

***HIV/AIDS Initiative  
Quarterly Newsletter  
Issue 1  
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**Welcome!**

Welcome to the first edition of the CCA HIV/AIDS Initiative quarterly newsletter. This newsletter is an e-mail publication to inform you of our most recent and upcoming activities.

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*CCA is a 501(c) 3 non-profit organization comprised of over 180 corporations with direct financial investments in Africa. Collectively, the members represent approximately 85 percent of all U.S. private sector investment in Africa. Visit our website at [www.africacncl.org](http://www.africacncl.org)*

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THE CORPORATE COUNCIL ON

**AFRICA**



**THE HIV/AIDS INITIATIVE**

# HIV/AIDS AND THE PRIVATE SECTOR

## *The CCA HIV/AIDS Initiative*

The CCA HIV/AIDS Initiative, funded by The Bill and Melinda Gates Foundation ([www.gatesfoundation.org](http://www.gatesfoundation.org)), addresses issues faced by businesses with operations in Africa and seeks to increase corporate involvement in the fight against HIV/AIDS. Over the grant's three-year duration, CCA will work with its corporate members invested in Africa to assist them in the design, development and implementation of HIV/AIDS workplace policies and prevention education programs for CCA member corporations, their workforce and the families of the employees. In addition, the Initiative works to enhance member company participation in developing national HIV/AIDS plans and collaboration with African national commissions and business coalitions on HIV/AIDS issues. The Initiative also seeks to increase corporate partnerships in the financing of effective HIV/AIDS programs. For more information regarding this Initiative, please contact Victor Barnes, Director of the HIV/AIDS Initiative, at [vbarnes@africacncl.org](mailto:vbarnes@africacncl.org).

## **Making the Case for Private Sector Investment in HIV/AIDS Prevention, Care and Treatment Programs for Africa**

*“The business sector, through its workforce, its ability to advocate at the highest levels of government, and its economic ties to both donor countries and those hardest-hit by AIDS, has the unparalleled opportunity to change the course of the epidemic for individuals and families, communities and even nations. The fight against AIDS cannot be won without it.”*

- Excerpt from an article by Dr. Peter Piot, Executive Director of UNAIDS in the 2003 December/January issue of the CCA Africa Journal.

### **HIV/AIDS in the workplace raises the cost of doing business because of the following side effects:**

- Lowered productivity
- Excessive absenteeism
- Increased labor turnover, including the loss of experienced personnel
- Greater recruitment, training and retraining costs
- Decline in worker morale
- Increased company health care and death benefits costs

In many African environments, HIV/AIDS is a serious impediment to economic productivity and continued foreign investment. The disease impacts societies across generations, from the young, who are frequently the most vulnerable, to the elderly who are left with dependent children. The loss of trained and skilled workers in the prime of their productive lives has severe economic implications for business and investment in Africa's private and public sectors.

- In 2000, the World Bank declared HIV/AIDS to be not only a health problem, but also a development crisis, jeopardizing human welfare and socioeconomic advancement as well as having degenerative effects on societal structure, production capacity and even national security.
- In 2002, USAID reported that by 2010, at the present rate of infection, life expectancy in 11 sub-Saharan African countries would fall to 30 years. Without the presence of HIV/AIDS, the projected life expectancy in these countries would reach near 70 years by 2010.
- In 2001, HIV/AIDS had reduced the labor force in Africa by approximately 20 percent. It is projected that at the present rate of

infection, by 2020, the size of the labor force will be 10 to 30 percent smaller than originally predicted.

It is in the companies' interest, and an example of good corporate citizenship, to develop HIV/AIDS workplace policies and programs; to assist in the provision of treatment for opportunistic infections; and in cases where low cost HIV/AIDS medications are available, to aid in the distribution of anti-retroviral treatment.

### **Development of a CCA HIV/AIDS workplace policy**

With assistance from the National AIDS Fund, the HIV/AIDS team has developed an HIV/AIDS-in-the-workplace policy for CCA.

This is a "basic" policy for a non-profit organization of less than thirty direct employees.

The policy became official in March 2004 and it has been added to the employee job hand book.

The CCA HIV/AIDS Initiative also has an ongoing series of HIV/AIDS awareness and education seminars to accompany this policy.

## CCA Welcomes Director for HIV/AIDS Initiative

**Victor Barnes** is the Director of the Corporate Council on Africa (CCA) HIV/AIDS Initiative. Mr. Barnes has a long career in HIV/AIDS and related healthcare issues. Before taking his position at CCA, Mr. Barnes worked for The National Center for HIV, STD and TB Prevention, a part of the Centers for Disease Control and Prevention, in Atlanta, Georgia. Mr. Barnes served as the Deputy Director of The Division of HIV/AIDS Prevention and most recently as the Associate Director for External Relations in the Division of HIV/AIDS Prevention. While at CDC, he directed the Business and Labor Responds to AIDS Partnership, a public-private partnership initiated in 1992 to engage the U.S. private sector in HIV/AIDS prevention in the U.S. and abroad.

Mr. Barnes began his federal government experience at the Department of State in Washington, D.C. as a development officer for the U.S. Agency for International Development (USAID). After twelve years, serving primarily in sub-Saharan Africa as a human resource officer, Mr. Barnes joined the Division of HIV/AIDS Prevention at USAID. He began his HIV/AIDS prevention work overseeing the USAID HIV prevention program, which provided funding and technical assistance to 35 countries to develop and implement HIV prevention programs. He remained with that program for seven years, eventually becoming the Acting Chief of the Division.

Mr. Barnes holds a BA degree in French, an MA in African Area Studies and a PhD in International Development Education. He speaks both French and Swahili.

## African Ambassadorial Corps

In an initial effort to foster public-private partnership and to engage the public sector, Maty Niang Toure, HIV/AIDS Program Manager has met with several members of the African Ambassadorial Corp to ensure the support of African governments in the fight against HIV/AIDS. Ambassadors, Health Attachés and Chargé d'Affaires from the embassies of South Africa, Ivory Coast, Angola, Mozambique, Gabon, and Senegal have expressed their support in working with the public/private component of the Initiative.

## HIV/AIDS Initiative Advisory Group Formed

The CCA HIV/AIDS Initiative has recently formed an Advisory Group to provide ongoing advice and direction to the Council's newest Initiative.

Policy and program design and evaluation are fundamental components of the Initiative, and the Advisory Group will be critical in guiding the CCA in these and other essential aspects of this Council initiative.

The Advisory Group is co-chaired by Mr. Stephen Witort, Director of Federal Government Relations at 3M Public Affairs and Government Markets and Dr. Terra Thomas, President and CEO of Human Resources Development Institute, Inc. The Group has convened two meetings since its inception in March.

The primary goal of the CCA HIV/AIDS Initiative is to engage the private sector in HIV prevention care and treatment with the ultimate objective of reducing HIV infection rates and mitigating the impact of HIV/AIDS on the African continent. In order to accomplish this goal, at a minimum, the Advisory Group aims to guide the Initiative to:

1. Determine the prevalence of workplace policies and programs within CCA member companies using a survey developed by the Futures Group International.

2. Engage all CCA membership in the development and implementation of HIV work plans.
3. Establish evaluation criteria to determine the progress of the CCA Initiative.
4. Implement fundraising events to sustain the CCA Gates Foundation grant.

In addition to the co-chairs, the members to date are as follows: Tamela Hultman (AllAfrica.com); Susan Bornstein (Technoserve); Anna Pavlova (American Soybean Assoc.); Sasha Gainullin (Noel Group); Jeff Jordan (Futures Group); Percy Wilson (IRC Group) John Teeuws (The Washington Post); Nick Welch (Shell), Steven Phillips (Exxon Mobil)

We will also be inviting a select number of representatives from our partnerships and potentially other influential and experienced members of the private sector and HIV/AIDS community to join as ex-officio members. Should any CCA member have an interest in the Advisory Group, please contact Victor Barnes, Director of the HIV/AIDS Initiative, at [vbarnes@africacncl.org](mailto:vbarnes@africacncl.org)

The first meeting was held on April 30, 2004 and the Group will continue to meet every 6 weeks.

# PARTNERSHIPS

## Partnerships

The private sector has frequently displayed a commitment to address HIV/AIDS issues in the workplace. Information, technical assistance and funding to assist in these efforts are also available. However, these resources are not always easily accessible to the private sector.

In order to provide CCA members with the tools and strategies necessary to develop and implement effective HIV/AIDS workplace programs, the CCA HIV/AIDS Initiative strives to develop partnerships with technical assistance providers, international donor organizations and resource dissemination providers. The Initiative acts as a facilitator, linking private sector companies with these resources.

A recent example of that facilitation occurred between a CCA member representing the oil exploration and development sector and CCA HIV Initiative partners. The result of two days in Washington D.C. with senior corporate managers from our member's Africa office was the establishment of several key partnerships between the private sector member and appropriate donor, technical assistance and support partners. The member also benefited from two days of careful review, by key HIV/AIDS experts, of their strategic approach to HIV/AIDS prevention, care and treatment for their employees and associated communities.

The CCA HIV/AIDS Initiative facilitated this series of meetings, including the identification of key stakeholders and the arrangement for bringing strategic partners together. These partnerships will assist our member in expanding HIV/AIDS prevention, care and treatment programs into the community from which the company draws its workers and help to establish synergistic relationships with public sector programs.

## Technical Assistance Providers

There are many domestic and international organizations that provide technical support and guidance to the government, the community and the private sector as they work to develop and implement HIV/AIDS education programs, HIV workplace policies, Voluntary Counseling and Testing (VCT) centers and treatment facilities. These organizations work on the ground in Africa and in other developing countries and therefore have the experience, knowledge and tools to effectively develop these types of programs.

The CCA HIV/AIDS Initiative has formed several partnerships with technical assistance providers. CCA can assess a corporate member's technical assistance needs and then match that member with the organization that best fits those needs. The organization and the company then work together directly to accomplish the development of HIV/AIDS based programs in whatever capacity needed.

## International Donor Organizations

Some businesses have assessed their needs, identified a technical assistance provider that can help them fulfill their needs, but experience a lack of funding. To assist members in these situations, the HIV/AIDS Initiative has developed several partnerships with international donors including USAID, The Centers for Disease Control and Prevention (CDC) and the World Bank Multi-Country HIV/AIDS Program (MAP). These donor organizations have received funds from the President's Emergency Plan for AIDS Relief in Africa (PEPFAR) and have the funding available for government, community and private sector led initiatives in PEPFAR countries.

All too often, private sector companies don't realize they too can apply for funds through these agencies. CCA works to inform its members of these funding

opportunities that exist and assist members through the application process. Please see page 7 for funding opportunities through the MAP.

## Resource Dissemination Providers

The Initiative has also developed a special partnership with AllAfrica Global Media, a multi-media content service provider, systems technology developer and the largest electronic distributor of African news and information worldwide. Their website, AllAfrica.com, serves to disseminate news regarding Africa to the continent and to the rest of the world. In the near future, AllAfrica.com will launch HealthAfrica.org, a web page focused on health issues in Africa. CCA and AllAfrica.com/HealthAfrica.org have agreed to work together to provide enhanced computer-based access to an informational database for the provision of resource materials including policies templates, curricula and educational materials for HIV/AIDS workplace programs in Africa.

Other resources will include access to information and technical assistance regarding HIV/AIDS workplace policies and programs for Africa. CCA will be responsible for collecting the information to be posted on the website, and AllAfrica.com/HealthAfrica.org will be responsible for disseminating that information.

The ultimate goal of the CCA Gates Foundation grant is to ensure that every CCA member has HIV/AIDS workplace policies and programs in place. Providing CCA members direct access to technical assistance providers, donor agencies and other resources through the development of partnerships is a key step in accomplishing this goal.

## DaimlerChrysler's Response to HIV/AIDS in Africa

(Case Study taken from the World Economic Forum's Global Health Initiative case study library.)

DaimlerChrysler has the third largest automotive revenues worldwide. DaimlerChrysler is one of the world's largest automotive, transportation and services companies. It has manufacturing operations in 37 countries and distribution operations in more than 200 countries. In 2001, it employed 372,000 people, its revenues were US\$ 136 billion and its net income was US\$ 590 million.

DaimlerChrysler South Africa (DCSA) has three main plants that manufacture, market, import and export motor vehicles and automotive parts. East London is their largest facility with 79% of the workforce. They also provide financial and fleet management services. In 2001, DCSA had 4,500 employees and 3,000 suppliers and contractors working at these three facilities. Although not part of the workplace and community projects, DCSA indirectly impacts 2,900 other workers who are members of other DaimlerChrysler affiliates or employed as part of the dealer network. DCSA.s estimated 2001 revenues were US\$ 1.4 billion and its 2001 net income was US\$ 79 million.

### Business Case

DCSA established its workplace and community HIV/AIDS project in 2001 to address the increasing financial burden associated with HIV/AIDS. DCSA also decided to provide prevention, care, support and treatment services to employees, their dependants and the community as part of DCSA.s obligation to these stakeholders based on the principles of corporate social responsibility (CSR). This is also an extension of DaimlerChrysler's signing of the UN Global Compact on CSR.

\* DCSA established a program objective to reduce further spread of HIV infections and Sexually Transmitted Infections (STIs) and ensure access to treatment, care and support for people living with HIV/AIDS among the workforce of DCSA, their families and their immediate communities and to effectively manage the impact of HIV/AIDS on DCSA.

\* DCSA estimated a 2001 HIV prevalence of 9% in 2001. Further, DCSA had observed an increase in the proportion of employee deaths attributable to HIV/AIDS since 1997; although no increase in the death rate has been detected. In 2002, DCSA estimated that the average present value cost per HIV infection is US\$ 31,000. In the forecasted peak year for HIV/AIDS related expenditures, DCSA forecasted expenses equivalent to 4% of DCSA.s salaries.

\* In order to determine whether or not the project was effective, German Technical Cooperation (GTZ) and DCSA established project process and outcome indicators aligned with project objectives and interventions. DCSA.s 2002 HIV/AIDS project budget is US\$ 44 per employee per year or 0.5% of payroll

### Program Description

DCSA formed a partnership with labour, represented by the National Union of Metalworkers of South Africa, management and GTZ to prevent new infections, to provide care, support and treatment for HIV+ employees and dependants and to play an advocacy role regarding HIV/AIDS interventions at the workplace, in the community and at provincial and national levels.

\* DCSA first codified its HIV/AIDS workforce policies in 1996. The policy is updated annually in the first quarter of every year and the most recent version was written in April 2002. Each version is signed and approved

by the union and management.

\* Workplace prevention programs focus on behavior change through intensive employee and management education, utilization of a peer educator approach, services of nurse practitioner counselors, condom promotion and distribution, and Voluntary Counseling and Testing (VCT).

\* Every employee is required to belong to the Corporate Health Plan, which ensures funding for HIV/AIDS treatment for employees and dependants (Aid for AIDS (AFA) disease management program) including Highly Active Anti-Retroviral Treatment (HAART). Each business unit also provides wellness programmes, which can include general health promotion, nutritional support and counseling, Syndromic STI management, tuberculosis (TB) treatment through Directly Observed Therapy Short course (DOTS) and health status monitoring.

### Programme Evaluation

DCSA and GTZ regularly review project performance.

\* GTZ and DCSA are contractually obligated to submit regularly scheduled activity and outcome reports. The reports measure and analyse specific processes, outcomes and interventions dictated by the co-authored project strategy and operational plan documents.

\* Upon completion of the project, DCSA will conduct an HIV seroprevalence survey and a Knowledge, Attitude, Perceptions and Behaviour (KAPB) profile assessment.

DCSA and GTZ will continue to focus on project interventions dictated by the project operational plans but will also focus on community interventions, assessing the cost-benefit impact of prevention and treatment, and institutionalization of the project.

*DaimlerChrysler HIV/AIDS South Africa Case Study.* The World Economic Forum's Global Health Initiative. March 2004.

<<http://www.weforum.org/globalhealth>>

# CCA MEMBER PROFILE

## Chevron Texaco's Response to HIV/AIDS in Africa

*(Case Study taken from the World Economic Forum's Global Health Initiative case study library.)*

ChevronTexaco is a large, international, integrated oil company. ChevronTexaco, the second largest US-based integrated oil and gas company, engages in oil and gas exploration, production, refining, supply, transportation and marketing around the world, with operations in nearly 180 countries and territories. In 2001 ChevronTexaco's sales were \$104 billion and income was \$3.3 billion.

ChevronTexaco has upstream (extraction) operations in African countries including Angola, Cameroon, Chad, Democratic Republic of Congo, Republic of Congo, Equatorial Guinea, Namibia, and Nigeria. In 2001, the company directly employed more than 55,000 people worldwide.

Chevron Nigeria Limited (CNL) is 60% owned by the Nigerian Government and 40% owned by ChevronTexaco. CNL's upstream operations produce 517,000 barrels per day from 39 field operations and 6 shallow-water fields. CNL employs roughly 1,800 employees and 3,000 contractors (90% Nigerian nationals).

### Business Case

Through proposed interventions, CNL aims to reduce the risk of HIV to its employees, families and business. Although HIV prevalence among workers is less than 2.5%, they are at risk because of a higher prevalence in the community, their poor HIV knowledge, and high risk-taking behaviors.

\* In 2001, UNAIDS estimated Nigeria's HIV prevalence to be 5.8%. In 1999, HIV seroprevalence surveys conducted by the Federal Ministry of Health demonstrated that the prevalence in the communities where CNL workers live were 1-2% higher than the national average. Although CNL did not conduct a worker prevalence assessment, they estimate that their workforce HIV prevalence is <2.5%.

\* A knowledge, attitude, and practice (KAP) assessment of workers, and a Participatory Rural Rapid Assessment (PRRA) of community members and commercial sex workers (CSW) indicated that there is a high level of sexual networking amongst these groups.

\* Field-based oil workers are considered to be high risk because of their distance from their spouses, their comparatively high disposable incomes, as well as the single sex housing while on location, and the presence of sexual networking at these locations.

\* Although CNL did not conduct a formal economic impact assessment, it was determined that investing in the community, families and workers is a necessary and economical method to prevent significant costs associated with a larger scale HIV epidemic.

### Programme Description

CNL's HIV/AIDS programs focus mainly on prevention of the escalation of the epidemic by targeting employees, their families, the community and CSWs, as well as supporting and caring for HIV+ employees.

\* Chevron's Workplace AIDS Prevention Program (CWAPP) focuses on peer education, workplace events, condom distribution, manager and supervisor training, and awareness tools.

\* Community prevention programs focus on workshops for children of employees, joining HIV/AIDS awareness events and working with CSWs.

\* CNL offers Voluntary Confidential Counseling and Testing (VCCT) services to its employees; however, only 1% of its workforce took advantage of VCCT in 2001.

\* CNL provides support for HIV+ employees through a joint support agreement with government clinics and home based care. Antiretroviral drugs are used to prevent mother to child transmission (MTC) and for post-exposure prophylaxis (PEP).

\* Capacity building efforts focus on providing funding for the Nigerian Government to provide HIV/AIDS education in schools, and with the media to increase journalists' HIV/AIDS knowledge.

### Programme Evaluation

The programme has reached the majority of workers with its education and awareness activities, improved employee health seeking behaviour, increased stakeholder involvement and successfully prevented mother to child transmissions.

CNL will expand its programmes to ensure that it is able to meet the goals stated in its vision of minimizing increases in prevalence and treating HIV+ workers.

*ChevronTexaco HIV/AIDS Nigeria Case Study.* The World Economic Forum's Global Health Initiative. Sept. 2003. <<http://www.weforum.org/globalhealth>>

# FUNDING OPPORTUNITIES FOR PRIVATE SECTOR

## Private Sector Access to HIV/AIDS Work Related Funds through the World Bank Multi-Country HIV/AIDS Program (MAP)

Obtaining access to international donor organizations is a key step in leveraging potential funds. To this end, CCA has developed a partnership with the World Bank's Multi-Country AIDS Program (MAP) to provide CCA members with more direct access to important funding opportunities.

## The Multi-Country HIV/AIDS Program (MAP)

In September 2000, the Bank launched the Multi-Country HIV/AIDS Program (MAP) for Africa. The MAP addresses the obstacles faced by many sub-Saharan Africa countries working to develop a strategic response to HIV/AIDS by committing substantial International Development Association (IDA) resources and leveraging co-financing on a country-by-country basis through the International Partnership Against AIDS in Africa (IPAA).

MAP made an initial amount of US\$500 million in flexible and rapid funding available to African countries to assist in scaling up national HIV/AIDS efforts. The Bank also approved an additional US\$500 million in IDA financing in 2002 for the second stage of the Multi-Country HIV/AIDS Program (MAP) for Africa.

The funds are available to any African country (and organizations/businesses within that country) that meets simple eligibility criteria, including eligibility for IDA credits.

## MAP Objectives

The overall development objective of the MAP is to dramatically increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups (such as youth,

women of childbearing age, and other groups at high risk). The specific development objectives of each individual country project, as stated in the national strategic plans, provide the basis for this program and are agreed upon at the time of appraisal of the national projects.

## MAP and the Private Sector

Many companies are not aware they are eligible for MAP HIV/AIDS work related funds. However, a key feature of the MAP is direct support to community organizations, NGOs, and the private sector for local HIV/AIDS initiatives.

MAP funds are channeled through each country's National AIDS Commission (NAC). NAC is responsible for coordinating the implementation of the National HIV/AIDS Strategic Framework. The Framework seeks to reduce the transmission of HIV and other Sexually Transmitted Infections (STI) and improve the quality of life of people infected and affected by HIV/AIDS.

NAC recognizes that civil society – including private businesses, NGOs, local government, central ministries and communities – plays an important role in the fight against HIV/AIDS. To engage and support civil society partners, NAC has instituted a funding mechanism through which any private sector organization can apply for MAP funds. Eligibility criteria for private sector organizations are:

- \* Legal status allowing the institution to enter into contracts and carry out work
- \* A minimum of 18 months of existence in business
- \* A clear and efficient accounting system that can handle the funds requested
- \* Skilled staff to implement proposed activities
- \* Ability to mobilize human and material resources
- \* An organizational structure in place to support decision-making, implementation, follow-up and accountability.

## Services private sector companies propose to implement should be:

- \* Consistent with national priorities. These priorities are outlined in each country's National Strategic Framework and HIV/AIDS Operational plan, including the workplaces supported by the Global Fund for AIDS, Malaria and Tuberculosis (GFATM). (these documents are available from each country's NAC)
- \* Consistent with national technical guidelines and protocols.
- \* Consistent with community needs.

The CCA HIV/AIDS Initiative recognizes the funding opportunities presented by the MAP, and our team can assist CCA members in applying for these HIV/AIDS work related funds.

If your company is interested in pursuing this avenue of funding, please contact Elizabeth Ashbourne, Senior Coordinator, Private Sector Partnerships, World Bank AIDS Campaign Team for Africa (ACTAfrica) at [eashbourne@worldbank.org](mailto:eashbourne@worldbank.org); or Caroline Hope, HIV/AIDS Program Manager, CCA at [chope@afriacncl.org](mailto:chope@afriacncl.org)

## Countries Eligible for MAP Funding

MAP Projects in the following countries have been approved as of September 28, 2003:

Benin	Kenya
Burkina Faso	Madagascar
Burundi	Malawi
Cameroon	Mauritania
Cape Verde	Mozambique
Central African Republic	Niger
Eritrea	Nigeria
Ethiopia	Rwanda
The Gambia	Senegal
Ghana	Sierra Leone
Guinea	Tanzania
	Uganda
	Zambia

Country list taken from the MAP website: <http://www.worldbank.org/afri/aids/map.htm>

## **HIV/AIDS: Lessons from Botswana**

**Many problems including the stigma that surrounds HIV/AIDS have resulted in Botswana having one of the highest infection levels in the world.**

*(Article taken from the African Investor: The Botswana Issue, June 2004)*

Botswana has the highest level of HIV infection, measured at antenatal clinics, anywhere in the world. Although the rate dropped slightly from 38.5% in 2000, to 36.2% in 2001, and 35.4% in 2002, President Festus Mogae acknowledged that the seeming improvement is at least partly attributable to the rising death rate of a maturing epidemic.

Despite this, Botswana is seen as a hopeful case. Mogae has been at the forefront of his country's fight against the disease. Unlike the denial which paralysed much of Africa's leadership, Mogae realised, as he told the UN General Assembly in 2001, that the epidemic was "a crisis of the first magnitude". Botswana, he said, "was threatened with extinction".

The National AIDS Co-ordinating Agency, set up in 2000, is chaired by the President and, as with Uganda's President Yoweri Museveni, the fight against AIDS has become Mogae's personal crusade. At a one-day conference on 'Botswana's strategy to combat AIDS', held in Washington on 12<sup>th</sup> November 2003, US officials praised Mogae for his "clear and candid" vision, and for tackling the problem "effectively and honestly". US Senator Norm Coleman (Minnesota) praised Mogae, too, for publicly taking an HIV test, to demonstrate to his people that no-one must believe he or she is immune to HIV/AIDS.

The US, in turn, was committed to helping Botswana financially and in providing human capacity to deal with the epidemic. A major initiative, the African Comprehensive HIV/AIDS Partnerships (ACHAP), is a collaborative public/private partnership between Botswana's government, the pharmaceutical company, The Merck Company Foundation, and the Bill and Melinda Gates Foundation. The foundations have both pledged \$50 million in assistance over five years. Merck is also offering two ARV drugs at no cost. In another initiative, the Harvard AIDS Institute has developed a training programme for the country's healthcare workers, and opened a research laboratory in the capital, Gaborone. In June 2003, a \$9.7 million centre for AIDS-afflicted children, funded by Bristol-Myers Squibb and the Baylor College of Medicine in Texas, opened in Gaborone.

### **Denial getting in the way of behavioural change**

And yet, despite strong leadership, generous funding, and even some free drugs, the AIDS programme is struggling. The ACHAP goal of no new infections by 2016 seems impossibly difficult to attain. Despite very high profile safer-sex education initiatives, AIDS workers complain that behaviour has not changed. In his state of the nation address in November 2003, Mogae said: "We have spoken of the HIV/AIDS pandemic as a war that needs to be won. Yet in this war we remain our worst enemy: it is we alone, who through behaviour change, must achieve our victory."

Despite the ravages of the disease around them, probably 90% of the population do not know their HIV status. The disease is surrounded by denial. At funerals where there are routinely mentions of cause of death, the family will speak of tuberculosis, or the anger of ancestors. Suzette Heald of Brunel University in London, who did research on social

perceptions of the disease in Botswana, found that the views of government health education programmes, those of traditional healers, and of the separatist churches, with their prophet healers, were often in conflict. While the government programmes take a conventional Western biomedical, 'neutral' view of the disease, traditional healers might see AIDS as a 'new' version of 'old' Tswana diseases, brought on by breaking taboos, or linked to witchcraft; the prophet healers might see AIDS as a punishment sent by God for unnatural or sinful acts. Some of Heald's informants believed that the disease had been deliberately introduced by whites with genocidal intent. Bombarded with such conflicting theories, it is easy to see not only how the 'neutral' health message can be undermined, but how denial and stigmatization of the disease are reinforced.

### **Routine testing now available at health facilities.**

Late last year, the Boston Globe reported President Mogae as saying: "I'm very frustrated. We think because of the stigma attached to this sexually transmitted virus, and because some of our religious people have said this is a curse or those who have it are sinners, that people are afraid to get tested. One way of removing the stigma is making testing of HIV a routine thing."

A decision has since been made by President Mogae that all patients visiting health facilities should be routinely tested for HIV, unless they object. Although this strategy will undoubtedly meet with resistance from the human rights activists, he believes that unless the infected know their status they will not enroll for Botswana's free antiretroviral treatment programmes until it is too late - one factor that has meant the programmes have not grown as quickly as anticipated.

Of the 110,000 estimated to need ARVs, far less than the 19,000 it was believed would access treatment by the end of 2002 are receiving treatment, and it was

# COUNTRY PROFILE

hoped that an additional 20,000 would be admitted to treatment each year.

Not knowing one's HIV status, and the stigma that persists around the disease, partly explain why patients wait until they are very ill and require hospitalization before going on to ARVs. As a result, plans to treat HIV/AIDS with ARVs on an outpatient basis, involving four or five visits a year, must instead anticipate seeing patients a few times a month, sometimes needing hospitalisation. Staff and facilities remain overstretched - something earlier recourse to ARV treatment could have alleviated.

Scarcity of personnel and infrastructure is a major constraint on Botswana's ARV programme. Even mother-to-child-transmission prevention is hampered by a shortage of midwives to counsel pregnant women. As a result only between 11% and 20% of women were enrolled in these programmes in 2002, although Mogae says that the figure has improved substantially recently.

Botswana does not have a medical school; 95% of its doctors are foreigners. To add to its woes, Botswana, like South Africa, loses its trained medical personnel to richer countries that can offer higher salaries and better working conditions.

The problem is compounded by an internal 'brain drain'. Mogae told the Washington conference that the shortage of doctors, nurses, pharmacists and other health workers was in part due to the way in which international organizations and NGOs, which come to help Botswana, raid the country's scarce professional resources. Offered better pay and benefits, they leave the public health system, forcing Botswana to recruit outside from India and Cuba, but also from other African countries. "If they let us steal them, we will," he said, "because our problem is worse."

Effective ARV treatment also requires a massive upgrade of infrastructure - not just clinic buildings and laboratories, but systems, preferably computerised, to track patients and keep medical staff in touch with information sources, and secure drug warehouses and distribution systems. Slow delivery on this front has also impeded the expansion of ARV programmes.

## 'Learn as we go policy' gets the ball rolling

In an article in the Financial Mail on 4th July 2003, Dr. Donald de Korte, project leader of ACHAP, and Dr. Ernest Darkoh, operations manager for ARV therapy in Botswana's ministry of health, set out some of the lessons Botswana had learned since starting its ARV programme in January 2001.

While the problems are 'daunting', they believe countries should not wait until all the components are in place before starting such a programme; they had "agreed upfront that we would 'learn as we go' because the goal was to save lives". They found, too, that "strong political will from the highest level of government, in conjunction with public-private partnerships such as ACHAP, is essential."

Interwoven with this should be other systems such as "leaner community-based models" which can ensure successful and sustainable service delivery.

At a World AIDS Day gathering in Gaborone, UNAIDS's director Peter Piot warned that Botswana's prevention efforts need to be "scaled up dramatically if we want to keep future generations AIDS-free".

Botswana's infection levels show no real sign of declining, and prevention is undoubtedly the first prize in the war on AIDS. Providing ARVs cannot be seen as a substitute for this, but it can alleviate the impact on those already infected. As Mogae points out, this cannot happen unless they come

forward for testing - if they do not, he says, "we have only ourselves to blame for our suffering"

Source:

Omega Investment Research. "HIV/AIDS: Lessons from Botswana." Africa Investor: The Botswana Issue. June 2004. [www.omegainvest.co.za](http://www.omegainvest.co.za)

## Botswana in Brief:

The population of Botswana is around 1.6m, giving the country an overall population density of 2.7 persons per sq km (7.1 per sq mi). The majority of the population is concentrated in the eastern part of the country, and 50 percent live in rural areas. Many live in small villages surrounded by agricultural land.

The population growth rate in 2002 was 0.2 percent annually. Gaborone, the main business center, has a population (1999) of 202,680. Other business centers are Francistown (97,050), Selebi-Pikwe (47,868), Molepolole (45,811), Kanye (36,189), and Serowe (30,706).

Botswana received its name from the country's principal ethnic group, the Tswana. Representatives of several other peoples are also found, including a small number of San (Bushmen), who have inhabited the region for many centuries.

About one-half of the population practice traditional African religions; most of the remainder are Christians. English is the official language, but most of the people speak Setswana, the language of the Tswana, which belongs to the Sotho subgroup of Bantu languages.

In 2001 Botswana's adult literacy rate neared 88.6 percent.

Most primary schools are supervised by the district councils and township authorities and are financed from local government revenues assisted by grants-in-aid from the central government.

Virtually all primary school-aged children were enrolled in school in 1998, while 77 percent of secondary schoolaged children were enrolled. Specialized education was provided by teacher training schools and vocational training schools.

# EVENTS

## Coca-Cola Ebony Festival

The Coca-Cola Ebony Festival to be held in Dakar, Senegal will raise HIV/AIDS awareness and celebrate the hope, spirit and cultures of the African people. The three-day festival, which takes place June 3-6, 2004 on Goree Island, will launch a global movement calling upon Africans and the rest of the world to actively participate in renewing their commitment to the continent and her future and in particular helping Africa in its efforts to combat HIV/AIDS. The festival maintains extensive media partnerships that will promote the event to millions of viewers worldwide. Television and radio partners include Canal France International, which will broadcast the festival live to over 40 African national television stations, in addition to coverage through TV5, Trace TV & Magazine, MTV Base, Radio France International, BET Jazz and others.

### The Private Sector Mobilization Sub-regional Forum on HIV/AIDS (June 14-18 Blantyre, Malawi)

Currently, Caroline Hope is working with the World Bank's Multi-Country AIDS Program (MAP) to assist in the organization of the Private Sector Sub-regional Forum on HIV/AIDS to be held in Blantyre, Malawi June 14-18.

The Malawi Forum is the third in a series of four conferences designed to develop innovative partnerships between the public and private sectors in the fight against HIV/AIDS. The series is jointly sponsored by the World Bank, UNAIDS and the World Economic Forum.

The Forum will bring together leaders of business coalitions and associations, national AIDS commissions, and other public and private sector policy makers. It will provide the participants with the tools to support and implement action plans and work programs and to engage the private sector in the national AIDS agendas of participating countries.

The key objectives of the meeting are to:

- Develop strategies and identify mechanisms and tools that can be used to maximize effective private sector engagement in the fight against the epidemic.
- Discuss the role of national business coalitions in the areas of HIV/AIDS prevention, care and treatment.
- Identify the components of a comprehensive HIV/AIDS workplace policy.
- Discuss collaboration between the different sectors and locate financial and technical resources available to the private sector.

Representatives from Malawi, Namibia, South Africa, Mozambique, Ethiopia, Ghana, Nigeria, Uganda, Mauritania and Kenya are expected to participate.

For more information about this Forum, or the fourth Private Sector Mobilization Regional Forum, to take place in October, 2004, please contact Caroline Hope, HIV/AIDS Program Manager, CCA at [chope@africacncl.org](mailto:chope@africacncl.org).

The event is sponsored by Coca-Cola and UNAIDS, and is hoping to engage African youth in the promotion of HIV/AIDS education and awareness in Africa. The promotion of HIV/AIDS prevention among African youth is critical, as young people between the ages of 15-24 account for 42 percent of new HIV infections and represent almost one third of the people living with HIV/AIDS worldwide. Every day, 7,000 young people under the age of 25 contract HIV (UNAIDS, 2001). In Africa, young people are disproportionately impacted by HIV/AIDS considering the fact that 55% of the population is under age 18 (ILO, 2001).

The Coca Cola Ebony Festival will promote HIV/AIDS awareness among youth through the concept of Edu-Entertainment. The entertainment industry can play a very important role in the fight against HIV/AIDS given its powerful influence on society in general and young people in particular. Tapping into its potential can help raise HIV/AIDS awareness. The festival will feature concerts, including performances by renowned African and international artists such as Jimmy Cliff; Angelique Kidjo; Youssou N'Dour; Miriam Makeba; and MC Solaar. Stevie Wonder and Tracy Chapman are also anticipated to perform. Senegal was selected as the venue for this event because it is considered a success story in Africa in the fight against HIV/AIDS. Senegal is the only sub-Saharan country to contain the prevalence rates below 2% thanks to early government intervention and strong social marketing. Therefore, it is believed to be a model response that can be replicated throughout the sub-continent.

The Coca Cola Company, a member of the Corporate Council on Africa, is well recognized in Africa for its comprehensive HIV/AIDS programs including community outreach. The company uses its extensive resources to deliver HIV/AIDS education, prevention and treatment programs in Africa. By sponsoring this event, Coca Cola would also like to encourage businesses to take leadership positions in the HIV/AIDS struggle. As the continent's largest foreign consumer-products investor, Coca Cola's beverages are marketed and distributed by bottling partners in over 170 plants serving 850 million consumers in all 56 countries and territories. The Coca-Cola Company, with its 40 bottling partners, is the continent's largest private sector employer, with nearly 60,000 African employees. Over the last five years alone, more than \$US500 million has been invested in Africa, much of this going into new plants, updated equipment and advanced employee training. Coca Cola is also a supporter of cultural diversity. The Coca-Cola Ebony Festival provides a great opportunity for Coca-Cola to not only celebrate the richness of African culture but to also generate significant support from the public and private sector in the battle against the HIV/AIDS pandemic in Africa. According to Mr. Alex Cummings, President of Coca-Cola Africa, "Coca-Cola has been supporting music, culture and sports alongside a wide range of community-based activities, spearheaded by our Employee and Bottler HIV/AIDS Programs, across the African Continent for many years. The Coca-Cola Ebony Festival epitomizes these activities and the values which we believe are fundamental to Africa's renaissance."

### The XV International AIDS Conference Bangkok, Thailand

The XV International AIDS Conference links community and science to galvanize the world's response to HIV/AIDS through increased commitment, leadership and accountability.

The theme reflects the need for all groups, including scientists, community workers and leaders, from all levels, from the field, the public and private sectors, to have access to all resources developed after 20 years of living with HIV/AIDS.

For more information, please go to: <http://www.aids2004.org/>

# RESOURCES

**In each issue of the HIV/AIDS Initiative Newsletter, we will feature a list of resources regarding HIV/AIDS prevention and treatment in Africa and the role of the private sector in the fight against the pandemic. Please contact Maty Niang-Toure or Caroline Hope at 202-835-1115, or use the web site addresses listed below, to obtain copies of these documents.**

Bollinger, Lori, Katharine Cooper-Arnold, and John Stover. "Where are the Gaps? The Effects of HIV-prevention Interventions on Behavioral Change." *Studies in Family Planning* 35(1) March 2004. 27-38.

Feeley, Rich, Paul Bukuluki and Dr. Peter Cowley. "The Role of the Private Sector in Preventing and Treating HIV/AIDS in Uganda: An Assessment of Current Activities and the Outlook for Future Action." ARCH Project: USAID. March 2004.

Office of the United States Global AIDS Coordinator. The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy. 2004.

The World Bank. National AIDS Commission Guidelines for Responding to HIV/AIDS: Guidelines for the Private Sector. July 2003. [http://www.worldbank.org/afr/aids/map/ps\\_manual.pdf](http://www.worldbank.org/afr/aids/map/ps_manual.pdf)