on their time and lack resources to seek medical treatment as often as they should.	Promote family life education, i.e. human reproduction, STDs, etc. in formal and non-formal school settings, community centers, savings groups etc. IEC campaigns using mass media (radio and TV) and posters etc. in market places, community centers, savings groups etc. Establish information and/or counseling centers in conjunction with the provision of FP services or as separate units.	Effective integration of issues into curriculum. Selection of appropriate channels and forums for communicating messages. Media channels used need to take into account appropriateness of language. Timing of education and information dissemination efforts will need to be scheduled taking into account women's time constraints.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Relatively higher vulnerability of women to HIV/AIDS infection (cont.)			Women work in the informal sector, either in markets, on the street or at home and therefore access to various types of media may not be readily available to them.	Provide mobile HIV/AIDS counseling services, special media campaigns. Develop aggressive condom social marketing strategies targeted at general population and high risk groups, i.e. CSWs. Use family planning centers to provide counseling, drugs, condoms etc. targeted towards women. Launch education campaigns targeted towards young girls which use peer group discussions, schools, religious and community networks. Develop peer education programs and counseling services targeted towards CSWs. Identify and use female "role models" to serve as advocates for safe sex.	Identification of key gathering places/occassions for women. Availability of family planning centers and MCH clinics with outreach capacity. Credibility of role model and acceptance by target group.
	Women lack alternative employment generation activities and are forced to be involved in the sex trade.	Provide alternative employment opportunities for CSWs.	Women usually have limited skills and may find it difficult to seek alternative means of income.	Launch employment counseling and vocational training services to enhance mobility of CSWs into other employment opportunities.	Availability of alternative income generation opportunities

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Inadequate attention to the multisectoral dimension of the AIDS epidemic	Dominance of health issues and health personnel in HIV/AIDS activities.	Increase awareness at policy level of non-health impacts of AIDS epidemic – Agriculture, Industry, Education, etc.	Policy-makers do not fully understand non-health dimensions of AIDS epidemic.	Undertake analytical work on non-health impact of AIDS and disseminate results. Seminars/workshops targeted toward government officials, private industry, NGOs and community aimed at increasing awareness of multisectorality/ multidimensional of AIDS.	Willingness of various actors to view this issue as multisectoral. Messages relayed to policy-makers must be simple and effective.
	Limited involvement of non-health sectors such as Agriculture, Education, Industry, Planning etc. in HIV/AIDS activities.	Develop multisectoral strategies to deal with AIDS. Foster coordination for the development of integrated multisectoral and multilevel activities.	Sectoral imperatives make it difficult to perceive AIDS as a non-health issue. Lack of well-defined sectoral strategies for dealing with AIDS.	Identify and develop specific sector initiatives, in Agriculture, Education, Industry etc. and then establish institutional and sectoral linkages using sector personnel, i.e. agricultural extension workers.	Sectoral analyses and initiatives need to be clearly defined and clarified. Awareness must be raised among field-level personnel in non-health ministries.
	Lack of coordination between Government, NGO and community level organizations implementing AIDS activities.	Foster commitment at the highest level to develop multisectoral initiatives.	Financial and political constraints coordinating multisectoral interventions.	Broaden network of cooperative agencies to involve non-health personnel in HIV/AIDS activities.	Political leadership must be committed. Dialogue must be established between various actors including Government, private sector & communities.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Limited NGO and community involvement in HIV/AIDS interventions	Community involvement in the design and implementation of interventions is limited.	Foster ownership and sustainability by involving communities from the outset.	CBO/NGO programs might be "captured" by entrepreneurs.	Identify CBOs & NGOs who are committed to involvement in AIDS activities and get them involved in design and implementation of interventions.	Effective institutional arrangements with clear delineation of tasks and responsibilities among various agencies involved. "Grassroots" organizations should be kept relatively small, responsive and flexible.
			CBOs and NGOs may lack human and financial capacity to effectively implement interventions.	Provide technical and financial assistance to CBOs and NGOs to be involved in activities.	
	The potential of NGOs to serve as liaisons to Government and communities has not been adequately organized and utilized.	Encourage more active involvement of NGOs in program implementation. Promote the involvement of CBOs and NGOs in activities in which they are more efficient such as education programs, information dissemination, counseling etc.	Management capacity of NGOs/CBOs may often be limited. There could be a tendency to overfund NGOs/CBOs with more financing than they could use. Lack of clear communication of activities may lead to duplication of efforts and misuse of resources.	Assess capacity of NGOs/CBOs to finance and/or implement HIV/AIDS interventions. Establish mechanism that enables clear communication between agencies on respective activities.	Adequate resources to finance activities. Awareness of constructive versus destructive overlaps and redundancies.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Constraints due to restrictions on procurement of STD drugs, kits and other essential commodities	Current bilateral donor regulations and restrictions on STD drugs and other essential commodities such as condoms make it difficult and more expensive to provide them at the country level.	Promote more flexible procurement procedures for STDs drugs and other commodities.	Difficulty in revising donor agencies' regulations on procurement.	Dialogue between donors to foster establishment of less rigid procurement procedures for commodities i.e. to enable purchase of commodities in least expensive way.	Willingness of bilateral and multilateral agencies to relax procurement procedures. Availability of accessible markets for STD drugs, condoms etc.
	Multilateral agencies have relatively fewer restrictions on country of origin of commodities.	Multilateral agencies could play a more significant role in the procurement of these goods.	Possible encouragement of monopoly distribution conditions for drug companies.	Encourage increased involvement of multinationals in the provision of goods.	Collaboration between multilateral and bilaterals in purchase and/or provision of essential drugs and commodities to ensure efficient allocation and distribution.
	Limited resources are available to purchase commodities.	Encourage multilateral and bilateral donor agencies to provide financing of goods.		Encourage donor agencies to provide more financing for goods.	Availability of financial resources for purchase of STD drugs, condoms etc.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Inadequate funding for AIDS interventions places constraints on program implementation	Funding for national-level AIDS interventions is inadequate.	Increase funding to national AIDS program from domestic sources.	Multitude of demands/priorities on public resources which limits capacity of Sahelian governments to generate necessary funding for AIDS programs from public sources.	Mobilize domestic resources for the financing of AIDS activities through more efficient reallocation of available public resources. Promote and encourage the participation of the private sector in financing and implementing HIV/AIDS activities, such as companies financing mass media programs, counseling at work sites etc.	
	Limited external resources have been major constraints in rapid implementation of AIDS prevention programs.	Increase external assistance to AIDS activities.	Limited external (donor) resources to fund activities.	Mobilize external donor community to increase its resource commitment to AIDS interventions. Promote the inclusion of AIDS related activities in Bank-funded projects.	

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Lack of policy position on AIDS in the workplace	Stigmatization of individuals who are known to have or are believed to have HIV/AIDS.	Create working environment that enables those who are capable of working to work. Sensitize employers and employees to modes of transmission of HIV/AIDS.	Confidentiality of individuals is not respected. Insufficient knowledge and misconceptions concerning the transmission of HIV/AIDS.	Educate employers of the impact of AIDS on profitability and productivity of enterprises. Companies to enact regulations that protect the confidentiality of HIV infected persons. Employers, including Government, to put in place regulations that ensure "fitness to work" as the only criteria for work. IEC, peer education campaigns at place of work to sensitize workers and employers to HIV/AIDS. Activities may include training, discussion groups, film viewing, condom distribution. Encourage companies to become involved in IEC initiatives & other HIV/AIDS prevention activities.	Employers must understand the consequences of inactivity. Companies need to endorse HIV/AIDS initiatives.
	Lack of legal recourse for employees who lose employment due to stigmatization.	Enact legislation to ensure the rights of employees who have HIV/AIDS	Legal and political impediments to enacting legislation aimed at addressing needs of people with HIV/AIDS.	Mobilize trade and workers' unions & other professsional associations to obtain support for legislative reforms/ changes. Enact legislation that protects the privacy and rights of employees with HIV/AIDS and guarantees employment.	Strong lobbying to pressure Government to enact legislation that protect rights of people with HIV/AIDS.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Lack of policy position on AIDS in the workplace (cont.)	Employees in informal sector have relatively fewer opportunities and/or avenues for recourse when they lose their jobs due to stigmatization.	Develop legislation that would protect informal sector workers from stigmatization and loss of employment.	Workers in the informal sector usually do not have lobbying capacity and a forum to express their needs.	Sensitize policy-makers of the need to enact legislation for informal sector workers.	
	Limited avenues for dissemination of information on HIV/AIDS to informal sector workers, particularly those working at home or selling on the street etc.	Develop outreach strategies for workers in the informal sector to educate them on HIV/AIDS in the workplace.	The diversity of work activities and workplaces in the informal sector prohibits the development of one cohesive strategy to address this issue.	IEC campaigns using radio and posters and pamphlets in market places, construction sites etc.. Provision of mobile HIV/AIDS counseling services targeted towards people who work at home or sell goods on the street. Condom distribution in specific work areas or through mobile facilities.	

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Weak epidemiological surveillance	Lack of reliable information to assess levels, trends and paterns.	Develop effective/simple epidemiological surveillance system at peripheral <-> regional <-> central levels.	Unreliable information on epidemiology of most frequent STDs and HIV/AIDS for planning and evaluation of programs/services.	Adequate staffing at central/ peripheral levels.	Priority given by national authorities to adequate epidemiological surveillance system on STD and HIV/AIDS.
	Difficulties in monitoring/forecasting epidemics.	Begin systematic collection of simple/rapid indicators on morbidity/mortality related to STDs and HIV/AIDS.	Severe under-reporting of STDs.	Conduct of rapid risk assessment surveys when necessary.	Better integration of epi. surveillance systems with other STD/HIV program components, i.e. clinical management, laboratory capacities, etc. and with monitoring of other infections (TB cases) and non-infections diseases, i.e. comprehensive/integrated health information system (HIS).
	Collection/analysis/diffusion of data weak.	Analyze/diffuse information on a routine/systematic basis.	Weakness of laboratory support for diagnostic of STD and HIV/AIDS.	Procurement of material/ supplies to improve data collection/analysis i.e. laptop computers; EPIINFO software, etc.	Availability of information to monitor trends/levels on STDs/HIV and AIDS.
	Lack of adequately trained health personnel (field epidemiologist) at central/ peripheral levels.		Lack of equipment/ material i.e. standard form for data collection distinct level, regional and central levels; computer facilities for data analysis..	Strengthening of health information systems at peripheral (data collection) and regional/central levels (data analysis/dissemination of results)	

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Weak laboratory support and inadequate blood safety procedures a) Laboratory support	Lack of minimal laboratory facilities in all countries (human, material, financial resources), at both the central (reference laboratory) and regional/district levels.	Recognize the importance of laboratory support in management of STDs and strengthening of epidemiological surveillance.	Constraints in infrastructure, lack of adequate laboratory facilities/lack of competent trained laboratory technicians/ frequent rupture of stock of laboratory supplies/ equipment.	Furnish/strengthen laboratory facilities. Improve training/ supervision of laboratory technicians.	Improvement in lab. diagnostic facilities at central/regional levels, (minimal microbiology) and peripheral (simple diagnostic kits). Improvement in clinical management and follow-up of STDs patients and in counseling .
	Lack of laboratory support for clinical management of STDs/AIDS. Inadequate training capacities and personnel. No linkage between laboratory and epidemiological surveillance units.	Establish mechanism for laboratory confirmation of clinical diagnoses.		Support the development of essential laboratory facilities.	Planning of adequate services based on prevalence of STDs/HIV.
	Deficiency in the reporting system.(lab. <-> epide-miology units). Lack of maintenance of laboratory equipment and material.	Develop an effective mechanism for reporting of laboratory results.	Problems with referral system mechanism; Management problems	Elaborate simple diagnostic/treatment algorithms at PHC facilities and referral centers.	Improvement in case reporting case management.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Weak laboratory support and inadequate blood safety procedures (cont.)					
b) Blood safety	Limited capacities of blood banks. Increased risk of transmission of HIV/AIDS through: Contaminated blood Supplies, contaminated instruments/infections from indigenous practitioners Ritual matters	Establish minimal safety guidelines for blood transfusion in all hospitals and major health centers. Train all health personnel/traditional practitioners on risk of HIV transmission through medical/surgical procedures. Educate traditional leaders, general population.	Risk of transmission of HIV/AIDS through contaminated needles, syringes, surgical procedures, piercing instruments.	Provide adequately-trained personnel, material and supplies Provide screening/ diagnostic tests where blood transfusions occur.	Improvement in blood safety to at least 90% of the blood supply in the next 5 years. Enhancement in the national user of blood transfusion.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Limited capacity for clinical management of STDs	Poor coverage by health sector in clinical management of STDs, both at central and peripheral levels.	Integrate STD management into HCH/FP programs and hospital outpatient facilities. Provide minimal laboratory and clinical facilities in main cities and regional hospitals.	Lack of medical supplies, drugs, clinical facilities.	Develop training programs for health personnel in STD case management and counseling develop guidelines on HIV/ STDs prevention and control and health centers and regional/distinct hospitals..	Better clinical management of STDs at hospitals and peripheral health centers.
	Inadequate and/or inexistent appropriately staffed and equipped STD clinics in most countries. Inadequacies in training/ supervision of clinical staff.	Develop training materials/supervision mechanism for staff at PHC level.	Lack of adequately trained clinical personnel. Weakness in counseling/ follow-up of STDs patients.		Improved referral mechanisms from peripheral to regional and central levels.
	Lack of drugs/antibiotics, medical supplies, etc.		Inadequacies in drug procurement/distribution mechanism in the public sector. Absence of coordination of policies between public/private sector (pharmacies).	Develop protocol/clinical algorithms to improve diagnosis, treatment and follow-up of STDs patients.	Reductions in STD prevalence and HIV transmission in high-care groups and general population.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
Weak management capacity	Poor absorption capacity of donors' support. Often highly centralized management.	Improve managerial capacities at the Ministry level, and at hospitals/health centers.	Lack of adequately trained program managers. Deficiencies in most administrative components of health programs (STDs and others).	Develop management skills at central/regional levels. Develop appropriate on-site training materials.	Increase in efficiency/ effectiveness of program management.
	Lack of integration of HIV/AIDS with STD program activities, and with other communicable diseases programs (ex TB program).	Improve coordination activities between various donors.	Problems in planning/ programming of intersectoral activities.	Facilitate involvement of non-health personnel in management procedures.	Achievement of target/goals/ activities as identified in Medium Term Plans.
	Lack of coordination between donors, between central and peripheral levels, between various sectors.	Plan activities according to real needs at country level (instead of donors specific agenda).	Deficiencies in functioning of NAC (i.e. representativity of other sectors) and problems of coordination between sub-committees.	Improve representativity of the National AIDS Committee, and reporting at the highest political level..	Improvement in cohesion between different.sectors' activities.
	Lack of commitment from other sectors.	Create greater awareness among different sectors/ community leaders.		Identify key persons (role models) among different population groups.	Increased awareness of HIV/AIDS and STDs among political/religious/community leaders.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
IEC	Lack of knowledge among general population/specific pop.groups about modes of transmission of STDs/HIV.	Improve level of knowledge about STD/HIV transmission and prevention, as well as attitudes and practices.	Inadequate programs/audio-visual materials to be used in mass media campaign.	Conduct well-designed KAP surveys. Investigate complex social/political/cultural issues pertaining to the Sahel.	Increased awareness among community leaders, health personnel.
	Lack of availability of condoms.	Improve condom distribution within/outside health sector, and at regional /district levels. Develop social marketing programs in each country.	Inadequate training of health personnel on strategies on social/behavioral aspects related to STDs and HIV/AIDS.	Develop social marketing programs for condom procurement/ distribution.	Increased condom distribution/ condom use among targeted population groups.
	Lack of coordination among different sectors, donors, agencies and NGO's in IEC interventions.	Strengthen coordination mechanism between various donors.	Coordination problems between different agencies.	Ensure sustainability of IEC programs. Develop programs aimed at specific population groups, particularly youth.	Development of appropriate intervention programs, with improved coordination.

ISSUE	SYMPTOMS	CHANGE ACTIONS	CONSTRAINTS/ IMPEDIMENTS	ACTIVITIES	CONDITIONS FOR SUCCESS
IEC					
	Lack of appropriate message/education materials to meet needs of population (particularly in rural areas).	Develop appropriate material.		Promote research activities on serial/ behavioral aspects related to STDs and HIV/AIDS.	Increased knowledge, and safe behavior among general population and specific higher risk groups.
	Problems in coordination of various categories of health personnel (i.e. medical personnel vs social workers).	Orient training sessions. Encourage team approach.		Train social workers and medical personnel	

PROPOSED REGIONAL IEC AND CAPACITY BUILDING PROGRAM
ESTIMATED COSTS BREAKDOWN BY ACTIVITY

	Activity	FY95	FY96	FY97	Total US$
1	Support for 2 Program Coordinators at regional level				
1.1	Fees (72 person months @ US$ 7000/month	170,000	170,000	170,000	510,000
1.2	Admin. & Travel budget	80,000	80,000	80,000	240,000
1.3	Communication/dissemination	150,000	150,000	150,000	450,000
2	Mobilizing Political and opinion leaders				
2.1	Regional seminars (two per year for five countries each)	200,000	200,000	200,000	600,000
2.2.	Technical workshops, training and annual review	200,000	200,000	200,000	600,000
2.3.	Study tours	100,000	100,000	100,000	300,000
3	Sponsoring national and local heroes (training, travel, dissemination budget, etc.,)	200,000	150,000	150,000	500,000
4	Funds for pilot initiatives(social marketing, community projects, IEC campaigns etc.,)	700,000	750,000	750,000	2,200,000
5	Multi-country studies on behavioral and economic consequences of the epidemic	200,000	200,000	200,000	600,000
	TOTAL	2,000,000	2,000,000	2,000,000	6,000,000

SUMMARY OF REQUESTED CONTRIBUTION FROM THE BANK

Grant	300,000	300,000	300,000	900,000
Administrative support	100,000	100,000	100,000	300,000