

AREVA NIGER CASE STUDY

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I. Presentation of the Public-Private Partnership (PPP) in Niger

AREVA and Human Rights

When the AREVA group became a member of the U.N. Global Compact in 2003, it was a public statement of the group's commitment to Human Rights. Anne Lauvergeon, Chairman of the Executive Board, was appointed to serve on the Board of the Global Compact in April 2006 by Kofi Annan, then Secretary-General of the United Nations, alongside 20 leaders from the business world and from labor and civil society organizations.

The AREVA group had created a business ethics function by the end of 2002 and, in 2003, based the development of its Values Charter on respect for and promotion of Human Rights. Respect for Human Rights is explicitly mentioned in the preamble and more specifically in the rules of conduct and principles of action the Values Charter decrees, including non-discrimination, respect for privacy, protection of health and welfare, and respect for human dignity.

In June 2006, AREVA joined the Business Leaders Initiative on Human Rights (BLIHR), an association of companies that support Human Rights. A French chapter of the BLIHR is being formed with support from AREVA. The AREVA group is one of the first French companies to have officially adopted the principles and criteria of the Extractive Industries Transparency Initiative (EITI), as regards its mining operations, and it has done so since the EITI Lancaster House Conference with international stakeholders was held in London in June 2003. EITI seeks to strengthen good governance in countries with abundant natural resources by verifying and publishing detailed information on payments made by extractive industries to governments and on revenues collected by the governments.

AREVA's Human Rights initiatives are anchored in:

- Principle no. 1 of the Global Compact
 - “Business should support and respect the protection of internationally proclaimed human rights within their spheres of influence.

- Article 25 of the Universal Declaration of Human Rights
 - “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”
 - “Motherhood and childhood are entitled to special care and assistance.”

The fight against HIV/AIDS has been one of the key focus in the AREVA group's actions to strengthen recognition of Human Rights in its policies.

AREVA and AIDS in Niger

The AREVA group has had a presence in northern Niger for more than 30 years at the mining towns of Arlit and Akokan, where it mines uranium via its subsidiaries Cominak and Somair. The group has been involved in the fight against AIDS in that country for several years, particularly with regard to its 1,800 employees and their families, for a total of 20,000 people.

Of the 80,000 people living with HIV/AIDS in Niger, women and children are particularly hard-hit, representing 53% and 11% of the country's HIV positive cases respectively. The country has 46,000 AIDS orphans living in precarious conditions.¹

Given the specific features of the mining region in question – i.e. desert land far from urban centers (240 km/149 miles from Agadez and 1,200 km/746 miles from the capital, Niamey) – it became apparent that it is crucial to seek synergies among the players active in Niger. With support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and working closely with the Nigerien government and the Esther public interest group, the AREVA group sought to leverage the impact of its contribution to public health in the regional population via a strong public-private partnership.

Following an 18-month process, an agreement was signed on December 1, 2006, by the Nigerien government (Ministry of Health & Disease Control, Ministry of Mining & Energy), the Esther (Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau, or Network for Therapeutic Solidarity in Hospitals) public interest group, and the AREVA group.

The public-private partnership in Niger brings together three key partners:

1. the government of Niger, represented by the Ministry of Health & Disease Control, the Ministry of Mining & Energy, and the Coordination intersectorielle de lutte contre le SIDA (CISLS, or joint coordination for the fight against AIDS);
2. the Esther public interest group; and
3. the AREVA group of France.

This three-year partnership agreement seeks to improve prevention, screening and care for people living with HIV/AIDS throughout the Agadez region.

Purpose of the case study

Since the partnership agreement was signed only recently, this case study does not aim to measure the impact of the partnership's AIDS program. Rather, this document has a narrower objective: to describe and assess the sometimes difficult and uncertain process that succeeded in bringing the partners together, despite their diversity, to design a joint action plan for the fight.

In detailing the time-line, the successes, and, most of all, the difficulties encountered during this preparatory phase, we hope to give other businesses, governments, international organizations and non-governmental organizations (NGOs) some lessons that they may use in following the sometimes tricky and fragile partnership path so essential to sustainable development.

¹ Source: UNAIDS, 2005

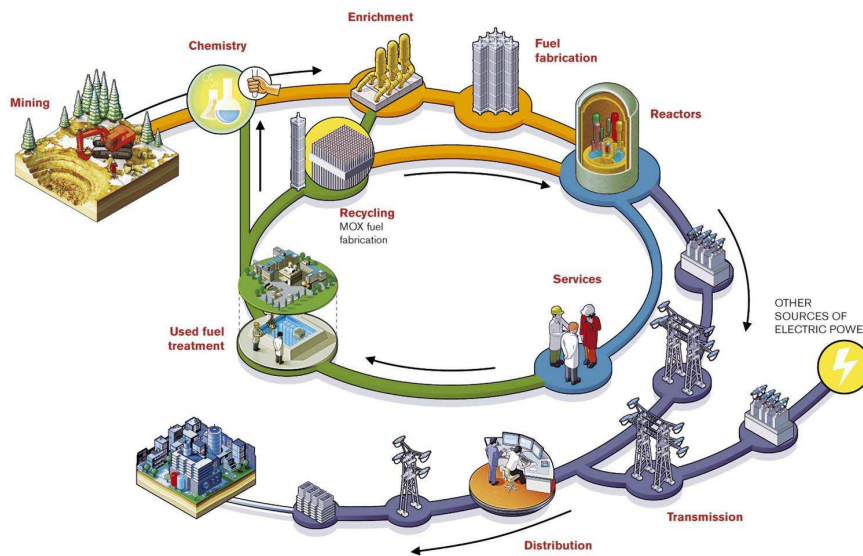
II. Overview of AREVA

AREVA is the world leader in nuclear power and is ranked third in electricity transmission and distribution equipment and solutions. With industrial operations in more than 40 countries and a sales network in more than 100 countries, its mission is to expand access to energy through technology solutions for CO₂-free power generation and electricity transmission.

The group operates in every area of the nuclear power cycle:

- Front End division: uranium mining, enrichment and fuel fabrication
- Reactors and Services division: reactor construction and power plant servicing
- Back End division: treatment and recycling of used fuel
- Transmission & Distribution division

Energy is AREVA's core business

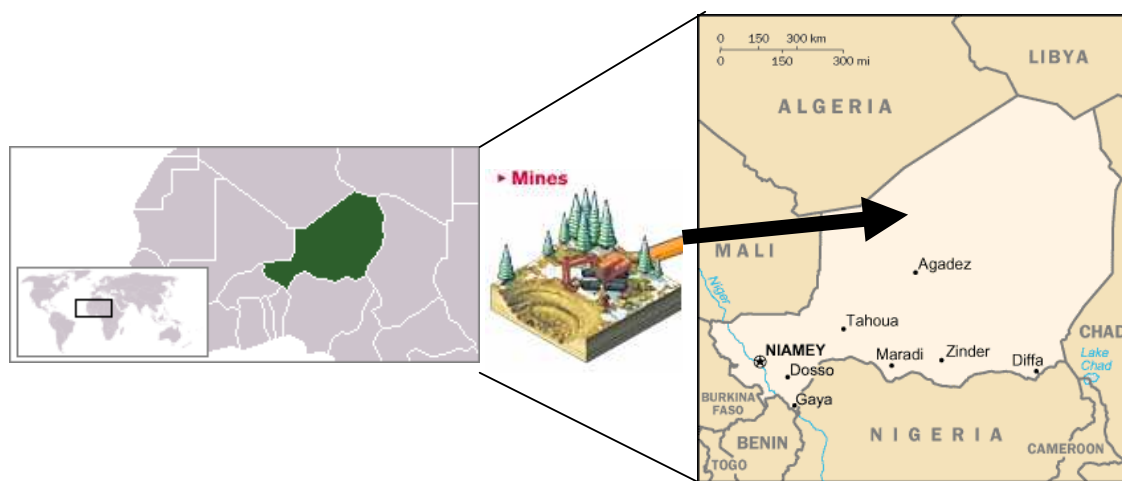


AREVA's consolidated sales and net income have risen continuously since the group was established. It had 2006 sales of **10.86 billion euros**, an increase of 7.3% over the previous year. It employs 61,000 people. 73% of its employees are based in Europe.

AREVA operates through two companies in Niger: Somair (63.4% AREVA, 36.6% Nigerien government) and Cominak (34% AREVA, 31% Nigerien government, 25% Ourd of Japan, 10% Enusa of Spain), which operate (mining and milling) a series of uranium deposits of sedimentary origin.

Somair and Cominak have produced a combined total of 100,000 metric tons of uranate since operations began in 1971 and 1978 respectively.

These AREVA group subsidiaries operate near Arlit and Akokan, two mining towns bordering the Sahara desert in the northwestern part of the country, more than 1,200 km (746 miles) by road from Niamey, the capital of Niger.



The 3,400 metric tons of uranium mined in 2006 by the AREVA group in Niger, the world's fourth largest producer country, represents half of the group's worldwide production and about 8% of the world's annual uranium production.

Uranium is the country's primary export, at 48% of all export revenues. The sharp upturn in world uranium prices since 2002 is stimulating renewed interest and new players, particularly from China and Canada. Exploration for new deposits is on the rise.

AREVA employs 1,800 people and is the region's largest private employer. The company must deal with the increase in population attendant on the wealth this creates. The ratio of employees to the surrounding population went from 1 to 10 in the 1980s to 1 to 60 today, raising the socio-economic pressure on the mining industry, AREVA being the main employer in the region.

III. Time-line of the Public-Private Partnership

Project time-line	
2004	AREVA becomes a member of the Global Business Coalition on HIV/AIDS
End of 2004	The Global Fund proposes a public-private partnership in Niger to AREVA
March 2005	First joint mission of AREVA/Esther
March 2005 – November 2006	Dialogue and consensus building among the partners: - development of a written proposal by AREVA - discussion and revision of the proposal by the partners
October 2005	The chief medical officers of AREVA's mine hospitals design an action plan to fight AIDS that will provide substance to the public-private partnership agreement
June 2006	The Esther process: An agreement in principle for a Franco-Nigerien hospital agreement is signed between the French and Nigerien ministries of health. Confirmation of interest by the Nigerien Ministry of Health in the overall approach of the public-private partnership.
December 1, 2006	Signing of the public-private partnership

From the beginning of its mining operations in northern Niger, the AREVA group has fully funded the two mine hospitals which quality standard is acknowledged in the region in providing quality health care to the entire community: employees, dependents and local communities.

With regard to HIV/AIDS, the mining companies set up a system for access to antiretroviral drugs for employees and dependents via a partnership with the French Red Cross and the Centre de Traitement Ambulatoire (CTA, outpatient treatment center) in Niamey.

As a member of the Global Business Coalition on HIV/AIDS since 2004, the AREVA group searched for the best response to the threat of HIV/AIDS to employees, their dependents and the entire regional community.

The group's subsidiaries had three alternatives:

1. continue along the same path, which meant limiting access to antiretroviral drugs to employees and their dependents;
2. unilaterally take charge of health care for the entire regional population;
3. facilitate a partnership approach to prevention and health care for the entire population with clearly defined responsibilities for each regional party.

As a private entity, the AREVA group reached the conclusion that its role should be to contribute to the quality of health care as well as to strengthen local capabilities, i.e. the public health care system and initiatives from civil society. From that perspective, the third alternative was preferred.

Approached with this in mind at the end of 2004 by the Global Fund, and after seeking advice from Esther, the AREVA group was open to the concept of cooperation with the Nigerien health agencies, a basic condition for local development. It should be noted that the general lines of this approach are consistent with the Sysmin² project funded by the European Union, which seeks to bolster public health organizations in the Arlit district.

The key principles of the approach are:

- integration with the national health program,
- long-term partnership,
- strengthening of local capabilities,
- an integrated approach combining prevention with screening and treatment,
- a clear definition and sharing of roles among the partners.

The signing of this public-private partnership agreement on December 1, 2006 sealed the partners' determination for coordinated action on a comprehensive program for fighting HIV/AIDS throughout the Agadez region.

² The sysmin project is funded through the European Development Fund. One of its components is aiming at improving access to primary health care for the Arlit District population through the strengthening of the public health system.

IV. Assessment

A. Corporate goal: taking effective action against AIDS

1. The fight against AIDS in the Agadez region, 1997 – 2004

(a) First cases of HIV/AIDS: fear of ostracism

The mine hospitals established and funded by AREVA detected Niger's first cases of AIDS in the Arlit region at the end of the 1980s. The physicians did not yet have drugs or special training to care for the disease, and it was difficult for them to provide patient care.

Regular, targeted care for these patients was provided by a dermatologist-venereologist beginning in 1997. Patients suffering from HIV/AIDS were received like patients with skin problems to protect their confidentiality.

At the end of the 1990s, the hospital physicians recommended an action plan to energize the community in the fight, to raise awareness and to provide condoms and antiretroviral therapy (ART). Peer educators from the workforce were trained and served as additional support to medical personnel for raising awareness. The Nigerien subsidiaries accepted and funded the plan. In the early days, the mechanism for medical reimbursements to AIDS patients ran into the thorny issue of confidentiality, since employees with the disease had to request reimbursement from administrative services. As a result, some patients did not put in claims for reimbursement, for fear of ostracism by their families, colleagues and the community at large.

(b) The first milestone: employees suffering from AIDS return to work

A significant milestone occurred in early 2000, when some employees returned to work, including a 43-year old AIDS patient who weighed only 38 kilograms (84 pounds) a few weeks earlier. Word of mouth began to spread that the therapy appeared to be working. Those who were thought to be lost gained new courage and were even able to have a normal work life. This first success was to bolster the credibility of the program recommended by the subsidiaries' physicians.

(c) Partnership for health care and guarantee of confidentiality

In 2004, a partnership agreement was signed with the French Red Cross and the Niamey outpatient treatment center covering health care and patient management for employees of the mining companies and their dependents, and the training of company personnel (medical and paramedical, educator peers and information/awareness raising). By ensuring patient confidentiality through medical evacuation to Niamey, the agreement allowed more patients to agree to receive treatment.

(d) General assessment: limited impact

Although the program met the needs of identified patients by giving them access to antiretroviral therapy and ensuring follow-up care, it did not encourage either massive screening of the 1,800 employees and their families (20,000 people), or screening and access to treatment for the local community (100,000 people). It also did not improve health care services at the public hospitals in Arlit and Agadez. The response to HIV/AIDS, although it generated significant results, with 26 people benefiting from antiretroviral therapy, still had a limited impact.

2. The fight against AIDS becomes an international strategy for the group: 2004 – 2006

(a) Leadership and involvement by top management

Involvement by AREVA's top management grew through the leadership of Anne Lauvergeon, Chairman of the Executive Board, and through consideration by the Executive Committee.

In view of the magnitude of the disease's impact on the working population in many countries, the company confirmed its involvement in the fight against HIV/AIDS in March 2004. AREVA became a member of the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC), and Anne Lauvergeon became involved directly as a member of the GBC's Advisory Board. Membership in the GBC increased awareness within the group of the need to join the fight against the disease and gave AREVA a better understanding of the challenges and of the actions to be taken.

In February 2005, it was decided to expand the programs in the priority countries of China and South Africa. Given the global nature of the pandemic, the scope established for the group's actions includes all of the countries in which it does business, and not just the hardest hit. It became to explain, raise awareness and manage the project as an international program within the group.

In December 2005, it was decided to accelerate deployment of the HIV/AIDS program. A year later, on November 24, 2006, the group's HIV/AIDS program was endorsed. It sets forth the values, principles and commitments to action (see below).

In October 2006, Anne Lauvergeon, attended the European summit for the heads of businesses in the fight against AIDS organized by the GBC. On December 1, 2006, the public-private partnership was signed with the government of Niger and Esther.

(b) AREVA Internal structuring

The magnitude of activities to be carried out by the group called attention to the need to structure and organize the response internally. A project manager with experience in this field was hired in May 2005. To strengthen its expertise in HIV/AIDS treatment at the group level, AREVA entered into a partnership with the pharmaceutical laboratory MSD Interpharma in 2005, which provides advice and technical support to define and establish the HIV/AIDS response in Niger.

In January 2006, a Corporate AIDS Committee was formed that draws together several internal components:

- Sustainable Development and Continuous Improvement Department
- Human Resources Department
- business units
- the Group's medical advisor
- Communications Department

The committee's mission is to validate and deploy the group's HIV/AIDS strategy.

Activities to raise employee awareness, a key factor for deployment of the HIV/AIDS strategy, continued throughout 2006 at several events:

- the Convention of AREVA Executives, which brings together the group's top 300 managers;
- the European Works Council, which assembles its labor partners from European countries;
- specific communication programs in Niger, China and France; and
- the Executive Committees of the group's first-tier subsidiaries, beginning in 2007.

(c) Designing the group's HIV/AIDS policy corporate responsibility and commitment, a tool for building trust internally

To earn legitimacy, a second important milestone consists of defining the scope and limits of the company's responsibilities. This was done in "The Group's HIV/AIDS Policy" adopted in November 2006.

The policy mentions the company's awareness of the disease's consequences:

"The AREVA group is aware of the scale of the human, social and economic consequences of the HIV/AIDS pandemic..."

It makes a point of connecting the policy to the group's concern for Human Rights:

"...The group is also mindful of health preservation, a key component of Human Rights..."

Because the group is particularly aware of the care that must be taken concerning principles of confidentiality and non-discrimination, the policy articulates these principles:

"...In accordance with our values, the Group supports HIV/AIDS programs that respect Human Rights and help prevent any form of exclusion..."

The Policy also emphasizes prevention, education and, within its sphere of influence, access to treatment in the most affected countries by endeavoring to develop partnerships with local players. Its reaffirmation of the principle of integration with national health programs makes a strong statement concerning the need for both quality treatment and coordination of action.

This places the company in a broader context that includes not only its employees but, depending on local circumstances, their families and the population of the region in which the company operates. Because unilateral public health care by corporations carries risk in terms of continuity, the Group's HIV/AIDS Policy encourages the company to turn to new and local partners to jointly own the approach and to fight the disease effectively over the long term³.

³ It is important to note that this public-private partnership was not triggered by pressure from NGOs or community-based organizations.

B. Corporate goal: creating a public-private partnership

1. A Global Fund initiative

With encouragement from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and spurred on by the chairman of the Executive Board, the group opened discussions with the government of Niger and with Esther in late 2004.

The Global Fund played a key facilitating role by supporting the project at the Comité Intersectoriel de Lutte Contre le SIDA (CISLS, or Joint Committee to Fight AIDS), the primary recipient of AIDS funding in Niger.

2. The public-private partnership project

After considerable consensus building in accordance with the National Nigerien Policy on the Fight against AIDS, a public-private partnership agreement was signed by the government of Niger, Esther and AREVA.

The Nigerien government is the party in charge of the program for prevention and care for people living with HIV/AIDS in the Agadez region, while the public interest group Esther and AREVA provide support, as outlined below:

Nigerien Ministry of Health & Disease Control:

- screening and case management for HIV positive people for whom the public health establishments of Agadez and Arlit are responsible, with resources including:
- supply of antiretroviral drugs and treatment for HIV positive people, and
- transfer of biological samples from Arlit to the Niamey Laboratory (1,200 km/746 miles) for measurement of the viral load.

AREVA:

- screening and treatment for HIV positive people for whom the mine hospitals are responsible (employees and dependents), with resources including:
- STD/AIDS prevention activities in the Arlit and Akokan communities,
- specialized biological examinations, such as lymphocyte counting for persons referred to AREVA by the Arlit health facilities;
- transfer of biological samples from Arlit to the Niamey Laboratory (1,200 km/746 miles) for measurement of the viral load.

Esther:

- capability-strengthening for the analytical laboratory at the Agadez hospital;
- training for analytical laboratory personnel and ARV drug prescribers;
- mentoring of ARV drug prescribing physicians,
- organization of patient care and monitoring of people living with HIV/AIDS;
- support to associations working for continuity of treatment.

This initiative is considered one of the first substantial “co-investment” partnerships between a corporation, a government and a major funding organization, the Global Fund. For AREVA, this is the first program to merge prevention, screening and access to treatment on such a large scale. The signing of the agreement is a decisive milestone in the fight against HIV-AIDS in the Agadez region.

Although this is only a starting phase of the program, the consensus building process has demonstrated the feasibility of participatory approaches based on a consensus of multiple partners. To foster the emergence of as many of these types of initiatives as possible, the challenges that the partners had to face in this process are presented hereafter.

C. Challenges, lessons learned and unresolved issues

The process for setting up a public-private partnership, from the initial contacts between the different partners to the final signing of the agreement, raised challenges. This document presents the challenges, gives clues to solutions known as “lessons learned,” and discusses the unresolved issues facing the company and its partners.

1. The challenge of preconceived notions

(a) From bias between organizations...

Two important observations concerning these partnerships are that:

- the different partners are biased, sometimes negatively;
- building trust is a prerequisite, but takes considerable time, which is sometimes viewed as “lost time” and a sign of inefficiency by the partners themselves.

These difficulties of cooperation are not just from cultural differences between countries, but are also due to the inherent nature of the different parties: public or private, each one bears the stamp of its organizational logic, history and historical relationships, and mode of operation.

It is important to point out that these doubts:

- can be real obstacles to sealing partnerships;
- can resurface when there is tension, despite every effort;
- are sometimes deep-seated, but are rarely shared by everyone in the entities involved; this then opens the door to dialogue, with discussion among the different players often leading to agreement by the various internal levels: the external partner becomes a key factor for moving internal players forward
- can be effectively set aside once the various "field operators" of the project (people in regular contact with each other) have built up enough trust, making it easier to surmount internal reticence that continues to be expressed by each partner.

Lessons learned

- 1- The project planning and design phase does consume a lot of time. This is because more is involved than defining the scope of a program; trust is being built up between partners who are often far apart culturally, and this is vital to the success of a joint project.
- 2- The creation of a project with multiple partners cannot hope to achieve a consensus from every individual in each of the organizations from the beginning. As an example, criticism by NGOs in early 2005 of the health effects of AREVA's operations in Niger slowed down the discussions and the process of trust-building among the partners. The creation of a "core" group of people from each partner is a necessary starting point to achieve the necessary critical mass in these organizations as a second step.
- 3- Trust is not forever: Care must be taken at all times to fight against the natural inclination to blame other partners for delays and difficulties encountered along the way. Biases can resurface at any time and partners can feel manipulated or ill-treated. Holding regular progress meetings is time-consuming but necessary to erase misunderstandings that can weaken partnerships. The long and gradual consensus building approach has sometimes been seen as a luxury detrimental to the effective progress of the project.
- 4- Without any doubt, the commitment of AREVA's representatives and of its subsidiaries in Niamey and Arlit was a decisive factor in the process of discussion, consensus building and dialogue with the Nigerien government. With their involvement, solid foundations were laid based on principles of integration with the national health program, strengthening of local players and long-term action.
- 5- The "multicultural" background of the contact persons from each of the organizations (varied professional experience: administration, private sectors, NGO, funding organization, etc.) is a key factor for understanding. It contributes to better intermediation and management of pressures between the organizations. The project manager recruited by AREVA in May 2005 and the Esther manager for Niger both had significant management experience in large international NGOs. Some of the Global Fund contact persons also had prior experience in the private or governmental sectors.
- 6- Commitment by the parties is a decisive factor in the process of discussion, consensus building, and dialogue.
- 7- The Global Fund, whose financial support is essential to this project, played a key role in moving the process forward. The involvement of its representatives in facilitating relations among partners (Nigerien government, AREVA group) was decisive in the discussion and project design process. Similarly, despite its inherent constraints, the Global Fund proved flexible in budget planning, allowing partner needs to be taken into account on several occasions.

(b) ...to bias within organizations

Even after the project managers for the different partners were convinced of the merit of the “multiple partners” approach, there was still a lot of convincing to do internally. The biases within organizations are a major challenge due to the number of people involved, most of whom are not accustomed to cooperation on such cross-cutting subjects.

Getting the operating level on board (Nigerien subsidiaries Cominak and Somair) is a long-term effort, in spite of the awareness raising initiatives undertaken. The legitimacy of the approach by AREVA’s corporate headquarters, which seeks to offer another perspective, should be combined with legitimate risk management practiced by the line managers. This is all the more true in that maintaining the status quo (keeping the partnership with the outpatient treatment center in Niamey) might seem to be a solution fraught with fewer uncertainties over the short term. Moreover, strong pressures for increased production at the operating level – Niger is one of several key countries for the group -- are sometimes hard to reconcile with objectives seen as being far removed from the priorities of mining operations.

The private mine hospitals funded entirely by the group's subsidiaries also find themselves in a paradoxical situation, which does not facilitate their integration into the project. Even though the burden borne by these units is growing with the local population, the hospitals’ medical personnel have access to significant resources. This project, which also seeks to strengthen local capabilities, has created an “alert mode” attitude among the mine hospitals’ medical personnel, who fear that the transfer of skills to public organizations might not be lasting. In relation to the Sysmin project mentioned earlier, it should be noted that, except for employee dependents, the local population itself has expressed similar doubts about the future, not only in terms of the quality of health care, but also in terms of funding: unlike the public system, which operates on cost-recovery mechanisms, health care is free in the mine hospitals.

Despite the demographic pressures on the mine hospitals, there is internal debate within the AREVA group between the option of bolstering the mine hospital’s resources and greater development of the capabilities of the local public health system. The progress made on this project was made possible, as discussed above, by strong leadership at the highest level, subsidiary expertise, the structuring of the project organization, raising employee awareness and seeking external expertise (MSD laboratory) for credibility.

Lessons learned

- 1- Strong involvement by top management is crucial and a prerequisite for the continuity of the process internally for a subject that the various levels of the corporation have a hard time considering as part of their responsibility.
- 2- Bringing in outside expertise lends strong legitimacy to the project, which does not fall within the company’s traditional area of expertise.
- 3- Commitment at the operational level is decisive for the success of the partnership process.

2. Slowness: the necessary evil of partnership?

The process of consensus building during these past two years has been a slow one, especially for private groups for which efficiency is paramount. There are at least two reasons for the slow movement:

1. the official one: the creation of a project built together by all partners with defined roles and responsibilities for all;
2. the unofficial one: the gradual construction of real dialogue that respects the nature of the other partners, as different as they may be.

It took two full years, from late 2004 to December 2006, for the public-private partnership agreement to be signed after the first contact between the Global Fund and AREVA. The slow progress in setting up the process was sometimes denounced by the players themselves

Hurdles to project acceptance: AREVA

The slow process of winning acceptance inside AREVA for the need to work cooperatively with the key partners – the Nigerien government, Esther, the Global Fund, and others – slowed the consensus building process further. More exposed to operating realities, the group's subsidiaries in Niger are still in a phase of "gradual involvement." Kicking off the project and emphasizing participation, particularly via the steering committee, should help overcome the difficulties inherent in any project involving multiple partners.

Administrative hurdles: Esther

Several of the features of the Esther public interest group make it a unique tool for improving health care in developing nations, while others can cause delays: public funding, dependency on the French Ministry of Health, prior political agreements, and coordination of private North/South organizations, among others. These hurdles are often not fully understood by the other partners, yet they constitute an in-depth approach to development involving all players by putting long-term results before short-term but superficial effectiveness.

Organizational hurdles: Government

The noticeably improved coordination among the various Nigerien government players – the joint coordination for the fight against AIDS (CISLS) and the Ministry of Health – for the establishment of a national program to fight AIDS is a key factor in moving the consensus building process forward. However, in the past, the distribution of responsibilities between the main recipient of international aid (CISLS) and the prime contractor (Ministry of Health) also contributed to slowing down the implementation process.

Slowness: a blessing or a curse?

With its engineering expertise, it could have been tempting for AREVA to take over management of the project by itself in the interest of efficiency. This would not have been very different from the health programs previously deployed by the group. As mentioned above, the health care services wholly financed by the companies and initially offered to

employees and their dependents by the mine hospitals (excepting HIV/AIDS patient care) are now provided to the surrounding community. More than half of the mine hospitals' budgets are for the secondary public (i.e. non-employee or dependent).

It is important to note that the approach selected by the project typifies the "180-degree change in perspective" that the group has accomplished: changing from a "binary" approach (AREVA towards the community) aimed primarily at the quality of a service (health, education, basic services, etc.) to a "development" approach that adds the need to transfer skills to local partners.

The new approach can meet with strong resistance, starting with the surrounding community, whose status changes from that of a "passive" beneficiary to that of a partner fully involved in the chosen action plan. This is an undeniable obstacle that should not be ignored in the future.

Lessons learned

Ever since mining operations began at Arlit in the 1970s, the "monolithic" approach of "providing basic services" has produced good results in terms of quality health care. The health care services offered by the mine hospitals reach a very high quality. However, the system has reached its limits, and a transition from the "guardian angel" company to "corporate leverage" must be made. Little by little, the group must go from being a leader in these fields to concentrating on its role as a facilitator. Strengthening local capabilities and developing local partners' autonomy are the new conditions for bolstering a private sector player's "social license to operate."

At this very preliminary stage of the project, a somewhat concealed but very real result has already been achieved: stronger ties between the different partners. Niger succeeded in demonstrating what few countries have been able to do: a calculated gamble that partnership, though difficult and uncertain, is necessary to achieving lasting results. The foundations for start-up, though shaky, have been laid.

3. The PPP experience in Niger: a base for AREVA's global AIDS strategy?

In relation to other groups, AREVA's business locations give it relatively low exposure to the AIDS pandemic. It has few operations in Africa, where Niger represents about two-thirds of its employees on the African continent. The Niger experience, one of the most complex health situations that the group has had to manage, is contributing depth to its policy and to its geographic deployment. The group's endorsement of its HIV/AIDS policy in late 2006 and the start-up of a prevention program in China are, as mentioned above, decisive milestones made possible by the experience acquired in Niger.

The "Niger lessons" have made it even more imperative to include as a program objective not only the design of quality services, but also the method used, which necessarily means working in partnership and strengthening local capabilities. Understanding these mechanisms is part of corporate responsibility.

More generally, the Niger experience feeds into the group's overall consideration of the scope and limits of its contribution to development in countries in which it does business. We hope that it will also help the Nigerien government and Esther consider new forms of partnership to fight AIDS more effectively. The challenge is also to demonstrate how the pooling of skills, expertise and experience from multiple sources can boost the impact for the affected communities.

Although its businesses vary substantially from one country to the next, the group gained considerable experience in Niger that feeds into its overall thinking, not only on its response to HIV/AIDS, but also on the changes that need to be made to its "community involvement" programs.

In closing, it is worth noting that setting up this partnership was a learning experience for AREVA as well and helped the group's employees understand the nature of the connection between "business as usual" and the new concept of corporate responsibility.

Sources

The information used for this case study comes from a variety of sources, including in-house documents of the AREVA group as well as external documents and more general documents on AIDS (UNAIDS) and on Niger (World Factbook, etc.).

In addition, the author, Sylvain Romieu, interviewed the followed people:

Global Fund for the Fight against AIDS, Tuberculosis and Malaria

- Mr. Michel Lavollay, Senior Advisor for the Private Sector and External Relations
- Mr. Olivier Vilaça, Co-Investment Manager
- Mrs. Tina Draser, Fund Portfolio Manager

Esther

- Dr. Jean-Loup Rey, Project Manager
- Mr. Arnaud Laurent, Project Manager

Nigerien Ministry of Public Health

- Dr Fatimata Moussa. General Secretary. Minister of Public Health.
- Dr. Hubert Balique, Technical Advisor to the Ministry of Health

Prime Minister cabinet

- Dr Abdoulaye BAGNOU, Principal Advisor, Coordination intersectorielle de Lutte contre les IST-VIH/SIDA, .

AREVA

- Mr. Yves Coupin, Senior Executive Vice President of Sustainable Development and Continuous Improvement
- Mr. Damien Desjonquères, AIDS Project Manager

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- Mrs. Annick Gerardin, Coordinator of Local Development Activities

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Diallo Sanata, M.D., Dermatology and Venerology

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- Dr. Christophe Longuet, HIV/AIDS Medical Manager, Africa