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ブリティッシュ・カウンシルの人口/エイズ分野での取り組みについて

—The Activities of the British Council in the Fields of Population and AIDS/HIV—

平成7年11月

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「国総研セミナー」とは・・・・・

国総研セミナーとは国際協力事業団国際協力総合研修所において行っているセミナーの略称で、国内外の有識者、援助関係者により、わが国の国際協力にかかわる関係者を対象に開発援助の現状、課題、展望等の情報を提供することを目的としています。

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国総研セミナー

テ ー マ：ブリティッシュ・カウンシルの人口
／エイズ分野での取り組みについて
(The Activities of the British Council in the Fields of Population and AIDS/HIV)

日　　時：平成７年１１月２９日(水)　１４：００～１６：００

場　　所：国際協力事業団本部(新宿三井ビル)５０階　５０１～２会議室

講　　師：Dr. Douglas J. Buchanan
Lead Health Consultant,
Consultancy Group Professional Services, The British Council, U.K.

講師略歴：

1961-66	University of Edinburgh	MB ChB
1969 (3months)		
	University of Liverpool	DTM&H
1969	Royal College of Obstetricians & Gynaecologists	DRCOG
1974	Royal College of Surgeons Edinburgh	FRCS
1975	Royal College of Surgeons England	FRCS
1990-	The British Council	

要　　約

1. ブリティッシュ・カウンシル（British Council 以下 B.C.）は1934年に設立されたRoyal Charter Bodyであり、設立以後1940、50年代を通じ、世界の多くの国々において英国との文化交流の中心的役割を果たしてきた。
   現在では協会の果たす役割・機能も多様化し、次の3つに大別されている。
   ア．文化交流
   イ．政府開発事業（委託）
   ウ．英語教育に代表される企業活動

2. 政府開発事業については、保健・教育等の分野におけるプロジェクトの実施と英国内における研修事業の実施の2つが上げられる。いずれも英国海外開発庁（ODA）の委託事業が多いが、最近ではEC、世界銀行、アジア開発銀行などからの委託による案件実施も行っている。

3. B.C.が開発事業案件を委託により取り組むことについては、NGOとの連携実施や小規模なイノベーションの実施など、その活動内容に流動性があり、きめ細かい対応がより容易にできることが上げられる。
   特に今般取り上げたHIV/AIDSの予防対策については、協力の対象となる国の人々の第一の医療機関へのアクセスが必ずしも公共の医療機関ではなく私立の医療機関である場合が多い国もあり、その場合の対応については、政府間の協力実施がより困難であることも、B.C.が開発事業を実施することの意義として上げられる。

4. B.C.の当該分野における協力で特徴的なのは、高度な医療技術／機器等の投入する多額の資金を必要とするものではなく、特にエイズ予防については人々への啓蒙／教育を拡大していくことに焦点がおかれていることである。また、個人主義の欧米諸国と、例えば家族単位での意思決定を重要視するアフリカとの文化的事情の違いを勘案したカウンセラーの育成を、協力対象国のしかるべき実施機関を通じ、現地での活動の持続性を維持することが重要視されている。

5. 以下に実際の活動につき事例を2件紹介

ア．タンザニアの家族保健プロジェクト

プロジェクトサイト：MBEYA区（人口1万人）、およびその近隣の4区域

実施目的：人口増加率が3.2%と高く、一方避妊実施率は5.4%と低い同地域の住民に避妊及び性感染その他マラリアなど疾病に関する知識を普及し、バーススペーシングによる家族計画の実施を促進し、STDおよびマラリアの発病を減少させる総合的な家族保健プロジェクトとする。

実施内容：国レベルでの保健サービス行政の向上と、地域の私立医療機関やNGOの能力向上を通じた区レベルでのReproductive Healthサービスの質的向上を図る。

英国側のプロジェクト参加機関

－ 組織内容（プロジェクトにおける担当事業）

Marie Stopes International

－ 避妊具の社会マーケティングを中心とする家族計画プロジェクト実施を活動の中心とするNGO（家族計画の実施促進）

Coopers & Lybrand

－ 国際会計および経営コンサルタント会社（保健サービス行政の改善）

Institute of Child Health

－ 児童保健研究所（母子保健の実施）

イ．インド、西ベンガルのSexual Healthプロジェクト

プロジェクトサイト：西ベンガル州全域

実施目的：インド国政府のIndian National AIDS Control Programの一環として、対象地域住民のSexual Healthを改善し、HIV感染の拡大を減少させエイズによる社会経済上の影響を軽減することを目的とする。

活動内容：具体的には、プロジェクトの協力機関であるNGOのスタッフに対する技術支援にかかわる研修を提供、政府の保健政策／財政部門担当者間のネットワーク形成、

80人余の地域の保健婦と保健教育者に対するSexual Healthに対する理解の促進とサービス提供の改善を施すこと等、数々の活動を通じ、STD患者あるいは感染リスクの高い人々のSexual Healthサービスへのアクセスを増加させる。

特　　徴：インドにおけるNGOの地域に果たす役割を重視し、50～70に及ぶNGOの参加を集っている。

The Activities of the British Council in the Fields of Population and AIDS/HIV

Dr. Douglas J. Buchanan
Lead Health Consultant
Consultancy Group Professional Services
The British Council, UK

Moderator: Welcome to the IFIC seminar. The seminar today is going to be about the activity of the British Council in the field of population and HIV/ AIDS. We have here today with us Dr. Douglas James Buchanan from the British Council. So far as I'm concerned, I think this is our second chance to have somebody from the British Council to explain to us and show us some of their activities in the field of development cooperation. We remember last year, we had Dr. Neil Kemp, and I heard that he is the director of the Indonesian Office of the British Council now. He gave us some lecture about the British Council's activity in the field of human resources development, which many of us found it very interesting and informative in many ways. And I heard that Dr. Kemp has also been giving us some cooperation for today's Dr. Buchanan's lecture here, too.

Dr. Buchanan has been engaged in the activities with the British Council since 1986. I think he started there as the medical advisor, and he's now the lead health and population consultant. He has also been having long experience in Zambia, altogether about 15 years. Today, I have asked Dr. Buchanan to give us the lecture in this title, and it's going to cover a whole range of activities in this field.

First he would give us some information about the British Council itself, and then coming to the British Council's activities and works with ODA, that's the Overseas Development Administration of U.K., grant funding. The focus of the lecture will be on the population and HIV/AIDS related cooperation. And then, finally, the explanation will be about the activities through management of ODA projects, which will be picked up from Tanzania and West Bengal, India.

We have one hour and 15 minutes lecture from Dr. Buchanan followed

by 45 minutes of question and answer and discussion session. I would very much like all of you to feel very free to ask any questions to Dr. Buchanan, and I hope he will be a very generous person.

Dr. Buchanan: Thank you very much. First of all, I should say it's a great honor to be invited to speak to you here at JICA. This is my second visit to Japan. I do hope you will ask questions. I know that Japanese people are very polite, but if you don't understand something as I'm going along, please stop me and say you don't understand, and I'll be very happy. I am not a professional lecturer. I am not a teacher. I am a practical person, as I will now explain, and I have no problem at all about being stopped at any time.

Just before going into the theme of human resource development and what the British Council does, I would like to tell you a little about my own background in the field of development so that you will understand my credentials for speaking to you.

I first became interested in development as a medical student in Edinburgh, Scotland in the early 1960s. And as a result of that interest, prepared myself to go abroad with what was then our Ministry of Overseas Development. They, in fact, sent me to Zambia late in 1969, where I first worked for the government as a medical officer, mostly in surgery with a little primary care. I returned to Britain and undertook further surgical training and went back to Zambia in 1975 as a surgeon with a mining company, which was a large organization with over 60,000 employees and 2,000 health staff. I worked in the mining company firstly as a surgeon and then as a chief medical officer, which included responsibilities for public health. And at one stage, I had to implement health for all in my district, which meant training, traditional birth attendants, and community health workers to achieve the objectives of the Alma Ata Declaration, with which I am sure you are familiar.

I returned to the United Kingdom and joined the British Council as a health advisor. We used old fashion terminology in those days. In fact, I was called a medical advisor. Now we have more broad mind, so now I am a health person. I've been with the Council for nearly 10 years. The work I do in the Council covers both cultural relations and development. And I will

go back to that a little bit later to explain the way we in Britain draw a distinction between activities which are cultural relations and activities which are developmental. They are not always the same thing, and I wonder if this is an area where we might not discuss later at the discussion period because I think you might do things a little differently in Japan, and I would like to learn about that.

My work in the British Council is training advice, primarily for the Overseas Development Administration's technical cooperation training program, finding the right places in Britain for the students who come, about four or five hundred a year in the field of health. Myself and my colleagues are responsible for finding the right places. I give advice on development activity to British Council directors abroad, and I will expand on that part of my work later. I and my colleagues carry out consultancy work for development agencies, particularly the Overseas Development Administration but also the European Commission and the World Bank. For example, this year I lead a team of four consultants doing some work for the European Commission to write a project proposal to improve medical education in Angola. A pretty tough job. As you probably know, Angola has had a civil war for a very long time, and things are in a bad way. But we hope that our projects will be acceptable and will be implemented.

So you can see that my experience is practical in the field of development. I'm not a theoretician of development. So you must forgive me for any lack of academic rigor in what I will present today.

Now, what is the British Council? Forgive me if you already know this, but the British Council is what we call a Royal Charter body. It's a body, not a government department. It's a body run by a board of governors in a similar way to the BBC.. But nonetheless, because the government contributes quite a lot of our funding, and I will demonstrate that to you shortly, both the foreign and commonwealth office and the Overseas Development Administration are represented on our board of governors and influence the Council policy. But they do not influence directly the day to day activities of the British Council.

The Council was established in 1934 with a grant of 5,000 pounds. It was a big beginning. The objective was to put the case for the British way of life and government at a time when alternative philosophies of a more authoritarian nature were gaining ground in Europe. The Council rapidly expanded in the 1940s and 50s to become a major cultural relations organization with representatives in many countries. And I learned today that we opened up in Japan in 1953 with an office in Tokyo and Kyoto in 1954.

So we've been in Japan for a long time as a cultural relations organization. More recently, the Council, which developed a very wide range of activities, has been repositioned. The reason for this was that, starting as a cultural relations organization, we developed three areas of activity: cultural relations, development, and what we now call enterprises. At one time, these were all mixed together, and it didn't really matter. But then, the people at the Foreign Office and the Overseas Development Administration demanded more transparency about how we were spending their money. So the Council was repositioned into three streams of activity: a cultural relation's stream, a development stream, and the enterprises. At one time, we called them three businesses, but then we decided that wasn't a very good idea. So that's roughly now how we divide up our work. And this is important so we can demonstrate to the Foreign Office and to the ODA that we are spending their money according to their purposes, and the enterprises fund themselves. And I will expand on that just a little now.

(JOICFP): What do you mean by enterprises?

Dr. Buchanan: Enterprises are parts of the Council which are financially self-supporting, primarily English language teaching, which we do in Tokyo, Osaka, Kyoto, and I think it would be fair to say that the British Council is the world market leader in English language teaching. We have 1,500 teachers around the world, teaching English. The second is examinations. Many countries value British qualifications, and we set a large number of examinations overseas. And the third is a program of international seminars, primarily run in the United Kingdom.

Now the budget. The British Council budget has grown from 5,000

pounds a year in 1934 to be somewhat over 400 million pounds now; 90 million from the foreign and commonwealth office, 30 million from ODA, and 70 million from our enterprises budget. The balance is money we get for managing programs for agencies, business sponsorship, and other minor sources. For example, under the agency work, we manage the technical cooperation training program for ODA, which is 8,000 new students every year.

Another way to express the budget is to look at what actually happens. So last year, 33% of our budget came from government grants, 27% was revenue from our activities such as English language teaching, 22% was working for ODA, and 13% from other agencies, and a small 5% from the foreign and commonwealth office for managing their scholarship program.

Another way of putting it is in the form of activities: 46% on exchange of people, 18% on English language, 18% on science and education, 13% on libraries, and only 5% on arts, which I think which is perhaps, surprising, because many people think of the British Council as an organization which puts on exhibitions and cultural events. But in fact, it's a relatively small part of our spending.

A few more statistics. 1,250 staff in the United Kingdom, half of them in Manchester where I work with the health team, 5,000 staff overseas, most of whom are nationals of the country in which we operate. We work in 109 countries, 228 cities. We run 1,400 arts events overseas, brought 1,800 specialists to seminars in Britain, lent 9 million books, looked after 18,000 students, taught 846,000 classroom hours, and ran 320,000 examinations.

I said before that there were three activity streams: cultural relations, development, and enterprises. If we deal with the development side first, the development work of the Council is organized by a part of the Council called Development and Training Services. And there are two primary areas of activity, which are management of development projects, and management of training. Both of these areas now, the work comes to us largely by competitive tender. We are not given this work as our right. We have to go into the market and compete with other organizations to manage this work. We've been very successful in training management because we actually manage 97% of

ODA's training. Our competitor manages 3%. But project management is a much tougher business, and we think we are doing well if we win about one-third of the projects to which we bid.

The enterprises are English language teaching, examinations and international seminars. I brought a few brochures here which you are welcome to look at afterwards to give an example of the types of seminars we run. I won't talk about enterprises any more.

The third area of work is the cultural relations work. This is what we call the Grant-in-Aid, the work we do for the Foreign Office with their 90 million pound grant. We are divided into 10 world regional directorates, so we divide the world into 10 groups, each with a regional director. The regional directors are based in London except for those looking after Africa, who are based in Africa. We have offices in 109 countries providing various services. In addition, we have a group of common services, the professional services, of which I am a part, a network of staff in the United Kingdom whose primary job is to look after students who come to Britain, a country services group who provides services for arranging programs for visitors coming to Britain, and of course, the usual; personnel, finance, corporate relations, information technology groups.

The development activities of the Council are not found in all our 109 offices. Our Overseas Development Administration has a policy to focus its development activity on development which will help the poorest people in the world. So ODA's activities are focused on the poorest countries. At the moment, there's quite a long list of countries in which ODA is active, but they're about to reduce that and focussing more strongly on the poorest countries. So if we look at health, for example, ODA policy in health is based on activities which will improve women's reproductive health. That takes in safe motherhood, population, and sexually transmitted diseases. [interruption]

We were reviewing ODA's policy for health. The first thing is women's reproductive health as a priority. The second is reform of health services to make them more effective, that's improved health management; utilization of resources. The third area to which ODA gives priority in health is major

infectious diseases such as malaria, tuberculosis, and HIV/AIDS. So you will see that the two areas you've asked me to talk about today, which is HIV/AIDS and population, both feature in ODA's priorities.

The way the Council grants are divided between our overseas offices, there are offices in wealthy countries like Japan, where all of our work is cultural relations. For obvious reasons ODA doesn't spend any money in Japan. Then, there are a minority of countries where the funding of the British Council comes both from the Foreign office and from the ODA. Depending on the position of the country in the poverty league, a varying proportion of the funding of the Council comes from ODA and the Foreign Office. I can give you an example. In a poor country like Bangladesh, 75% of our core grant is for developmental purposes, and 25% for cultural relations. In less poor countries, it will be 50-50, and in the countries that are moving out of development needs, only a minority of the money we get comes from ODA.

So if we can now come on to the next overhead which is about our activities in development. We've now left behind cultural relations, we've left behind enterprises. We're going to focus from now on on development.

Our development activities are project management for the Overseas Development Administration and international agencies, such as the European Commission, World Bank, Asian Development Bank, and program management. We manage the technical cooperation training program for the ODA. We manage European Union fellowships where these are held in the United Kingdom. We manage fellowships for the International Atomic Energy Agency. And for some of the European donor countries such as Denmark, Sweden, Norway actually ask the Council to manage some of their training programs in Britain where they don't have the resources in their own countries. And we also, as a development activity, and one which I'm going to focus on in a little while, we utilize the ODA grant to promote development.

So what do we do with the ODA grant, Overseas Development Administration grant? What we do is, inevitably it has to cover the overheads of our offices. You actually have to pay to have a presence on the ground. You have to rent a building and pay for staff. A lot of the money is spent

on library and information services, and on development activities, and I'll be shortly giving you examples.

Library and information activities. We make sure in ODA priority countries, that the libraries maintain materials which are of developmental importance. So the professional advisors in the Council give advice to our library staff on the type of materials that should be kept in our offices overseas which are developmentally important.

As part of an information services, we also produce some publications. One of these is development priority guidelines, and I've got two copies here which I can leave with you. These are guidelines for our directors overseas on what are the priorities of the ODA, and how they might act to promote ODA's priorities using their grant. This particular booklet covers education and health.

We also produce a publication called Development Update. I've got quite a number of copies of the latest edition of Development Update. This has articles on current issues in development. This, the sixth edition which we produced in September, has got a lot of interesting things. It's got an article, for example, which will amplify, give more information about what I'm going to talk about in relation to work on AIDS and HIV in West Bengal. There's an article by the lady who's taking the lead for the British Council. I'll leave copies with you as well.

The British Council also publishes a journal called The British Medical Bulletin. Amazingly, we started publishing this in 1943 when you'd have thought we had other things on our minds. It's been going for more than 50 years now. This particular issue I brought with me is on contraception. It was produced in 1993; state-of-the-art of contraception in 1993. The Overseas Development Administration bought a thousand copies of this from the Council. We had to print extra for them. And we distributed it to people concerned with population work in ODA priority countries on their behalf. This is the very latest issue of The British Medical Bulletin, called rationing health care, a slightly provocative title. But I think we are all familiar with the fact that no country can provide all the health services that are technically possible. And

this particular issue of the journal which came out last month, explores the issues in rationing health care.

Just before we go little further, I'd like to just advise you about my team, the health consultancy team, in the Council. We are a team of two doctors, of which I am one, a nurse, and a health scientist based in one of the British Council's headquarter's office, the office in the United Kingdom in Manchester. We've all had practical development experience. As you've already heard I worked in Zambia for 15 years. The other doctor who's working with us, Sarah Davis, worked in Zambia as a district medical officer. She got her masters degree in health planning and financing, and then she worked in Fiji as a health planner in the Ministry of Health in Fiji. Our nursing advisor, Pat Pettigrew, worked in Brazil. She's worked in the Sudan, in Yemen, in Papua New Guinea, and she's recently spent a period as a manager of our nursing education project in Bangladesh. Our health scientist, David Britt, has got a Ph.D. in an aspect of parasitology. He's worked for the Overseas Development Administration as a technical cooperation officer in Nigeria, and he taught health sciences in Kuwait until he was rudely interrupted by Saddam Hussein.

What do we do? Well, as I've already said, we provide advice on training programs for people coming to Britain about, 400 to 500 people every year. We give advice on the health of the 8,000 students who come to Britain every year. Inevitably, the health screening shows up problems, and some of the students develop health problems which need assistance while they are in Britain. We provide consultancy services. We assist our development and training service colleagues in writing the technical parts of projects when we are bidding to win projects from ODA and other agencies. And we're involved in project management. For example, at the moment, we recently successfully bid to manage a World Bank project to provide consultancy services to the Ministry of Health in Malaysia, and I'm the technical manager of that project, and responsible, for making sure that the Ministry of Health in Malaysia gets value for money from the consultants. So I have to go to Malaysia once or twice a year for that work.

I think it's always useful to remind ourselves that health services are not necessarily the most important thing when we're thinking about health in poor countries. This is a recent press release by WHO, "Poverty is the world's leading cause of death". I think it's very important to remind ourselves. If I look at the history of my own country, United Kingdom, it's quite clear that from a time in the middle of the last century when cholera and typhoid and typhus and tuberculosis were rampant in our country, things improved greatly even before medical services were improved. The health of the British people, and I don't believe Japan was any different, really improved because of sanitary reforms, because of clean water, sanitation, better housing. Those of us who are working in the field of health should keep reminding ourselves that if countries get their economics better, if people have jobs, etc., that's when their health will best improve. What we are doing in health is not the greatest single thing that can be done, in my view, to improve people's health. It's their economies.

Some information about JICA was sent to me prior to my departure for Tokyo. And I was very interested to read that JICA also subscribes to the basic needs approach to health, which was first described by Dudley Sears in the 1960s. I think that's a very good starting point and I agree. I was also pleased to see that the JICA's view is that development cooperation is based on the concepts of humanitarian and moral obligations, and the recognition of the independence among nations. I think these are concepts which should be very much shared by British people working in health.

Now, you could very well ask the question, why does ODA give money to the British Council? Why don't they just spend it themselves? And in fact, ODA themselves ask that question, and they ask it regularly, particularly now. As you probably know in Britain we're getting close to an election. The government wants to give tax cuts to the people so they can be re-elected, so they want to cut government expenditure. And they've just announced that they are cutting over the next three years, ODA's budget by 12%. So ODA is going to be asking even more, why do we give money to the British Council?

Well, our answer goes like this. We're not a government organization. We can operate in a way that the ODA cannot operate. We can act quickly. We can work with small NGOs. We can take risks. We can innovate, but on a small scale. And we're much more nimble, much more agile in trying out new ideas than it is possible for a government agency to be. We believe that it's in this way that we add value to ODA's development activities as well as providing library and information services. Our expectation is that successful activities will gain the support from ODA and other agencies to work on a larger scale. The example I will give of our work in AIDS and HIV in West Bengal, I think, will very well illustrate that fact.

So I'm going to give you some examples of work we have done using the ODA grants in the field of HIV and AIDS. The first example is AIDS counselor training in Zimbabwe. You are all aware that Africa was the first developing area where AIDS became a problem. And in fact, I was working in Zambia when the AIDS epidemic started. I was even doing the postmortems in my hospital on people who died of AIDS when I didn't even know what AIDS was. Fortunately, I survived that.

Now, you are also aware, I'm sure, because you're development people, the orthodox medical response to AIDS is extremely expensive. And very poor countries with poor health resources cannot deal with AIDS by an orthodox, highly expensive technical medical model. Their response to AIDS has to be in the community, trying to prevent the disease by education, and trying to deal with the problems of people who are HIV positive, people who are looking after people with AIDS and their families. And one of their responses is to train the local people to have counselling skills to give advice to people about AIDS and what it means for them.

We started to get a lot of requests for training for AIDS counseling, people wanting to come to Britain. But counseling is a very culturally dependent activity. And particularly, there is a difference between Africa and Britain. In Britain, people are accustomed to work or operate as individuals and make their own decisions for themselves. In Africa, it's not like that. Important decisions are family decisions. An individual does not make an important

decision by his or herself. And we felt that the sort of counseling training that would be available in Britain was culturally inappropriate. So what we did was, we found through our contacts, an organization in Zimbabwe that had the resources to set up a six-week counseling training which we provided on a regional basis. We used British Council money to help them develop the materials, and to pay for the first group of students to go from Zimbabwe and neighboring countries for this counselor training in Zimbabwe. This is something that the Council could do quickly. It didn't need a government agreement, with all of the time that that takes. We just made an agreement with the organization in Zimbabwe. We told our offices in the other countries in the region, look, we got this, now send the students, they send the students using their grant money. The course was successful, it was culturally appropriate, and it now carries on without any need for our funding. But it's a regional resource which was started by modest amounts of money which we were able to put in.

Another example is sexually transmitted disease training in Thailand. I'm sure you're also aware that Thailand was an area where HIV and AIDS became a problem. We looked into this. By this time we were getting more interested and involved in the AIDS scene. And what we realized was that commercial sex workers in Thailand were treated by the government health services and relatively well provided for. The government health services were aware of the need to improve STD services. But what we also found was, the clients of the commercial sex workers were treated by private doctors. My experience is that development agencies nearly always work with governments. They often work with NGOs. But very often that's where it stops. Where in fact, if you look at many countries, most of the health services are in the private sector. India, for example, 70% of all health expenditure in India is in the private sector, not the government sector. And a further sector which is almost completely ignored by aid agencies is the traditional medicine sector. But that is in fact very important to lot of people. So what we did in Thailand was we put on a small training course to train private doctors in improved methods of STD diagnosis and treatment. This again was supported by British Council

grant money using a small number of British experts to provide a small training course and to help the private doctors to better manage sexually transmitted diseases.

A third example is HIV in Calcutta, India. And this, as I will demonstrate, has a link with a major project. As I said there's an article in the sixth edition of Development Update by Vena Lakamalani, who is our senior projects officer in Calcutta. Our interest in HIV in India started in fact from an interest in drug addiction.

About 10 years ago the Council became aware that drug addiction was a major problem in India, but people were not doing anything about it. And there were few services for drug addicts and their families. The Council started to put on training courses for doctors, social workers and counselors using expertise in the United Kingdom funded by our grant, to assist with the counselling and rehabilitation of drug users. This produced a very major response in India. I remember visiting India 1989, and seeing a very excited seminar of psychiatrists, social workers, ex-drug addicts, and lay people all sitting down together working out how they could tackle drug addiction in Calcutta. I think this was, for India to get these different groups of people all working together was really exciting. The experts who came from Britain alerted the Indian participants in these seminars about the HIV and AIDS problem in 1989. In 1990, they came back, and actually gave some part of the seminar on the HIV and AIDS. But Indians said this is all very interesting but this AIDS thing, this has nothing to do with India, this is these promiscuous people in Europe. It has nothing to do with India.

But a few weeks after they left, the first case of AIDS was reported in India, in fact in Calcutta, where the seminar had taken place. Now people said, well, maybe these people were right, maybe we should be listening to them. And in fact, as a result of this, the British Council felt that they had done enough in drug addiction, and they should move into HIV. So the next seminar was on HIV, sexuality counselling, confidentiality, ethics and support services. And the Council rapidly expanded this. The Council staff themselves took training in HIV and AIDS so that they could train other people and there

became a very great demand for their services. So much so that Vena, who's now our senior projects officer, is now in demand in the region as a consultant in HIV and AIDS. She started five years ago with absolutely no knowledge of this subject at all. She's now been as far as Kazakhstan and Uzbekistan to advise on HIV and AIDS work.

This is a useful point at which to go on from our development activities using our core grant from the Overseas Development Administration to the management of development projects. We've now moved up a scale, as you'll see.

Examples I'm going to talk about in some detail are the Tanzania Family Health Project and the West Bengal Sexual Health Project, but I'll briefly mention the bottom line, BKKBN. I think, you know this is the Indonesian family planning organization. The British Council is involved in two projects in Indonesia to do with family planning and midwifery. Our role in these projects is relatively limited. It's to provide management of trainees who come to the United Kingdom. Our knowledge base for managing these trainees is the fact that in 1991, we conducted a survey for the Overseas Development Administration of all the population training resources in the United Kingdom. So we developed our knowledge of what training population is available and use that to make the best placements for the staff from Indonesia who were coming to Britain to train.

So now we'll go on to the Tanzania Family Health Project. This is a large project funded by the Overseas Development Administration; 6 million pounds in value. It'll be over five years. It was awarded to the Council by competitive tender. In other words, the Overseas Development Administration issued an invitation to tender and a number of organizations in the United Kingdom were asked to tender competitively to offer the best product at the best price for this project. They usually cause problems for tendering organizations by inviting large numbers of organizations, maybe eight or ten to bid for a project. Tendering for projects is very expensive. It takes a lot of your staff time. The usual thing we do, is we get together with some of the other organizations invited to tender; well it reduces the competition and

makes our bid stronger. So the ODA ends up with maybe three or four tenders, instead of ten.

On this occasion, we made a partnership with Marie Stopes International. This is a non-governmental organization based in the United Kingdom with particular expertise in family planning, particularly in things like social marketing of contraceptives. They've got a lot of experience in developing countries. We brought Coopers & Lybrand, one of the international accountancy companies and management consultants because there was an element of health service finance in this project, and we wanted to use their experience to deliver that part of the project, and the Institute of Child Health, for the mother and child health components of the project.

The project is located in Mbeya town in the western part of Tanzania close to the border with Zambia, and four surrounding districts. The population of Mbeya district is around one million that figure is approximate, but that gives you an idea of the size. The population growth rate is rather alarming; 3.2% which is, I think you would agree, a very high growth rate. And the contraceptive prevalence is 5.4%, which is very low. So this is the environment in which this project is operating.

The goals of the project are to increase the opportunities for exercising choice over the number of children the families have. This terminology of the Overseas Development Administration, "children by choice," is a response to the earlier rather coercive attempts by governments, and also represents sensitivity to the pressure groups in our own country.

So these are the project's goals. When I describe the next project, I'll actually show you logical framework which is a hierarchical system.

The intention of the Tanzania Family Health Project is to increase the knowledge and use of multiple contraception for birth spacing and children by choice, and to decrease the disease burden from sexually transmitted infections and malaria. These are all, you see, going back to the ODA priorities; population, sexually transmitted diseases, malaria, and to contribute to the fight against HIV transmission. The means by which this will be achieved are assisting the government of Tanzania to strengthening the management, another

ODA priority, health service management, and delivery of reproductive health services at district level, the integration of family planning and reproductive services into improved health systems, and increasing the capabilities of NGOs. And importantly here, which is a relatively new thing for ODA, private sector providers, recognizing that in the Mbeya area, there will be private doctors who are actually important deliverers of care who very often, working on their own no continuing education, out-of-date, poor practices, need help. It's no good ignoring them just because they're in the private sector. Because they're actually important.

The project will improve the provision of quality in mother-and-child health care including family planning services. It will improve the prevention, diagnosis and treatment of sexually transmitted infections, and the diagnosis and treatment of malaria.

You're going to ask me what do they actually do. I brought a project document, if anybody wants to look at it. This is the document that the British Council produced, that persuaded the ODA that we were the right people to manage this project. There are more details in there.

The management team for the project is a project manager who is a doctor recruited from the United Kingdom, a mother and child health family planning coordinator, and the building supervisor. The building supervisor is because a lot of the project activity is to renovate the health centers from which the project operates. It's a bit depressing from my experience in parts of Africa where projects come along, they put up nice buildings, project finishes, they go away, and the government doesn't have any money for maintenance. Five, ten years later, another project comes along. You have a building supervisor, and you renovate the clinics that you built twenty years ago. But this is a fact of life.

I guess as people working in health, you're familiar with the World Development Report. This book produced in 1993 estimates that it takes a minimum of 12 dollars to provide a basic package of health services. But countries like Tanzania have only two dollars a head to provide health services. It's not surprising they have difficulty maintaining their infrastructure, because

if you've got to decide between providing chloroquine for malaria or oral contraceptives and painting your clinic, it's pretty obvious that you're going to provide the supplies, and you're not going to paint your clinic. I think we would all have the same response.

In addition, there are local staff who'll provide a lot of the training. There are volunteers from Voluntary Service Overseas, which is the British equivalent to the Peace Corps. You have a Japanese organization of volunteers as well, don't you? We have a similar organization, and some of their volunteers are working on this project. We also have short term consultancies in relation to training design, in relation to the financial side of the project, and they are managed by the project manager. He brings the short term consultants in as and when they are needed. In fact, on page 43, there is a bar chart [showing] when all the consultancies will be done over the five years.

The West Bengal Sexual Health Project. We've already covered the fact that the British Council, using the ODA grant, developed expertise in sexual health, HIV and AIDS in West Bengal. And because of that, the ODA asked the British Council to help them develop the West Bengal Sexual Health Project. This was ODA's contribution to the Indian National AIDS control program.

The objectives of this program are improved sexual health to be achieved in project supported communities in West Bengal, to reduce the spread of the HIV epidemic in West Bengal, and to reduce the social and economic impact of AIDS in West Bengal, which automatically follows. The British Council didn't actually get the management of this project by competitive tender. It was actually awarded to another organization which failed to deliver. So the British Council was asked to come in when the project had already started.

The purposes of the West Bengal Sexual Health Project are to increase access to and use of sexual health services by people in the project-supported communities who have an STD or at risk of STD; to provide training courses and technical assistance to staff and volunteers for the project partner organizations — this is a project very much based on activities by non-governmental organizations — formation and operation of networks of sexual health policy makers, finance providers and beneficiaries, and a program of

skill development in sexual health promotion and service delivery for approximately 80 women clinicians and health educators and the project management unit.

This project, will have outputs like this. There will be funding to between 50 and 70 non-governmental organizations and other partner organizations to actually provide the health service. So this is very much an NGO-based project. There will be training courses and technical assistance to provide to the staff and volunteers of these organizations. Formation of networks of policy makers and the program skill development.

And finally, the features of this West Bengal Sexual Health Project are that its what ODA calls a process project. What we mean by a process project is that it's not a blue print project where you start with a rigid plan and you follow it through to the end. It's a project where you review your activities as you go along, and you learn from your experience and change the plan of the project as you go along.

The objectives and priorities are developed by a participative process. You remember on the previous slide we said there were between 50 and 70 NGOs involved. If you don't have a participative process, you will not get the cooperation of so many small organizations. So it's got to be done in this way. And how fast the project develops depends on how quickly NGOs can be brought into the activity.

The project is budgeted for 0.29 million pounds in the first year and 4 million pounds in years two to five. The area is based on what's called the Sonagachi project, which is the project that the Council started with its own grant in a small scale where the incidents of HIV had been already established. That's really the limit of what I'm able to tell you today in a formal way. I'd like to thank you for staying awake, and I'm very happy to answer your questions.

The Council budget in 1994/95 was £427 million and a similar figure is expected in he current financial year. We earned this revenue from a number of sources:

Sources of funding 1994-95 (total receipts £426.9 million)	%
Government grants	33
our own revenue	27
work for Overseas Development Administration (ODA)	22
work for other agencies	13
work for The Foreign and Commonwealth Office (FCO)	5

FCO money is distributed to all our 109 offices around the world and ODA funds to those countries which are ODA priorities for development activities. Work for the ODA is made up of managing the Technical Co-operation Training Programme, managing ODA funded development projects and taking new development initiatives."

資　　料

IFIC Seminar on the Activities of the British Council in the Fields of Population and AIDS/HIV

Presentation by Dr Douglas J Buchanan, Lead Health Consultant, Consultancy Group, Professional Services, The British Council, UK
at the Headquarters of the Japan International Cooperation Agency (JICA) 50th Floor, Rooms 501 & 502, Mitsui Building, Shinjuku
Wednesday 29 November 1995

In this presentation I propose to give a brief outline of the purposes and structure of the British Council and describe its role as a development organisation.

In particular I will give examples of development activities carried out using the Council's core grant from Britain's Overseas Development Administration (ODA) and outline two development projects managed by the Council on behalf of the ODA.

The British Council

The British Council is a Royal Charter body run by an independent board of governors, a characteristic shared with the BBC. The two principal government contributors to the budget, the Foreign and Commonwealth Office (FCO) and ODA are represented on the board and influence policy.

History

The Council was established in 1934 with a grant of £5,000 to put the case for the British way of life and government at a time when alternative philosophies of a more authoritarian nature were gaining ground in Europe.

The Council grew rapidly and extended its role from cultural relations to development in the 1960's. More recently the Council has been repositioned to be an organisation with three clear activity streams of cultural relations, development and enterprises. This was necessary so that we could clearly demonstrate that sponsors' funding is used for only sponsors' purposes.

Budget

The Council budget is just over £400 million annually of which £90 million comes from the FCO, £30 million from ODA and £70 million from our enterprises. The balance is made up of revenue from activities such as managing development projects for ODA and other agencies, managing ODA's technical cooperation training programme (8,000 new training awards annually), management of training programmes for other bodies and business sponsorship which is largely for arts events.

FCO money is distributed to all our 109 country offices and ODA funds to countries which are ODA priorities for development activities.

Organisation of the Council

As previously mentioned the Council is organised in three activity streams. Development and Training Services (DATS) manages the development work of the Council principally training and development projects.

The Enterprises group manages English language teaching, examinations and International Seminars. Subsidy from other activity streams is not permitted and a relaxation in Treasury financial control has allowed Enterprises to build up an operating reserve.

The cultural relations work of the Council is called the Grant-in-Aid activity stream. We are represented in 109 countries, grouped into 10 Regional Directorates. Most Regional Directors are based in London, but those for Africa are overseas.

A group of common services based in the UK supports the overseas activities. These include Professional Services, the UK regional network which provides student support and the usual corporate services for personnel, finance and information technology.

Development activities can be divided into those of a project nature for the Overseas Development Administration and international agencies, the management of training programmes and development activities funded by the core grant. The core grant pays for library and information services, development activities and overheads.

Library and Information Services

Most overseas offices have libraries and all offer information services. In countries where development is a part of our activities, we ensure that the libraries stock materials of a developmental relevance. We also publish advice for overseas staff. Development priority guidelines were published two years ago to guide staff and their knowledge is improved by regular editions of Development Update.

The health consultancy team of two doctors one nurse and a health scientist gives training advice, advice on student health and welfare, undertakes consultancies and assists in project proposal writing and project management.

At this stage it is reasonable to answer the question "why does ODA need to provide funding to the Council for development activity." Indeed ODA in our present hard financial times does ask this question regularly. Our answer is that we are not a government organisation we can act quickly, work with NGOs large and small, take risks and innovate in ways which ODA cannot. We are required to make an annual report to ODA on how we have utilised their funds. Some activities such as our libraries do present difficulties over reporting impact.

Work using the ODA grant

1. AIDS counsellor training in Zimbabwe

As the AIDS epidemic unfolded demands were made from Africa for short training courses for counsellors. We were sure that for cultural reasons this training could not be provided in the UK and using our grant funds as pump priming set up a training course with an NGO in Zimbabwe 3 years ago. This is culturally appropriate for the region and successfully repeated annually.

2. STD Training in Thailand

It was brought to our attention that help could be given to providing a short training course to improve STD management by private doctors. Commercial sex workers were usually treated for STDs by their government health services, but their clients utilised private doctors. Continuing education in STD management for this professional group was successfully undertaken on a trial basis.

3. HIV in Calcutta

Our involvement in HIV control in Calcutta grew out of work on drug addiction. Council staff in Calcutta encouraged a response to the drug problem through seminars which brought together doctors and social workers, former addicts, lay people and experts in the community response to drug addiction from the UK. There was a logical progression from work with intravenous drug abusers to HIV and AIDS. Thus it was that through a succession of small projects leading onto STD control for commercial sex workers that a middle class Indian lady has become an expert in AIDS control in demand as a consultant in countries adjacent to India and further afield.

4. The Tanzania Family Health Project

A £6 million project funded by ODA in the Mbeya region of Tanzania over 5 years. The project was awarded to Council management by competitive tender. The Council is providing management and consultancy services in partnership with Marie Stopes International, Coopers and Lybrand and the Institute of Child Health. The Mbeya district has a population of around one million people, a population growth rate of 3.2% and contraceptive prevalence rate of 5%.

The project goals are:

to increase the opportunities for exercising choice over the number of children families have; and

- to improve the health of inhabitants of the region especially that of women and children.

The means by which these will be achieved are:

- assisting the Government of Tanzania in strengthening management and delivery of reproductive health services at district level
- integration of family planning and reproductive services into improved health systems and
- increasing the capabilities of NGOs and private sector providers

It is the intention of the project to:

- increase the knowledge and use of modern contraception for birth spacing and children by choice
- decrease the disease burden from sexually transmitted infections and malaria
- contribute to the fight against HIV transmission

by improving:

- the provision and quality of maternal and child health care, including family planning services

- the prevention, diagnosis and treatment of sexually transmitted infections

- the diagnosis and treatment of malaria

The project management team is a Project Manager, MCH/FP coordinator and Building Supervisor supported by local staff and short-term consultants. The project will develop financial systems, undertake building work, provide training and ensure community participation in the health activities.

5. The West Bengal Sexual Health Project

This project is the ODA contribution to India's National AIDS Control Programme.

The objectives of the project are:

- improved sexual health in project supported communities in West Bengal

- reduced spread of the HIV epidemic in West Bengal

- reduced social and economic impact of AIDS in West Bengal

The purpose of the project is to

- increase access to and use of sexual health services by people in project supported communities who have an STD or are at risk of STD infection.

Outputs of the project will be:

- funding allocated to 50-70 NGOs and other partner organisations to provide effective sexual health services

- training courses and technical assistance provided to staff and volunteers of project partner organisations

- formation of and operation of network(s) of sexual health policy makers, planners, providers and beneficiaries supported

- programme of skill development in sexual health promotion and service delivery for approximately 80 women clinicians and health educators established and operational

- project management unit established, staffed and operational

Project Features

A process not a blueprint project so activity can readily be changed in the light of experience

- The objectives and priorities developed by a participation process

- The pace of the project will depend on the identification of partner organisations and their ability to deliver effective services

- Budget - £0.29 m in first year; £4m in years 2-5

- The project area is that of the preceding Sonagachi project which has established HIV incidence in this area of West Bengal.

JICA