



Report of the Regional Workshop of National AIDS Authorities on the Implementation of The SADC HIV and AIDS Strategic Framework

July 26th to 28th 2004 - Kopanong Hotel, South Africa



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Southern Africa Development Community - August 2004



DFID Department for International Development

List of abbreviations

ADB	African Development Bank
AFRO	Africa Regional Office
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Anti Retroviral Therapy (treatment)
ARV	Anti- Retroviral
AU	African Union
BCC	Behaviour Change Communication
BNLS	Botswana, Namibia, Lesotho and Swaziland
CBS	Cross Border Sites
CCM	Country Coordinating Mechanism
CRIS	Country Response Information System
CSW	Commercial Sex Workers
DCI	Development Cooperation Ireland
DFID	Department For International Development
DRC	Democratic Republic of Congo
EQUINET	Regional Network for Equity in Health in Southern Africa
ESDEM	Demographic And Social Statistics of Mozambique
EU	European Union
GFATM	Global Fund to Fight AIDS, TB and Malaria
HIV	Human Immune Virus
HSRC	Human Sciences Research Council (of South Africa)
HTS	High Transit Sites
IDASA	Institute for Democracy in South Africa.
IEC	Information Education and Communication
IPT	Isoniazide Prevention Therapy
JICA	Japan International Cooperation Agency
LFA	Local Funding Agency
M & E	Monitoring and Evaluation
MDG	Millennium Development Goals
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NACP	National (HIV) AIDS Control Programme
NEPAD	New Partnership for African Development
NGOS	Non-Governmental Organisations
OVC	Orphans and Vulnerable Children
PEP	Post-exposure Prophylaxis
PLWHAS	People Living With HIV and AIDS
PMTCT	Prevention of Mother-to-Child-Transmission
SADC	Southern African Development Community
SAHARA	Social Aspects of HIV and AIDS Research Alliance
SAPP	Southern African Partnership Programme
SIDA	Swedish International Development Agency
SIPAA	Support to International Partnership Against HIV and AIDS in Africa
STI(S)	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZIMRA	Zimbabwe Revenue Authority

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Foreword

The Regional Workshop for the Implementation of the SADC HIV and AIDS Strategic Framework reminded us that Southern Africa is at the epicentre of the epidemic.

This workshop again demonstrated that today we know more about HIV and AIDS in Southern Africa than ever before. Improved surveillance techniques are providing light not only on the HIV and AIDS situation, but also on the behaviours that drive the epidemic. Increasingly Member States are expressing their political commitment to addressing the epidemic through the allocation of more resources to combat HIV/AIDS, including the provision of treatment. The provision of treatment needs to be complemented by the strengthening the entire health system including development and retainment of human resources who are critical for the future health and welfare of the region.

Through the sharing of ideas and information the workshop demonstrated that across the region, governments, civil society and ordinary people are engaging in extraordinary efforts to combat the epidemic. Botswana has taken the lead in terms of providing ARV treatment while many countries have mainstreamed HIV/AIDS into their national development plans and have formed national partnerships led by their

governments to respond to the epidemic. Zimbabwe has demonstrated that we can use innovative methods to mobilise additional resources in support of the national response to HIV and AIDS.

Despite these achievements, the workshop also demonstrated that we are only at the beginning of dealing with the epidemic. Treatment remains inaccessible to many people, more evidence is required to determine whether the prevention efforts in the region are making an impact, and there is a need to plan for the future, to develop national strategies and frameworks that respond to the growing numbers of children who have been orphaned by the epidemic.

Delegates to the workshop concluded by calling on the SADC Secretariat to coordinate the regional response to the epidemic, guided by the SADC Strategic Framework on HIV and AIDS. In this regard, this workshop will become an annual event convened by the SADC Secretariat. Furthermore, the SADC Secretariat together with its partners will publish an annual report to look at how the region is keeping the promises it has made in the SADC Declaration, the Abuja Declaration, the UNGASS Declaration, and the Millenium Development Goals.

Section 1 - Executive Summary and Recommendations

The three-day workshop was held from 26-28 July 2004. It was the first of its kind that brought together coordinators and managers of National AIDS Coordinating Authorities from 13 SADC Member States, civil society organisations, UN agencies, research institutes and representatives of different SADC Secretariat Directorates.

The objectives of the workshop were set within the context of the implementation of the SADC HIV and AIDS Strategic Framework, namely to:

- Facilitate information sharing on the HIV and AIDS situation and responses in the SADC Member States.
- Develop mechanisms for sharing best practices and lessons learnt.
- Establish strategies and mechanisms for networking and collaboration.
- Define processes for strengthening regional co-ordination and collaboration.
- Provide inputs to the development of the SADC Business Plan on HIV and AIDS.

Director of Social & Human Development a Special Programmes, Mr Sianga of the SADC Secretariat made the welcoming remarks noting that considerable progress had been made since the SADC Summit on HIV and AIDS in Lesotho and the adoption of the Maseru Declaration in July 2003.

Mr Mark Stirling of the UNAIDS Regional Support Team for Eastern and Southern Africa pointed out that despite increasing resources, service delivery and coverage remained below that needed for an adequate response.

The keynote address was delivered by Dr Mhlongo of the SADC Secretariat who emphasised the need for strengthened monitoring and evaluation so that the progress made and the challenges in addressing the epidemic can be appreciated. He pointed out that progress has been made in putting in place the policy and institutional framework for a strengthened SADC response to the epidemic. However, these successes are dependent upon the commitment of Member States.

Following the opening ceremony, the workshop comprised plenary presentations on critical issues. The following is a brief overview of the various sessions and the recommendations emanating from the discussions:

HIV and AIDS in the SADC Region

This session provided an overview of the state of the epidemic in the region. It explored the vulnerability of women and girls to HIV and AIDS as highlighted by the UN Secretary-General's Task Force Report on HIV and AIDS in Southern Africa. A review was given of the SADC response to the epidemic including the SADC Strategic Framework 2003 - 2007 and the Maseru Declaration and efforts being undertaken to harmonise the regulation of medicines in the SADC Region. The following recommendations were made:

- a) Undertake research to investigate the efficacy of strategies targeting prevention and behaviour change communication, including the provision of the female condom.
- b) Develop policies and guidelines to assist Member States to mainstream gender and HIV and AIDS into all development programmes.
- c) Provide technical support to Member States to implement the recommendations of the UN Secretary Generals Report on Women, Girls and HIV and AIDS in Southern Africa.
- d) Strengthen advocacy at national and regional level to address challenges associated with gender-based violence, rape, treatment, care and support programmes.
- e) Support the development of a volunteer charter to guide the involvement and participation of volunteers at the community level.
- f) Promote and support public debate on the Maseru Declaration on HIV and AIDS.
- g) Fast track the process of developing a regional protocol on the harmonisation of HIV and AIDS treatment in the region.
- h) Publication and distribution of guidelines, and evaluating the capacity of regulatory bodies in the region.

Session 4: Operationalising the SADC Strategic Framework (2003 - 2007) and the Maseru Declaration

This session provided an overview of the SADC/EU Project on HIV and AIDS, the SADC/DFID Project on HIV and AIDS, and the SADC Business Plan, which are being undertaken in support of the SADC Strategic Framework and the Maseru Declaration. The following recommendations were made:

- a) The EU and DFID Projects should jointly facilitate the development and harmonisation of regional guidelines related to access to treatment for migrant workers, mobile populations and commercial sex workers.
- b) That projects being supported by the EU and DFID Projects be scaled up to include all countries in the region.
- c) Ensure that agencies implementing projects supported by the EU and DFID work closely with existing government institutions to avoid duplication, and complement actions being undertaken at the national level.
- d) Mechanisms to monitor the implementation of the Business Plan should be put in place.
- e) Convene annual meetings of the coordinators of National AIDS Coordinating Authorities and HIV and AIDS Programme personnel to improve networking and information sharing.
- f) Document and disseminate best practices and experiences emerging from the implementation of the national response programmes, mainstreaming HIV and AIDS, innovative interventions and projects.
- g) Develop guidelines on how the SADC HIV and AIDS Trust Fund would be managed.
- h) Strengthen National Coordination Mechanisms within the concept of the Three-Ones, including monitoring and evaluation.
- i) Develop a comprehensive policy on human resource development and retention in the region.
- j) Support Member States to initiate innovative strategies for local resource mobilisation such as the "HIV and AIDS Levy" in Zimbabwe
- k) Map migration patterns in terms of source, receiving communities, characteristics of migrants, causes and the impacts in relation to HIV and AIDS.
- a) SADC and WHO should investigate strategies to ensure cheaper access to ARVs such as bulk procurement or regional production of ARVs.
- b) WHO should support training for staff on ARV management.
- c) SADC Secretariat should strengthen the capacity of Member States to improve the production, procurement, distribution and monitoring of their essential drugs systems.
- d) Community mobilisation strategies should be developed in support of ART so as to ensure uptake and adherence
- e) A regional strategy should be developed to monitor and track people on ART so as to increase adherence.
- f) SADC, UNICEF and WHO should develop policy guidelines on the administration of ART to children.
- g) SADC Secretariat should support the development of policy and appropriate interventions for people with disability and HIV/AIDS.
- h) SADC Secretariat should facilitate the development of regional guidelines and criteria to support and build the capacity for volunteers at community level.
- i) Ensure equity in the provision of financial and human resources for ART, prevention and the strengthening of the health system.
- j) SADC Secretariat should promote and support applied research and analysis of systems costs, benefits, and opportunities costs to guide programme choices.
- k) SADC Secretariat should facilitate the development of a regional care and support policy for orphans, including issues relating to inheritance.
- l) SADC Secretariat should facilitate capacity building for improved coordination of care and support programmes for orphans at country and regional level.
- m) SADC Secretariat should facilitate the development of guidelines for the carers of orphans including the registration of orphans by care givers.
- n) Member States should provide adequate social support to families living with PLWHAs on ART, and those living below the poverty datum line.
- o) Member States should include role models from the community to promote prevention initiatives and consequently complement the efforts of eminent persons.

Session 5: Promoting Treatment in the Region

Progress made and the challenges to the scaling-up of access to treatment including the WHO "3 by 5" Initiative. Equinet presented research on strengthening the health system to support the rollout of ARVs. Botswana shared its experience in scaling-up treatment access and Lesotho on expanding voluntary counselling and testing in the country. An overview was provided by UNICEF on the Rapid Assessment of the situation of orphans and vulnerable children in seventeen African countries. The following recommendations were made:

Session 6: Promoting an Expanded and Multi-level Response to HIV and AIDS through Mainstreaming and Decentralising the Response

UNDP opened this session by providing an overview of mainstreaming HIV and AIDS into social and economic development. South Africa, Namibia and Zambia shared their experiences in mainstreaming of HIV and AIDS into national and sub-national responses. The following recommendations were made:

- a) UNDP and the SADC Secretariat should provide guidance on the manner in which mainstreaming, decentralisation and multi-sectoralism affect structural changes in the national response.
- b) SADC Secretariat and UNDP should conduct practical training on mainstreaming HIV and AIDS.
- c) Member States should develop strategies to support civil society organisations and district level initiatives.
- d) Donor projects should support the national strategic framework on HIV and AIDS and national priorities to ensure integration and sustainability.
- e) SADC Secretariat should support a study on “civil society responses to HIV and AIDS” to establish their niche, available expertise, resources and the challenges they confront.

Session 7: Resource Mobilisation for the HIV Response

This session explored various strategies being undertaken to mobilise resources in support of the national response. Malawi provided an overview of its experience in managing resources obtained from the Global Fund and Zimbabwe provided an overview of its AIDS levy as an alternative form of national resource mobilisation. IDASA provided feedback from its multi-country study on HIV and AIDS budgets in four African countries. The following recommendations were made:

- a) SADC Secretariat, WHO, UNAIDS and UNDP should establish a pool of resource persons based in the region that Member States can draw upon to assist them in the development of their Global Fund Proposals.
- b) The Global Fund should provide clear guidance on the process and formats of funding proposals.
- c) Member States should document and share their experiences of the Global Fund.
- d) SADC Secretariat should organise a workshop on funding opportunities for HIV and AIDS for National Coordinating Agencies and National Control Programmes (Ministries of Health).

- e) SADC Secretariat should document and share information on the Zimbabwean HIV and AIDS levy.
- f) Training should be provided to assist Member States to track resources for HIV and AIDS.
- g) SADC Secretariat should establish a HIV and AIDS funding database including bilateral and multilateral donors and civil society organisations.

Session 8: Monitoring the Response in the SADC Region

UNAIDS opened this session by outlining the needs of monitoring and evaluation at regional and country level. It was highlighted that monitoring and evaluation is an important tool in determining the allocation of resources and in monitoring national response. The HSRC provided an overview of population household surveys as a complementary method of determining HIV prevalence rates and its SAHARA Network. Mozambique shared its experiences in operationalising a “Country Response Information System (CRIS)”. The delegates made the following recommendations:

- a) A regional M & E training programme should be developed to assist Member States to build and strengthen their capacity.
- b) SADC Secretariat and UNAIDS should facilitate the development of a regional M and E framework.
- c) UNAIDS should promote and support networking and sharing of information and experiences on M and E in the region.
- d) HSRC should compile and disseminate information on how countries can collaborate with it and participate in the SAHARA network.
- e) HSRC should share the concept and methodology of population based surveys.
- f) HSRC should train the National AIDS Coordinating Agency on “Population Based Surveys” using the experiences of South Africa and Botswana.

Session 9: Coordinating National and Regional Responses to HIV and AIDS

UNAIDS provided an overview of the “Three One’s Principles” emphasising that the adoption of these principles are aimed at strengthening national coordination in support of the national response. Swaziland and Tanzania provided their experiences in coordinating the national response. The following recommendations were made:

- a) SADC and UNAIDS should clarify the roles and responsibilities of National AIDS Councils, National

AIDS Coordinating Agencies and Ministries of Health.

- b) UNAIDS should facilitate the mainstreaming of the three-ones at country level and provide technical assistance to ensure that the institutions are effective and efficient.
- c) The technical support being provided by the SADC-DFID Project on AIDS in strengthening National AIDS Control Programmes should be extended to other countries.
- d) HIV and AIDS Coordinators should be appointed in all government institutions as a full time assignment, and not as an added responsibility.
- e) SADC Secretariat should monitor how individual Member States are moving towards harmonising the coordination mechanisms.

Session 10: Unique Experiences in Managing HIV and AIDS

This session explored unique experiences in managing

HIV and AIDS. Mauritius shared its strategy for maintaining a low HIV prevalence rate and the Democratic Republic of the Congo reflected on its experiences in managing HIV and AIDS in an emergency setting. Action AID provided an overview of its support to the International Partnership Programme Against AIDS in Africa (SIPAA) and its Southern Africa Partnership Programme (SAPP). The following recommendations were made:

- a) SADC Secretariat and UNAIDS should investigate how some countries are managing to maintain low prevalence rates.
- b) UNAIDS and WHO should develop strategies that assist countries in, or emerging from, emergency situations.
- c) SADC Secretariat should facilitate the development of guidelines on the development of programmes targeting children and adults living with disability and HIV/AIDS.

Section 2 - Introduction and Official Opening

2.1 Introduction

The Regional Workshop on the Implementation of the SADC HIV and AIDS Strategic Framework took place from the 26th to 28th July 2004 at Kopanong Hotel, South Africa. The meeting brought together 65 delegates from 13 Member States representing National AIDS Coordinating Authorities, National HIV and AIDS Councils and Commissions, Ministries of Health, civil society, UN agencies, research institutes and the SADC Secretariat.

The objectives of the workshop were to:

- Facilitate information sharing on HIV and AIDS and the responses among the Member States.
- Provide inputs to the development of the SADC Business Plan on HIV and AIDS.
- Develop mechanisms for sharing best practices and lessons learnt.
- Establish strategies and mechanisms for networking and collaboration.
- Define processes for strengthening regional coordination and collaboration.

The workshop comprised plenary presentations, discussions and group work organised along thematic lines. Topics explored included:

- HIV and AIDS in the SADC region, regional mechanisms for responding to the epidemic, access to treatment, promoting an expanded response to mainstreaming HIV and AIDS, resource mobilisation and coordination of the regional and national responses.

2.2 Official opening

Director of Social & Human Development and Special Programmes, Mr Sianga from the SADC Secretariat welcomed the delegates. He noted that considerable progress had been made in the regional and international response to the epidemic since the Special SADC Summit on HIV and AIDS held in Lesotho. These include:

- Increased resources being made available through the Global Fund, the US President's Emergency Plan for AIDS Relief and the World Bank's MAP Programme.
- Increased access to treatment through the "3 by 5" programme including the scaling up of Voluntary Counselling and Testing Centres (VCTs) in most countries.
- The on-going process by Member States of revising

National Strategic Frameworks to align them with emerging developments.

In his statement **Mr. Mark Stirling, Director: UNAIDS Regional Support Team for East and Southern Africa** highlighted that Southern Africa is at the epicentre of the epidemic. He pointed out that new HIV infections and the number of deaths related to AIDS are increasing despite the availability of ART, VCT, PMTCT, care and support programmes. While resources and the demand for services are increasing, service delivery and coverage remained low. Mr Stirling identified the coordination of national and regional interventions as a priority to ensure an effective response to HIV and AIDS.

The Chief Director of SADC Secretariat, Dr. Mhlongo, officially opened the workshop on behalf of the Executive Secretary of SADC. Dr Mhlongo highlighted a number of issues for the delegates to consider while deliberating on the SADC HIV and AIDS Business Plan. These included:

- Improved and more efficient mechanisms for coordination and harmonisation of national response strategies.
- Strengthened networking to facilitate the sharing of best practices.
- Widening the scope of the response and outreach work in communities most affected.
- Managing cross border challenges associated with HIV and AIDS.
- The necessity to link interventions regionally.
- Considering effective strategies to increase the availability of and access to quality care and support, including ART.
- Ensuring a reduction in the number of new infections in the region.

Dr. Mhlongo challenged delegates and other development partners at the workshop to work together to develop simple, effective and efficient monitoring and evaluation strategies, systems and tools at national and regional level. He cautioned that *"Unless we are able to monitor our work, we shall not be able to appreciate our progress and challenges"*.

Dr Mhlongo observed that much progress has been made in putting in place the policy and institutional framework for a strengthened SADC response to the epidemic, but the success of these are dependent upon the commitment

of Member States. He highlighted that for the SADC Secretariat the challenge is to ensure that the response to HIV and AIDS is mainstreamed into the work of the SADC Sectors and Secretariat. He underlined the need for an effective and achievable Business Plan that will help the Secretariat and Member States to move from *“talking to action”*.

He noted that SADC Secretariat was strategically re-positioning itself to ensure better and more efficient technical support to Member States. This included the appointment of an HIV and AIDS Program Manager, the relocation of the SADC Health Unit from South Africa to Gaborone, and the development of a Draft SADC HIV and AIDS Business Plan.

Mr Moses Kachima, Executive Secretary of SATUCC, gave the vote of thanks. He thanked the EU and DFID for co-sponsoring the workshop and the SADC Secretariat for organising the workshop. He noted that the workshop was a good platform not only for networking but also for developing common positions. Mr Kachima called on the delegates and the SADC Secretariat to translate recent pronouncements on HIV and AIDS, such as the Maseru Declaration, the SADC Code on HIV and AIDS, and the HIV and AIDS Business Plan into action. He noted that failure to act will result in the epidemic increasingly reversing the development gains in the region, slow the development process, and ultimately undermine efforts to build viable regional human capital.

Section 3 - Overview of HIV and AIDS in the SADC Region

3.1 The State of the Epidemic in the SADC region

By Ms L. Thomas-Maple Technical Officer, WHO-AFRO.

Ms Thomas-Maple highlighted that Africa is home to two thirds (25 million) of people living with HIV and AIDS of which 14 million are in Southern Africa. Nine of the fourteen SADC Member States have adult HIV prevalence rates of between 9 and 40%, with adult HIV prevalence being higher in urban areas. Young people are still the most vulnerable with more than 50% of new infections occurring among young people aged 15 - 24, the majority of whom are women and young girls.

The social and economic impact on SADC Member States includes reduced life expectancy, reduced social and economic gains, increased poverty, number of orphans and a depletion of skilled human resources. Of particular concern is the high mortality rates among agricultural and mine workers with at least one fifth of the agricultural workforce possibly dying by the year 2020 if no serious actions are taken.

She noted that Member States are doing the best they can to respond, given the magnitude of the epidemic. She highlighted the need to scale-up effective strategies and programmes targeting young people, while improving coordination among key actors. She called on all partners to prioritise interventions that accelerate the pace of implementation of programmes such as 3X5, VCT and PMTCT.

Reflecting on progress made in scaling-up treatment, she said that only a few countries have developed national protocols for managing ART to children under the age of ten, and that people with disabilities were largely ignored. Where ART was available, communities were not adequately prepared and mobilised to ensure uptake and adherence. Quality care and support was further complicated by a lack of food at the household level in most Member States.

At national level the lack of access to cheaper ARVs (or generics) remains a strategic obstacle to scaling-up treatment. She suggested that a possible solution could be the bulk procurement or the manufacturing of ARV drugs in the region. She warned that the mobility of the SADC population, the absence of a monitoring and tracking

strategy for people on ART and differing treatment protocols across countries could potentially undermine adherence and result in drug resistance.

She encouraged the delegates to scale up the provision of ART, and to ensure equity in the allocation of resources between care and support, prevention and the general health system.

3.2 Women, Girls, and HIV and AIDS in the SADC Region: Report of the UN Secretary General Task Force

Ms Sisonke Msimang, UNAIDS Regional Office for East and Southern Africa.

Ms Msimang noted that the UN Secretary General's Task Force on Women, Girls and HIV/AIDS was created in 2003 comprising 27 prominent persons drawn from nine Southern African countries, namely: Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia, Malawi and Zimbabwe.

The Task Force was led by the Executive Director of UNICEF, Dr Carol Bellamy, and aimed to advocate for increased action to reduce the vulnerability of women and girls to HIV infection and its impact in society. The UNAIDS Regional Support Team served as the Secretariat for the Task Force.

The Task Force visited the nine countries where they interviewed women, girls and policy makers on the following key issues:

- a) Prevention of HIV infection among young women and girls.
- b) Girls education.
- c) Violence against women and girls.
- d) Property and inheritance rights.
- e) The burden of care.
- f) Access to treatment, care and support.

In summarising the findings of the Task Force, Ms Msimang concluded that all the countries have a strong legal and policy environments that are supportive of women's rights. However, implementation, resources are lagging behind. The systems and institutions responsible for ensuring gender mainstreaming are overstretched and poorly coordinated. Country level HIV and AIDS programmes lack the necessary technical skills to make them gender sensitive, while grassroots women's groups

are shouldering the burden of care with little or no support. The report recognised the important role of PLWHAs, the roles of women (both positive and affected), but said that these are not adequately articulated within national response frameworks. Furthermore countries lack capacity to address the legal and ethical issues associated with HIV and AIDS, inheritance rights of orphans and women, and in ensuring adequate access to treatment and care for women and girls.

She highlighted that the report provided recommendations for national and regional actions to address the situation of women and girls. At the national level it recommended that:

- Mechanisms be developed to track resources and ensure adequate support for interventions that specifically target women and the girl child.
- Gender audits be undertaken to ensure gender mainstreaming in all aspects related to HIV and AIDS
- Women participate in decision making institutions such as the National AIDS Councils.
- Support be provided to communities to help them cope with the impact of the epidemic.

At regional level recommendations include:

- Support for operational research on the situation of women and girls in relation to HIV and AIDS
- Development of a "Volunteer Charter" to guide the involvement and participation of volunteers at the community level.
- Strengthening of advocacy to address the challenges associated with gender based violence, rape, and up-take of treatment and care programmes.

3.3 SADC Response to the Epidemic

Dr Hembe, SADC HIV and AIDS Manager.

Dr Hembe focussed in her presentation on the response by SADC to the HIV and AIDS epidemic in the region. She noted that HIV and AIDS is the greatest obstacle to achieving the mandate of SADC, which is to "Promote sustainable growth and socio-economic development in order to reduce poverty."

She said that SADC Member States have demonstrated political will and leadership by prioritizing HIV and AIDS as part of their national development programmes and through the allocation of resources to support national

interventions. This commitment is demonstrated by the SADC Heads of State and Government endorsing major regional and international HIV and AIDS initiatives such as The Millennium Development Goals, UNGASS Declaration of Commitment, NEPAD, Abuja Declaration and the Maseru Declaration on HIV and AIDS.

She noted that SADC has the highest rates of HIV infection globally and that the collective response of Member States was to reduce the number of new infections and increase capacity for care and support. To achieve this required an effective and well-coordinated regional multi-sectoral response that has direct implications on country level programmes.

She pointed out that the national response varies amongst countries in the region. Most countries have developed National Strategic Frameworks, started VCT services, are scaling up ART, PMTCT, and have increased national budgets for HIV and AIDS. However, there remains an increasing gap between the national targets and the implementation process.

Turning to the regional response, she said that this focuses on reducing new infections, harmonisation of policies and legislation, mobilisation and coordination of resources for a multi-sectoral response, and monitoring of the implementation of the SADC Strategic Framework and commitments by Member States. She noted that the following milestones have been accomplished in the implementation of the regional response:

- The adoption of the Maseru Declaration and the HIV and AIDS Strategic Framework and Programme of Action 2003-2007 by Heads of State and Governments.
- The establishment of the SADC HIV and AIDS Unit.
- Piloting of innovative regional HIV and AIDS projects through the support of DFID and the European Union.
- The development of the "Code of Conduct on HIV and AIDS in the Work place" and the initiation of HIV and AIDS interventions by various sectors such as transport, health, mining and agriculture.
- Recommendations by SADC Ministers of Health on the use of nutrition and traditional herbal therapies to improve the health and well being of PLWHAs and the general population in the region.
- The initiative to establish a SADC Regional Fund for HIV and AIDS.

She said that at present the SADC Secretariat is focussing on mainstreaming HIV and AIDS into the work of all the SADC Secretariat Directorates, guided by the SADC HIV and AIDS Business Plan. This includes facilitating capacity building, retaining skills, providing of technical assistance to Member States in policy development and harmonisation, documentation and dissemination of best practices, and support for technical resource networks.

She noted that challenges requiring priority action include prevention of new infections, improving access to treatment (ART), access to VCTs and PMTCT, improving human rights, and access to information and knowledge of HIV and AIDS by the general population.

3.4 Harmonisation of the Medicine Regulations in the SADC region (SADC)

By Tangeni K Angula, Director Tertiary Health Care and Clinic Support, Namibia.

The presenter noted that the process to harmonise medicine regulations in the SADC region commenced in 1995, when the regulatory bodies of SADC Member States started networking on the subject under the auspices of the “Southern and Eastern Africa Medicines Regulatory Authorities Conference”. In 1999, the SADC Council of Ministers approved a proposal by the SADC Ministers of Health that the Medicine Authorities within SADC should harmonise their regulations in line with Article 29 of the draft Protocol on Health. South Africa took the lead in coordinating the process as it hosted the SADC Health Sector Coordinating Unit.

The process of harmonisation resulted in the approval by the SADC Integrated Committee of Ministers in June 2004 of the following documentation for review by Member States to ensure that their regulations are in line with regional standards:

- Registration of medicines general information.
- The registration forms.
- Stability guidelines.
- Good manufacturing practices.

She said that in addition to these documents the draft guidelines on “bioavailability and bioequivalence” are to be reviewed by the Harmonisation Committee prior to consideration by the Integrated Committee of Ministers for adoption. These guidelines specify manufacturing

conditions and quality and are important for the procurement and use of generic medicines by Member States.

She pointed out that in order to complete the process of harmonisation a number of draft guidelines still need to be considered by the Harmonisation Committee. However, prior to this the guidelines would need to be disseminated to the appropriate authorities in Member States for their inputs and an evaluation would need to be undertaken of the capacity of the regulatory bodies in the Member States.

Comments and Discussions

The state of the epidemic in the SADC region

Delegates expressed concern that prevention programmes are not making significant progress in bringing about behaviour change despite high levels of awareness. Possible reasons given for this included the nature and relevance of messages, the medium of communication being utilised and the lack of adequately skilled personnel.

They recognised that factors increasing the vulnerability of women to HIV and AIDS are not being adequately addressed in national responses. This they attributed to inadequate policies and guidelines to assist Member States to Mainstream Gender and HIV and AIDS into all national development programmes. Delegates highlighted the need for technical and financial support to increase access and availability to female-controlled prevention methods such as the female condom.

Financial and human resource limitations were cited as some of the main reasons why Member States are unable to meet their “3 by 5” targets. It was observed that the increased focus on ART treatment is counter productive if other aspects such as prevention and the strengthening of health systems are not addressed.

UN Secretary General’s Task Force report

The delegates agreed that there is an increase in gender-based violence and inter generational sex. They noted that the failure to address HIV and AIDS and gender is primarily based on a lack of effective policy frameworks to guide the process at country and institutional level. The delegates requested the SADC Secretariat to facilitate

skills training and technical support to Member States to address the challenges highlighted in the report.

SADC response to the epidemic

The delegates welcomed the mainstreaming of HIV and AIDS into the work of all SADC directorates. They called on the SADC Secretariat to increase public awareness of the Maseru Declaration through engaging communities and civil society organisations. They requested the SADC Secretariat to strengthen its networking and information dissemination to Member States.

Harmonisation of medicine regulation in the SADC

Concern was expressed over the slow process of harmonising medicine regulations. Delegates urged the SADC Secretariat as a matter of urgency to promote and support the harmonisation of a common protocol on HIV and AIDS treatment in the region. The SADC Secretariat was requested to establish a regional database on HIV and AIDS providing information on best practices in the areas of prevention, human rights, treatment and care and support of PLWHAs.



Section 4: Operationalising the SADC Framework and the Maseru Declaration

4.1 Overview of the DFID and EU-funded SADC HIV and AIDS projects

By Mr Manasa Dzirikure, Project Manager, (DFID) HIV and AIDS, SADC.

Mr Dzirikure provided an overview of the SADC–DFID and the SADC–EU projects on HIV and AIDS. He pointed out that both are five-year projects that commenced in 2001 when the European Union and DFID approved the provision of financial and technical support to the SADC Secretariat to address the challenges associated with the epidemic. He noted that both contribute to the implementation of the SADC HIV and AIDS Framework and the Maseru Declaration.

He noted that the European Union Project on HIV and AIDS is funded by the European Development Fund and the European Programme for Reconstruction and Development to the amount of € 7 614 000. The project has two main components (a) *Strengthening the SADC response* and (b) *Making a difference*.

He highlighted that the project strengthens the SADC response through the development, implementation and monitoring of the SADC Strategic Framework and Operational Plan. It also supports advocacy for the development of regional policy instruments, and building the capacity of the Secretariat to mainstream HIV and AIDS.

The project aims to *Make a Difference* by supporting nine innovative projects and studies that address a wide range of issues including orphans and vulnerable children, nurses and midwives, stigma and discrimination, HIV and AIDS and the transport sector, integration of HIV and AIDS in water resource management, migrant and mobile populations, improving surveillance of the epidemic, and the development of a regional database on HIV and AIDS intervention in the region.

The Project being supported by the Department For International Development (DFID) covers four countries; Botswana, Lesotho, Namibia and Swaziland (BNLS), and is funded to the amount of £7.6 million. It aims to create an enabling environment in support of the SADC HIV and AIDS strategy by targeting vulnerable populations such as women, men and young people. A major focus of the project is on interventions targeted at cross-border and high transit areas in the four countries. Implementation is

through government, NGOs and PLWHAs.

The project has four main components:

- Strengthening Syndromic Management of STIs.
- Enhancing social marketing and condom use.
- Strengthening Behaviour Change Communication (BCC) programmes.
- Strengthening National AIDS Control Programmes (NACP) and support to PLWHAs.

4.2 The SADC Business Plan for HIV and AIDS

By Innocent Modisaotsile, Project Manager, (EU) HIV and AIDS, SADC.

Mr Modisaotsile pointed out that one of the key objectives of the workshop was to consider the SADC Business Plan on HIV and AIDS. He said the comments provided by delegates would be incorporated prior to the Business Plan being provided to the Council of Ministers for consideration and adoption.

The Maseru Declaration and the SADC HIV and AIDS Strategic Framework 2003-2007 inform the Business Plan. It guides the strategic implementation of the SADC HIV and AIDS Programmes. The principles underlying the Business plan are:

- Multi-Sectoralism.
- Subsidiarity.
- Prioritisation.
- Gender mainstreaming.
- Comparative advantage – for regional interventions.
- Complimentarity.
- Human rights.

He outlined the key interventions in the Business Plan including:

- Policy development and harmonisation related to prevention, care and support, treatment, migrant/mobile or displaced populations and sectoral policies.
- Capacity-building and mainstreaming of HIV and AIDS through developing a regional policy on human resource development and retention as a response to the increasing human resource needs as a consequence of AIDS and the brain drain.
- Technical resource networks, coordination and improvement of knowledge management.
- Resource mobilisation including the establishment of a SADC HIV and AIDS Trust Fund and encouraging countries to initiate innovative strategies for local resource mobilisation.
- Monitoring and Evaluation

Comments and Discussions

EU and DFID projects

Delegates suggested that the EU and DFID projects should work together to facilitate regional policy development and harmonisation on issues related to migrant workers, access to treatment by mobile populations and commercial sex workers. They called on the SADC Secretariat to consider rolling out the projects to include other Member States based on the availability of resources. The delegates urged the SADC Secretariat to support the scaling-up of interventions as there is sufficient information and knowledge, and because HIV and AIDS is an emergency requiring an emergency response.

The SADC Secretariat was requested to ensure that the implementing agencies work closely with existing government facilities to avoid creating parallel systems that may not be sustainable in the long term. It was recommended that emerging best practices be documented and disseminated to enable Member States to learn from these experiences.

The Business Plan

Delegates welcomed the business plan as a first step towards greater regional cooperation and coordination by the SADC in response to the epidemic. It was noted that the Business Plan primarily focuses on interventions of a “regional nature”, for example cross-border initiatives, Trust Fund, the Regional HIV and AIDS database, and the support to the “transport sector”. The following recommendations were made for inclusion within the Business Plan:

- The SADC Secretariat should strengthen the documentation and dissemination of best practices on country experiences in particular in relation to ART, PMTCT and national monitoring systems.
- The SADC Secretariat should host the National AIDS Coordinating Authorities and HIV and AIDS Programme staff on an annual basis to improve

networking and information sharing.

- Member States should include “applied research” to improve the surveillance of the epidemic. This includes undertaking population-based HIV surveys.
- The SADC Secretariat should establish a regional information system that includes data on the number of orphans, PLWHAs and resources available for HIV and AIDS at both national and regional level.
- The SADC Secretariat should facilitate the development of strategies and tools for use by Member States, civil society organisations, and the private sector to track PLWHAs on ART.
- The SADC Secretariat should develop guidelines on the mobilisation and disbursement of funds through the SADC Trust Fund.
- The SADC Secretariat should develop tools to strengthen capacity for Member States to track resources on HIV and AIDS.
- That SADC, WHO, UNAIDS and others assist in defining and articulating “a multi-sectoral HIV and AIDS Coordination” including the roles and responsibilities of institutions such as the National AIDS Coordinating Authorities and Ministries of Health.
- The SADC Secretariat, in consultation with WHO, should assist Member States to access cheaper ART drugs, including exploring possibilities for joint procurement or production.
- The SADC Secretariat should map migration patterns in terms of source, receiving communities, characteristics of migrants, causes and the impacts in relation to HIV and AIDS.
- That the “Cross Border Sites STI/HIV/AIDS” initiative be rolled out to other countries as part of the Business Plan activities.
- That prevention activities be strengthened through the establishment of a Regional Strategy for Behaviour Change.
- Address cultural practices that increase the vulnerability of women and girls to HIV and AIDS and assist Member States on how to deal with it.

Section 5: Promoting Treatment in the Region

5.1 “3 by 5” Initiative

By L Thomas-Mapleh, Technical Officer, WHO – AFRO.

Ms Thomas-Mapleh commenced her presentation by saying that the “3 by 5” Initiative gives hope to those living with HIV and AIDS through ensuring that three million PLWHAs who need treatment receive it by the end of 2005. The purpose of the Initiative is to reduce mortality, opportunistic infections, orphans, and improve the quality of life for all people living with HIV and AIDS. Despite Africa being home to the majority of people living with HIV, only 2% of PLWHA in Africa in need of ART are receiving it.

She said that an assessment undertaken by WHO on the status of ART in 20 African countries, as part of the “3 by 5” Initiative, identified the following challenges for scaling-up ART:

- A lack of operational plans, adequate drug and diagnostics procurement and supply management systems, and weak laboratory services.
- Weak and inadequate monitoring and evaluation mechanisms.
- A lack of training materials and poor coordination mechanisms.
- Inadequate and under-qualified human resources, policy limitations and poor systems for tracking patients on ART.
- The need to strengthen human resources through training and retaining of personnel.
- The need for greater involvement of stakeholders including civil society organisations and PLWHAs.
- The need to further reduce the prices of ARVs which could be achieved through the joint / bulk procurement of ARV drugs and related technology at reduced prices.
- Effective strategies for community mobilisation and preparedness.

In terms of the progress which has been made in the implementation of the “3 by 5” initiative, she noted the following:

- Simplified guidelines for clinical management.
- Simplified guidelines for entry points.
- Monitoring and evaluation of national ART programmes and resistance surveillance.
- Finalising a human resource capacity building plan.
- National commitment at the highest level demonstrated by the setting of national treatment targets.

- Forty out of forty six countries have expressed the need for technical assistance to scale-up access to treatment and training of health workers and community groups in ART management.

She concluded by stating that the implications of the “3 by 5” Initiative for the SADC Secretariat are to assist Member States with the bulk procurement of medicines and diagnostics, and human resource development and retention.

5.2 The Orphans and Vulnerable Children (OVCs) Programme in the SADC region

UNICEF

The presenter provided an overview of the Rapid Assessment of the Situation of Orphans and Vulnerable Children in seventeen sub-Saharan African countries. Countries were selected on the basis of having a high HIV prevalence, high orphan population and being recipients of the US Presidential HIV and AIDS Emergency Funds. The study aimed to capture baseline data for planning, monitoring and scaling-up of OVC programmes, and to identify gaps and constraints.

The presenter noted that the data on OVCs is inadequate and hampers effective programme planning, implementation and service delivery. However, it is estimated that in sub-Saharan Africa the numbers of orphans had increased from 1 million in 1990 to 13 million in 2002, representing 80% of orphans globally. Despite the increasing numbers of OVCs, many countries in the region do not have strategic plans and policies in place to provide care and support to OVCs. Where programmes do exist these are fragmented, poorly coordinated and often located in government ministries and departments that are not directly responsible for HIV and AIDS. This has implications on resource allocation, programme integration and ensuring a multi-sectoral response.

As a result of the rapid assessment undertaken in Namibia, Zimbabwe, Zambia, Mozambique and Malawi, national action plans have been prepared and are to be submitted for funding to a Donors’ Roundtable meeting to be held in Cape Town, South Africa, towards the end of 2004. Ethiopia, Kenya and Swaziland are in the process of preparing their national action plans.

5.3 Country experience in rolling out ARV Treatment: the case for Botswana

By Ms Kgoreletso Molosiwa, Chief Health Officer, Ministry of Health.

The presenter provided an overview of the epidemic in Botswana. She noted that the country has adopted a comprehensive multi-sectoral programme to address HIV and AIDS. This includes:

- Prevention comprising BCC, PMTCT, Counselling, voluntary testing, IPT, PEP and syndromic management of STI.
- Care and support interventions include community home-based care, supportive counselling, OVC, nutrition, and ART.

She highlighted that Botswana was the first SADC Member State and African country to provide free ART. This was based upon a needs assessment conducted in 2000, which found that approximately 110 000 people needed ART. The ARV programme was introduced in 2001, and is known as "MASA, or "a new dawn". MASA forms an integral component of the national HIV and AIDS multi-sectoral response. The programme commenced in four pilot sites and has since expanded to 9 sites. Priority is given to adults and children with a CD4 cell count of below 200, those who had one defining illness, pregnant women, qualifying partners, and patients with TB. At present 23 000 PLWHAs are enrolled for ART and efforts are underway to roll out ART nationwide. The country aims to have approximately 36 000 PLWHAs enrolled for ART by December 2004 and its "3 by 5" target is 55 000 by the end of 2005.

Challenges that Botswana experiences in scaling-up ART include:

- Stigma discourages people from disclosing their HIV status as people are afraid of being stigmatised, isolated or rejected and only present themselves when they are at an advanced stage.
- Lack of adequate and qualified manpower, which is being addressed through the use of collaborating private sector and civil society organisations.
- High cost of ARV drugs.
- Trafficking of ARV drugs across borders and stealing within households.
- National bureaucracy in drug procurement.
- Availability of test kits.

- Capacity to track patients.
- Counselling of children under 10 for ARV.

Factors contributing to the success of the Botswana ARV programme include:

- Strong political and traditional leadership in community mobilisation.
- Strategic institutional capacity building both within the public, private and civil society organisations.
- Strategic roll-out of the programme based on community and institutional preparedness.
- An early set up of patient monitoring systems. While this has experienced some difficulties it has also proved to be a good strategy.
- Botswana has also avoided re-inventing the wheel where possible by learning from other countries that have achieved some results such as Uganda and Thailand.
- Effective coordination between the health sector and other sectors.

5.4 Country experience in promoting universal testing: The case for Lesotho

By Dr Maile Limpho, Director STI/HIV and AIDS Directorate, Ministry of Health.

The presenter noted that Lesotho had a prevalence rate of 28.9% (2004) and approximately 360 000 people were estimated to be living with HIV and AIDS. Of these 56 000 required ART. The number of orphans due to HIV and AIDS was estimated at 92 000, while the country was experiencing 70 deaths per day due to HIV and AIDS.

The presenter provided an overview of the epidemic in Lesotho noting that it is estimated that there are 36 000 people living with HIV and AIDS, of which 56 000 require treatment. The government declared AIDS a national disaster in 2000 and in 2004 launched a national strategy to guide its response. In addition each Ministry allocates 2% of its budget to AIDS.

In March 2004, Lesotho launched the "Know your status: - universal HIV testing and counselling". The strategy mobilises prominent figures in society to undertake voluntary testing for HIV and serve as role models. In July 2004, the campaign was extended to the textile industries reaching over 50 000 people.

The VCT strategy is supported by a number of interventions, including social mobilisation, awareness, education, and stigma reduction interventions. It is complemented by the STIs, TB, ANC, and in/out patient services at health facilities to which counsellors have been deployed in all district and health centres.

With the support of other development partners such as WHO and UNAIDS, Lesotho has developed guidelines on testing and counselling, training manuals, antiretroviral therapy guidelines and protocols, and a manual for community home based care. Challenges confronting the programme include a lack of adequate counsellors, and resources for training and ensuring that people who test positive and are in need of ART are able to receive it.

5.5 Health systems strengthening for treatment roll out

Dr R Loewenson, Director – Regional Network for Equity in Southern Africa (EQUINET)

Dr Loewenson's presentation was based upon research undertaken in Africa focussing on the challenges confronting health systems as a result of the increasing demand for ART. This includes equity and social justice within the health sector in terms of financial and human resource allocations.

It was pointed out that Africa has unequal access to ARVs owing to high prices, global trade practices and agreements. Universal access to treatment is only likely if significant improvements are made in global drug production and distribution systems, market access to drugs and client access to ART. To address this requires a more humane and ethical approach to marketing and drug pricing by the pharmaceutical industry and for governments to adopt a policy of "equity" in resource allocation.

She said that resource allocations often do not reflect national priorities owing to the pressures placed on governments to make ART available and accessible. Furthermore donor efforts are largely un-coordinated placing greater demands on countries and creating confusion at country and regional level.

Additionally, financial and human resources are often allocated for ART programmes at the expense of other health interventions. This is further exacerbated by the

"brain drain" and loss of health personnel to HIV and AIDS. An example is the Lilongwe Central Hospital, which has only 169 nurses where it requires 520 nurses, and only 6 laboratory technicians where previously there were 38. Reasons for the decline in health personnel are declining financial resources, the brain drain, and the joining of ARV projects. She highlighted that the depletion of resources for other health care interventions may ultimately undermine ART programmes.

The declining resources for health have been recognised by the SADC Heads of State and Government who have called for the "improvement and strengthening of the health care system" in the Maseru declaration. This recognises that the health sector response remains the cornerstone for quality care and support. However, existing health systems are fragile and are likely to be negatively affected if interventions were to continue being based on vertical disease programmes.

In conclusion she recommended that:

- Governments and development partners consider resource allocations in a holistic manner based on an analysis of needs.
- A priority intervention in the SADC Business Plan should be to provide technical assistance to Member States to strengthen production, procurement, distribution and monitoring of essential drugs.
- Capacity for monitoring HIV and AIDS funding and expenditures be strengthened both within government agencies and civil society organisations.
- Access, equity, and health care outcomes be monitored systematically using routine data systems, sentinel reporting and the involvement of civil society organisations.
- The SADC Secretariat support applied research and analysis of systems costs, benefits, and opportunity costs to guide programme choices.
- Civil society organisations be more involved in planning, programming and in service delivery.

Comments and Discussions

"3 by 5" Initiative

It was noted that the "3 by 5" Initiative is good but that sustainability will be a challenge confronting countries. It was pointed out that Member States are finding it difficult to finance the provision of ART while continuing to

provide other essential services in the face of declining economies, national external debt, increasing household poverty, competing national needs and the lack of bilateral and multilateral donor commitment in the longer term. The high cost of ARVs and lack of adequate access to generic drugs were cited as continuing concerns by the Member States. It was suggested that the possibility of manufacturing ARV drugs within the region be explored. They also suggested that the treatment protocols of Member States be harmonised to ensure consistency.

Delegates noted that Member States have insufficient human resources and capacity to meet the increasing demand for ART. It was suggested that the SADC Secretariat, in collaboration with the UN agencies and other development partners, develop strategies to assist Member States in responding to capacity shortages.

The delegates noted that a greater emphasis is being placed on financing ART interventions at the expense of other services and in particular the “health system”. They feared that increased funding for ART without strengthening of the health system could compromise the overall impact and quality of the ART itself in the medium and long term.

Orphans and vulnerable children

The delegates highlighted care and support for orphans and vulnerable children as a major challenge at the national level, especially in areas of conflict. It was noted that caregivers do not register OVCs for support owing to the stigma associated with HIV and AIDS.

They indicated that the monitoring of OVCs is complex, inadequate and in some countries non-existent. Care and support programmes are fragmented across different ministries and not coordinated by the national coordinating authority on HIV and AIDS. This negatively impacts on resource allocation and advocacy.

The delegates suggested that a more proactive approach be applied in identifying OVCs in need of support by identifying and providing care and support once the parents are identified and referred to home-based care or to other forms (i.e. hospice) of care.

The absence of policy guidelines on care and support, made it difficult for service providers to provide quality

care. It was recommended that the SADC Secretariat in collaboration with other development partners, in particular UNICEF and WHO, support Member States to develop and operationalise relevant policies that include guidelines on inheritance. Alternatively, relevant laws should be revised to include these provisions.

The delegates suggested that at the regional level, the SADC should document and share best practices such as the Botswana’s “Baylor Centre of Excellence” on care and support for children living with HIV and AIDS.

ART roll out experiences in Botswana

Delegates noted that Member States are at different stages of providing ART and different treatment protocols exist in different countries. None of the Member States have clear guidelines for providing ART to children below 10 years, to people with disabilities and refugees. The SADC Secretariat was requested to incorporate capacity-building for Member States to address HIV and AIDS and people with disability as part of the Business Plan.

The delegates praised Botswana for a well-established ART programme, which they attributed to the good economic environment that enabled the country to procure drugs from its own resources with a proportionate complement from development partners. In response to questions, the delegates were informed that ART was free to any citizen when accessed from a public health facility or from a collaborating private sector health facility. Patients seeking ART from private doctors on their own would have to pay for the costs. Some patients were said to prefer private doctors in spite of the cost due to stigma. Experience has shown that this is not a sustainable strategy as the cost of drugs are high and often those who seek ART privately are in most cases no longer employed and hence cannot meet the cost of drugs in the long term.

The delegates questioned why ARV was not freely available to non-Batswana residents residing in Botswana. This was attributed to the high cost of drugs and fears that if ART were made free to anyone, the country would experience a high influx of people seeking treatment.

The delegates recommended that guidelines be developed for a Caring for Carers Programme in the region. WHO

offered to facilitate the process in collaboration with the SADC Secretariat.

Universal testing – Lesotho experiences

Delegates questioned the social implications of high profile public figures taking the lead on testing. It was suggested that the actions of community role models should be given equal publicity, as this will enable greater identification by people.

Health systems strengthening for treatment roll out

The delegates noted the importance of monitoring HIV- and AIDS-related finances and human resources. However, they observed that data on actual expenditures

is difficult to determine as information is fragmented between various government departments.

They called upon governments to encourage Ministries of Finance to be more active in the tracking of resources for AIDS, including research, documentation and dissemination of such information.

They called for capacity building of the relevant national bodies in the methodology for “resource tracking”. It was suggested that the SADC Secretariat should develop a comprehensive database on funding from governments, bilateral and multilateral donors, private sector foundations and civil society organisations.

Section 6: Promoting an expanded and multi level response to HIV and AIDS through mainstreaming and decentralising the response

6.1 Challenges in expanding the response

Dr Lemma Merid, Regional Project for HIV and Development UNDP.

The presentation was made by Dr Lemma Merid on behalf of Dr. Ronald Msiska, the Regional Director of the UNDP Regional Project on HIV and Development in sub-Saharan Africa.

Dr Merid defined mainstreaming as “putting HIV and AIDS in the centre of efforts for social and economic development”. It is more than just having an AIDS policy in place, the allocation of resources, and having a sector coordinating body. Rather, mainstreaming is reflected by practical actions that have real impacts on HIV and AIDS such as stigma, discrimination, violations of human rights and the allocation of human resources.

Dr Merid said that the greatest challenge to “mainstreaming” is that it is often regarded as an add-on rather than an integral component of the national sectoral responses to the epidemic. She noted the need for further training and clarification of the concepts.

6.2 Country experiences in mainstreaming HIV and AIDS response

Sesupo Programme Manager – South African National AIDS Council

The presenter noted that the South African government’s efforts in mainstreaming HIV and AIDS is reflected in the *Partnership Against HIV and AIDS* launched in 1998 by President Thabo Mbeki.

South Africa applies a participatory approach that engages different stakeholders at different levels in the national response. This multi-sectoral approach has generated a wide range of activities that are the responsibility of individual organisations, sectors and partners.

It is through these partnerships that the government promotes and supports the mainstreaming of HIV and AIDS targeting several activities including policy, strategic plans, programme interventions i.e. prevention, care and support.

She said that the government provides technical and financial support to the implementing partners to enable them to mainstream HIV and AIDS. Several sectors including transport (targeting trucking industry using N1 – N4 roads), the Taxi industry, sports and recreation, mining and agriculture have mainstreamed HIV and AIDS. Civil society organisations have established a nationwide database and are in the process of forming a national coalition against HIV and AIDS. The public sector institutions have started institutional-based HIV and AIDS programmes based on their operational mandate.

She identified a number of challenges that prevent the realisation of the potential for mainstreaming HIV and AIDS in South Africa as: poor programme coordination, lack of sustainability of partnerships and poor management of PLWHAs. However, she said that opportunities are emerging that create new hope, especially for those interventions that link to NGOs and organisations of PLWHAs.

6.3 Decentralising the response: The Namibian experience

The delegate from Namibia pointed out that the country has adopted a participatory multi-sectoral approach for the implementation of the national response to HIV and AIDS. This approach creates opportunities for different stakeholders at different levels to identify their roles and responsibilities in responding to HIV and AIDS.

At the national level the response is coordinated by the Namibian National AIDS Coordinating Agency, while at the district level public institutions work in collaboration with the private sector and civil society organisations to provide quality services. The government provides financial and technical assistance to these partners whose programmes are in line with the national strategic framework of Namibia. Examples of these partnerships include:

- A public and private partnership with the Namibian National Council of Commerce where the private sector is complimenting government efforts.
- The promotion and distribution of condoms by the National Social Marketing Programme.
- Voluntary Counselling Centres for HIV and AIDS established by the Namibian Council of Churches in partnership with government.

- Home-based care programmes and income-generating activities being implemented in partnership with PLWHAs Support Groups, CBOs and NGOs.
- Training for health workers, counsellors and Regional HIV and AIDS Coordinators by the Namibian Network of AIDS Service Organisations (NANASO) in collaboration with the National AIDS Coordinating Programme (NACOP).
- Government and private health facilities are providing counselling for pregnant mothers participating in the PMTCT programme.

6.4 Promoting partnerships with civil society, PLWHA, Private Sector, Parliament

By Mr M Mukobe, Economist, Health Planning, Ministry of Health, Zambia.

Mr Mukobe said that Zambia's national response to HIV and AIDS is based on a multi-sectoral and participatory approach.

The National AIDS Council leads the national response and provides policy guidelines on HIV and AIDS, for example the development of the National Strategic Framework. HIV and AIDS are mainstreamed into the work of all ministries, which includes the allocation of specific budget lines for AIDS, the development of sector specific plans and the appointment of HIV and AIDS Coordinators in each ministry.

The Parliamentary Committee on HIV and AIDS ensures that the epidemic remains on the political and economic agenda and facilitates increased financial resources for the programme.

The Zambian Business Coalition on HIV and AIDS, comprising forty two companies, supports the development of workplace HIV and AIDS policies, voluntary counselling and testing, provision of ART to employees, peer education, and awareness creation.

People living with HIV and AIDS are involved through the Network of Zambian PLWHAs that provides counselling, managing small grants for community-based organisations, capacity development in positive living, and care and support including for orphans.

He said that the government works with NGOs in the

implementation of Global Fund supported projects. NGOs manage the resources, while the government provides monitoring oversight. Challenges to civil society involvement include lack of resources, coordination and a diffusion of leadership.

Traditional Healers play an important role in care and support through the Traditional Health Practitioners Association of Zambia. However, their capacity needs to be strengthened particularly as peer educators and in the treatment of opportunistic infections.

The challenges confronting Zambia in strengthening the national response include the need to improve the national capacity for monitoring and evaluating the performance of stakeholders.

Comments and Discussions

Expanding the response

The delegates called on the SADC, UNDP and other development partners to document best practices and provide capacity building for Programme Managers on mainstreaming, decentralisation and multi-sectoralism. They requested clarity in the manner in which these concepts affect structural changes in the national response.

Mainstreaming HIV and AIDS response – South Africa

The delegates expressed their appreciation for the lessons learnt from South Africa which were appreciated.

Decentralised response - Namibia

The delegates observed that the Namibian programme had a very high involvement and participation of civil society organisations. They called on governments and development partners to establish sustainable strategies for supporting civil society organisations and district level initiatives.

Partnership with other stakeholders - Zambia

The delegates wanted to know how Zambia had managed to deal with donor "conditions" related to funding HIV and AIDS programmes. The presenter noted that most donors identified their funding priorities in the context of the National Strategic Framework. This meant that the funding was tied to national priority areas outlined in the national response.

The delegates expressed concern at the lack of accountability and sustainability of civil society interventions. It was noted that in most countries NGO interventions are donor driven and their sustainability tied to the availability of funding. In response the presenter noted that the situation is not different in Zambia. However, he observed that NGOs were working towards a more strategic medium term plan that would enable the government of Zambia and its collaborating

development partners to plan how best to support NGOs to sustain their interventions.

Delegates urged the SADC to facilitate a study on "*Civil society responses to HIV and AIDS*" with the aim of establishing their actual strategic niche, available expertise, resources and challenges that they face in addressing HIV and AIDS, both at national and regional level.

Section 7: Resource mobilising for the HIV response

7.1 Country experiences with the Global Fund on AIDS, TB and Malaria

Dr Andrina Mwansambo, National AIDS Commission, Malawi.

Dr Mwansambo highlighted that the Government of Malawi has a participatory multi-sectoral HIV and AIDS programme. The implementation of interventions has been slow due to inadequate human and financial resources. To address this the National AIDS Commission of Malawi, in collaboration with civil society organisations and with technical support from its development partners, applied for financial support from the Global Fund. The Global Fund awarded Malawi a grant of US\$42million for a period of 2 years focussing in particular on HIV and AIDS.

The National AIDS Commission is the Principal Recipient, with the Ministry of Health and civil society organisations being the main beneficiaries. To improve financial management and accountability an independent Financial Management Agency was appointed. Project management is coordinated by the “Malawi Global Fund Coordinating Committee” that reviews progress made and provides guidance in the implementation of the projects. PriceWaterhouse is the Local Funding Agency (LFA).

The presenter noted the following challenges confronting Malawi in managing the Global Fund grant:

- The late disbursement of funds resulting in stakeholders losing interest.
- Communication on the financial status of the project often does not include the HIV and AIDS Commission or Ministry of Health.
- Lack of clarity on the roles and responsibilities of the HIV and AIDS Commission and the Ministry of Health.
- The lack of human resources.
- Poor inter-agency and donor coordination.
- An under-developed monitoring and evaluation system.

7.2 Innovative resource mobilisation: the case for the AIDS levy in Zimbabwe

By Mr A Mpofu, Manager Monitoring and Evaluation, National AIDS Council

The presenter noted that funding the national response is

a daunting challenge for Zimbabwe given the dwindling financial support from the international donor community. In response the government has mobilised national resources by introducing an AIDS levy of 3% on salaried persons in all sectors of economy.

The levy is collected by the Zimbabwe Revenue Authority (ZIMRA) and remitted to the National AIDS Council annually. In 2003, the government of Zimbabwe provided over \$16 billion Zimbabwe dollars for HIV and AIDS from its own resources.

Challenges facing Zimbabwe in the management of the HIV and AIDS levy are the:

- Ability of the economy to sustain employment and a pool of taxable salaries.
- Collection of the levy and submission of the funds from the ZIMRA to the National AIDS Coordinating Agency.

7.3 Mainstreaming AIDS Fund: Tools for tracking resources

Alison Hickey, Manager IDASA.

The presentation by IDASA was based on a multi-country study on HIV and AIDS budgets in Kenya, Mozambique, South Africa and Namibia. The objective of the study was to:

- Generate data and experiences in developing a common framework/methodology for tracking HIV and AIDS targeted expenditure in national budgets.
- Track the extent to which governments' were meeting their commitments such as the Abuja target that 15% of the total annual budget will be provided to health care.
- Strengthen the capacity of stakeholders and in particular civil society organisations for HIV and AIDS budget analysis.
- Influence policy decisions that will in turn help to ensure equity and adequacy of financial resources and priority setting in resource scarce environments.

The methodology involved a review and analysis of official budget documents, and face-to-face interviews with the relevant officials and stakeholders. Country reports were produced providing information on their budget formats, an analysis of their AIDS policies, resource allocation, funding and reporting mechanisms.

Ms Hickey said that the challenges confronted in undertaking the study included:

- Lack of accurate and timely data
- General financial information.
- The unwillingness of governments and development partners to give financial information freely.
- Separating HIV and AIDS funds from Ministries of Health funding which are integrated and difficult to separate at expenditure level.

She said the study found that the provision of ART is claiming an increased share of national budgets for HIV and AIDS in South Africa and Botswana. This is likely to surpass the general budget for national health care in the future as the epidemic unfolds. She said that governments are experiencing difficulties in resource absorption due to a lack of institutional capacity. Capacity building at national and community level is undermined by the use of expatriate consultants who have no contractual obligation to transfer skills to nationals.

She highlighted that the study recommended that resource allocations be balanced in relation to the needs (disease burden and demand for services) and absorption capacity (ability to spend) of countries. The presenter further recommended that a regional database of HIV and AIDS donor inflows be established and that national capacity, especially among NGOs, be strengthened to monitor HIV and AIDS funding and subsequent use of funds.

Comments and Discussions

Experiences with Global Fund

The delegates noted similar experiences as those of Malawi with funding from the Global Fund. Particular challenges confronted by countries included:

- Lack of clarity on the process and formats that proposals were expected to be in.
- Lack of technical capacity and experience to develop such proposals, or where these were in existence they were not generally known of.
- They requested WHO, UNAIDS, UNDP and the SADC Secretariat to establish a pool of resource persons that Member States can draw from when needed.

- No clear guidelines from the Global Fund on collaboration and funding of civil society organisations resulting in countries having to establish their own mechanisms. It was suggested that countries should document such experiences and share them within the region. They also suggested that the Global Fund should be encouraged to provide clarity and appropriate guidelines.
- The timeframe of 2 years is not realistic to achieve the kind of indicators. Such timeframe should be in the region of 5 years.

The delegates recommended that the SADC facilitate a workshop for Member States to specifically focus on HIV and AIDS funding opportunities and experiences in resource mobilisation.

AIDS levy in Zimbabwe

The idea of the levy was found by most delegates as innovative and a good strategy for sustainability. It was suggested that the SADC Secretariat document the case study and share the experiences in more detail with other countries.

Mainstreaming AIDS Fund - Tools for tracking resources

The delegates noted that the study focused on mainstreaming funding and had not taken into account additional resources such as out-of-pocket expenses, funds from Local Authorities or donor funds channelled through NGOs and CBOs. It was suggested that IDASA, together with other development partners, organise and conduct training workshops on resource tracking for National AIDS Control Programmes, National AIDS Coordinating Agencies and civil society organisations.

With regard to repatriation of funds through consultancies back to donor countries, the delegates indicated that the practice was more political and undermined local capacity building. They called on the SADC Secretariat to find possible solutions. One such solution was to establish a regional database of consultants in the region that Member States can draw from.

Section 8: Monitoring the response

8.1 Mechanisms for monitoring global, continental, regional and national commitments

Mr Emmanuel Yasheeka, Monitoring and Evaluation Officer, UNAIDS.

Mr Yasheeka said that the benefits of monitoring and evaluating national and regional responses to HIV and AIDS is that it allows for strategic management, targeted planning, resource mobilisation and results-based disbursements. In addition to these, it also assists countries in determining the extent to which they are meeting their national, regional and international commitments.

He provided an overview of the regional and national level mechanisms for M and E. He said that at the regional level mechanisms for Monitoring and Evaluation (M and E) include a “Regional M & E Partner Coordination Forum” that facilitates a harmonised approach including identifying core indicators, regional technical support plans and strengthened information sharing and management.

At the country level, M & E systems are fragmented, weak, poorly resourced and lack experienced personnel. Monitoring tools are not well developed or harmonised and reporting methods are weak and ineffective. Data analysis takes too long, compromising the use of this data in decision-making and planning.

Despite these challenges, he said that some progress is being made with several countries finalising their Millennium Development Goals reports, and identifying indicators to monitor the UNGASS commitments.

He noted that Action AID, in collaboration with UNAIDS, is conducting a study on the implementation of the Abuja Declaration in selected countries. As part of this process countries are revisiting their institutional arrangements for the coordination of their national responses including strengthening monitoring and evaluation through establishing one effective multi-sectoral mechanism.

At regional level, a regional capacity development plan has been developed and is being implemented to support Member States to unify data and reporting mechanisms through the “Country Response Information System”. Peer review experts are being placed within the Africa

Union, NEPAD and SADC. These experts will help to produce annual update reports for the AU on the epidemic that will eventually feed into the UNAIDS global reports.

8.2 Expanding mechanisms for monitoring the epidemic: population based surveys

By Dr Olive Shisana, Executive Director, HSRC.

Dr Shisana said that until recently HIV prevalence rates were based on antenatal clinic surveys among pregnant women. While this method is universally accepted, questions have been raised concerning the accuracy of this method. On this premise, the Human Sciences Research Council (HSRC) is working with Botswana, Lesotho, Mozambique and Swaziland, through the support of the SADC/EU project, to develop appropriate mechanisms for conducting population-based behavioural and prevalence surveys.

She noted that South Africa (2002) and Botswana (2003) have both conducted a population-based survey. Swaziland is in the process of developing a proposal for a population-based survey, and has already developed a Behavioural and Sero Status (BSS) survey.

She said that the first multi-country meeting of the project took place in January 2003 under the auspices of the UNAIDS Regional Office in Pretoria and the second meeting was held in Maputo, Mozambique. The meetings provide a platform for participating countries to share information, tools and experiences on population-based surveys.

A key outcome of these meetings is consensus on linking antenatal clinic data and population based survey data in addition to improving systems for information sharing. This resulted in the formation of the “Social Aspects of HIV and AIDS Research Alliance – SAHARA” in 2001, with financial support from the Nelson Mandela Children’s Fund. The network has the capacity to coordinate large comprehensive, longitudinal and cross sectional studies that could be done simultaneously in different countries and sites.

Dr Shisana highlighted that WHO-AFRO was developing an “Operational manual for conducting population-based HIV prevalence surveys” and that the HSRC had participated in the review of the manual.

8.3 Country experiences in Monitoring and Evaluation

By Dr M Saide, Head of HIV AND AIDS Dept., Ministry of Health, Mozambique.

Dr Saide pointed out that Mozambique has developed as part of its national strategic plan a “Country Response Information System” to monitor and document information and data on HIV and AIDS. The system is complemented by the “Demographic and Social Statistics of Mozambique”, commonly known as “ESDEM”.

The national M and E system provides a conceptual basis and operational mechanism for the management and coordination of the HIV and AIDS framework in Mozambique. The system contributes information for decision-making, planning and resource allocation. It assists other sectors in defining their roles and responsibilities by providing information and guidelines including priority indicators, tools for data collection and reporting.

Based on their experience in implementing CRIS, Mozambique has realised the importance for all sectors in understanding and appreciating the “national indicators”.

Challenges for the M and E system in Mozambique highlighted by Dr Saide included that it was inadequately staffed and under-resourced. At the operational level difficulties have been experienced in training and retaining personnel for M and E units. Efforts to link M and E operations with operational research initiatives have failed due to institutional fragmentation and lack of clarity in coordination responsibilities.

Comments and Discussions

Mechanism for monitoring responses

It was agreed that a strengthened M and E system, with clearly defined national indicators and tools, is a pre-

requisite for an effective national response. To ensure the efficacy of M and E, there is a need to improve the overall national coordinating mechanisms and to increase resources. The delegates requested UNAIDS and the SADC Secretariat to strengthen existing M and E, to harmonise the systems and to promote data and information sharing.

The idea of involving civil society organisations in assisting governments to monitor their commitments, as demonstrated by Action AID, was supported as this reduces the burden on already over-stretched systems and offers an alternative opportunity for effective monitoring.

Population-Based Surveys

Delegates called for improved networking in the region citing that they are not familiar with the work being done by HSRC on population-based surveys and SAHARA. They requested that the HSRC share information on the concept and methodologies with the rest of the Member States. They requested that this include the experiences of countries that have conducted population-based surveys i.e. South African and Botswana.

Country Experience in Monitoring – Mozambique

The delegates noted that there is a lack of understanding and appreciation of the role that M and E plays in the national response, resulting in insufficient resources being made available for M and E. Furthermore, Member States do not have adequately trained personnel and/or expertise in the use of computerised databases and technical analysis.

The delegates suggested that the SADC Secretariat in collaboration with UNAIDS, WHO and UNDP explore ways of facilitating a common strategic approach to developing and harmonising M and E frameworks in the region. They suggested that regional training on M and E be conducted so that countries can learn from each other.

Section 9: Coordinating the National and Regional response to HIV and AIDS

9.1 The “Three-Ones”

By Dr Mark Stirling, Director, UNAIDS.

Dr Stirling defined the “Three-Ones” as referring to:

- One national AIDS action framework that provides the basis for resource orientation and coordination of different stakeholders and partners.
- One national AIDS Authority, with a broad-based multi-sectoral mandate.
- One monitoring and evaluation system to track progress, enable learning, and inform development of strategic actions.

He said that this strategy is based on the premise that authority at national level is dispersed and hence leadership is unclear. National plans and priorities are often weakened by lack of effective coordination, resulting in resources not necessarily achieving the intended goals. Systems are often fragmented, reducing their impact to influence planning, decision-making and resource allocation. These factors have, in most countries, hampered the implementation of different interventions and the uptake of services across the board.

To address these challenges, he recommended that Member States:

- Establish clear strategic planning processes involving all stakeholders in setting priorities, identifying resource requirements and establishing accountability measures.
- Give legal power to the work being undertaken by the National Coordinating Mechanisms.
- Define the relationship between these mechanisms and others such as NAC, CCM and National Theme Groups.
- Promote a code of conduct that will support and enhance partner commitments.

9.2 Experiences and challenges in coordinating a national response: Lessons from Swaziland and Tanzania

By Ms Faith Dlamini, National Coordinator, NERCHA, Swaziland, and Dr J Temba, Director Policy and Planning, Tanzania Commission for AIDS.

The presenters highlighted that both countries have adopted a multi-sectoral approach to the implementation of the national response to HIV and AIDS. Initially the coordination, monitoring and evaluation responsibilities in both countries were fragmented between different

agencies and accountability was lacking. This negatively impacted on resource mobilisation and allocation, and contributed to slow project implementation.

They pointed out that the complex nature of the epidemic has created opportunities for multi-sectoral and multi-level interventions. While this has advantages, it presents management and coordination challenges, given that multiple stakeholders are involved in the implementation process.

In Swaziland and Tanzania the coordination challenges are being addressed through the establishment of independent National AIDS Councils that coordinate the national response, provide policy, technical and policy guidance, and undertake resource mobilisation. In these countries, donor forums, national networks of AIDS service organisations, networks of PLWHAs and Business Coalitions Against AIDS have been formed. At district or rural level, the coordination, monitoring and evaluation responsibilities have been decentralised to local authorities that work in collaboration with civil society organisations. At institutional or sector level, individual institutions had the responsibility of coordinating their own response in line with the National Strategic Framework.

Comments and Discussions

The Three-Ones

Delegates noted that the confusion at country level usually emanates from a global level where UN agencies advance different approaches and strategies that do not take cognisance of country level realities in terms of institutional arrangements, capacity and political commitment to ensure that systems put in place would work effectively.

At the programme level, concepts are introduced without adequate orientation, training and technical support. This further contributed to a lack of understanding of the different roles and responsibilities between national coordinating mechanisms and other institutions. In particular the delegates noted a lack of clarity on whether the national coordination mechanisms and UN agencies were meant to be implementers or technical supporters. The experience of Member States was that both the coordinating mechanisms and UN agencies tended to

implement programmes as opposed to working with relevant implementing partners in government and civil society organisations.

However, the delegates took cognisance of the need for effective coordination mechanisms both at regional, national and international levels. They requested the SADC Secretariat, in the context of the Business Plan, to assist Member States to achieve this goal. In addition, it was suggested that the SADC Secretariat should develop a monitoring mechanism on how individual countries are moving towards harmonising coordination mechanisms.

Experiences/challenges from Swaziland and Tanzania

The delegates indicated that effective coordination could not take place in the absence of national policies, strategic plans and an enabling environment that supported the active participation of all stakeholders.

At the sector level, most delegates felt that the creation of Sector HIV and AIDS Coordinators is a good practice. Their effectiveness and efficiency had been compromised

by the fact that their time was not solely devoted to their HIV and AIDS coordination roles. Some countries indicated that they were in the process of mainstreaming HIV and AIDS Coordinator positions in the staff establishment.

The delegates were of the opinion that in some instances the inclusion of civil society organisations in National AIDS Councils was more symbolic than strategic. This was attributed to the lack of adequate policy guidelines on the involvement of civil society organisations in national policy frameworks.

It was recommended that SADC and UNAIDS should support governments in improving national coordination mechanisms, and in particular articulating the roles and responsibilities of the National AIDS Coordinating Authorities. They also suggested that the DFID project supporting the strengthening of the National AIDS Control Programmes (NACP) in the BNLS countries should be expanded to include more SADC countries.



Section 10: Unique Experiences with managing HIV and AIDS

10.1 Strategies for maintaining a low prevalence rate: Lessons from Mauritius

By Dr K Deepchand, Principal Medical Officer, Ministry of Health and Quality of Life.

Dr Deepchand opened his presentation by pointing out that Mauritius is a country with a low HIV prevalence rate. Like other Member States, Mauritius has adopted a multi-sectoral approach to addressing the epidemic articulated in the National Strategic Plan 2001 – 2005. The “National AIDS Committee” is chaired by the Prime Minister and meets three times per year.

Financial resources are allocated to each ministry to address HIV and AIDS. Activities being implemented at the ministerial level include education and awareness, free condom distribution, a prisons programme on HIV and AIDS, and Voluntary Counselling and Testing (VCT). Strategies have also been put in place to protect health workers from accidental exposure to HIV and to ensure a safe blood supply.

At the community level, social aid is provided through the Ministry of Social Security. Vulnerable groups are supported to access care and support including ART. A Trust Fund for the Social Integration of Vulnerable Groups such as Commercial Sex Workers (CSW) has been established. Youth programmes including training for teachers, programmes targeting out-of-school youth and peer education have been established.

Measures being implemented to protect women and girls against HIV and AIDS include:

- Voluntary counselling and testing.
- ARVs for positive mothers and their children.
- Post exposure prophylaxis for all survivors of sexual abuse.
- Legislation that addresses domestic violence and sex discrimination.

10.2 Strategies for addressing the HIV epidemic in an emergency situation: Lessons from Democratic Republic of the Congo (DRC)

By Dr Jeremie Muwonga Masidi, Division of Laboratory and Research, HIV and AIDS National Control Programme.

Dr Masidi of the Democratic Republic of the Congo

provided an overview of HIV and AIDS in the DRC. He said that the first case of HIV was diagnosed in the early 1980s. In 1984 the government established the HIV and AIDS project, followed by the establishment of a coordinating bureau. Between 1991 and 1992, DRC was engulfed by war that disrupted all programmes and funding from official, bilateral and multilateral agencies. However, small levels of funding continued to flow facilitated by international NGOs that had projects on the ground. The problem was compounded in 1996–1997 when a full-blown war of liberation erupted in the country followed by acts of aggression in 1998.

The war made it impossible to sustain interventions as in most cases the attacking soldiers destroyed anything that came their way. People were on the run and tracking PLWHAs let alone those on ART, was impossible. Women and children are severely affected by the war. They are often captured, enrolled in the army and forced to have unprotected sex. The war had largely fuelled the spread of HIV among the adult and child population. The disruption and subsequent loss of families had led to some survivors turning to commercial sex and this increased their vulnerability. It was not until 2003, when political stability emerged, that the programme on HIV and AIDS started to be rebuilt in all sectors of society.

In 2002 the DRC, with assistance from World Bank (US\$ 8 million), embarked on strengthening its national response aimed at improving programme coordination, decentralisation of activities to sectors, districts and communities, and the mainstreaming of HIV and AIDS. The programme adopted a multi-sectoral approach, encouraged partnerships at all levels, and increased community participation and ownership. Some of the specific interventions under the World Bank supported programme are social mobilisation, promotion of condom use, ensuring blood safety, improved management of opportunistic infections (OI) and STIs.

10.3 Networking and collaboration on HIV and AIDS at regional level [Action AID]

By David Mwaniki, International Networking Programme - Action AID.

Mr Mwaniki noted that the International Partnership Programme Against AIDS in Africa (SIPAA) is a three-year programme funded by DFID to the tune of £23

million. The programme provides support to strengthen national responses and in particular cross country learning. Countries included in the programme are Ethiopia, Rwanda, Ghana, Burundi, Swaziland, Lesotho, Tanzania, Cameroon and Nigeria. Kenya and Uganda are learning countries. The programme is managed by a Steering Committee composed of an NAC Director, DFID, UNAIDS and AAI.

SIPAA provides financial and technical assistance and facilitates organisational development of National AIDS Commissions. Aspects of the programme include:

- Planning for HIV and AIDS in Sub Saharan Africa.
- Research and mitigation of the impacts of the epidemic in the public sector.
- Training in monitoring and evaluation.
- Documentation and dissemination of best practices.

Progress and achievements made by the programme include:

- Strengthened capacity of NACs.
- Greater involvement and engagement of CSOs and the private sector.
- Creation of partnership forums in countries like Ethiopia, Ghana and Uganda.

The Southern Africa Partnership Programme (SAPP) Initiative was launched in 2003 to cover the SADC region where Action AID did not have a country presence. The purpose of the programme is to build partnerships and strengthen networks around five programme areas including: food security and livelihoods, HIV and AIDS, trade and economic justice, governance and gender. The programme works with government institutions, the private sector, civil society organisations, research and academic institutions. It is working with NEPAD to support its *HIV and AIDS Panel of Experts Committee* and with the African Union's *HIV and AIDS Committee* that was responsible for drafting the Union's HIV and AIDS Strategy.

Comments and Discussions

Maintaining low prevalence rates

Delegates noted that the extent to which IEC and BCC programmes contributed to maintaining the low prevalence rates was not apparent as they had not been systematically evaluated. However, it was said that these programmes have extensive coverage, target a variety of vulnerable groups such as commercial sex workers, injecting drug users, men who have sex with men, and people employed in the tourism industry. The delegates suggested that the SADC secretariat conduct a study on how some countries were maintaining low prevalence rates. They suggested that it focus more on best practices that other countries can benefit from.

HIV and AIDS in emergency situations

The delegates expressed concern that it was too early for the DRC to conclude that it had a low prevalence rate given that they were just emerging from a war. It was suggested that the DRC undertake a comprehensive sentinel surveillance or community-based population survey to determine the actual prevalence rate.

It was suggested that the SADC should consider supporting special interventions and strategies to provide adequate and quality care for populations emerging from conflict situations, and in particular children and people with disability.

Networking and collaboration in the region

Some delegates expressed concern that they did not know of the Action AID SAPP and/or SIPAA programmes, despite the fact that some were recipient countries. This highlighted the need for increased and improved networking and information dissemination in the region and with other regions outside of SADC. The presenter offered to send information to delegates after the workshop.

Section 11: Conclusions

The regional workshop for the Implementation of the SADC HIV and AIDS Strategic Framework was the first opportunity for Member States, civil society, UN agencies, research institutes and the SADC Secretariat to share information on progress made with the national and regional response to the AIDS epidemic.

It underscored that while many efforts are being undertaken to respond to the epidemic, the lack of documentation and sharing of best practices and tools hampers the sharing of this information between Member States in the SADC region. Delegates noted that one of the most important contributions of this workshop was that it provided a good platform for networking, information sharing and an exchange of ideas.

Delegates to the workshop emphasised the need for a coordinated regional and national response as embodied in the UNAIDS Three One's principles. At the regional level, the SADC Secretariat should take the lead as the coordinating authority, in coordinating common

initiatives guided by the SADC Strategic Framework on HIV and AIDS.

To achieve this delegates to the workshop considered the SADC HIV and AIDS Business Plan, which is to guide the SADC Secretariat in supporting Member States in addressing HIV and AIDS interventions at national and regional level.

In this regard the workshop emphasised and made a number of recommendations where the SADC Secretariat should take the lead. This includes joint/or bulk procurements of ARVs, the development of a regional ART protocol, harmonisation of medicine regulations, strategies for human resource development and retention, a policy on orphans and vulnerable children, and the leveraging of additional financial resources. However, the workshop underscored the need for the SADC Secretariat to play a key role in documenting best practices from the region and convening similar workshops.

Section 12: Recommendations

Delegates made the following recommendations to improving the quality and content of the SADC HIV and AIDS Business Plan. The recommendations will be incorporated in the Business Plan in form of specific activities to be implemented by SADC Secretariat in collaboration with Member States and in partnership with other stakeholders in the region.

(a) Operationalising the SADC Framework and Maseru Declaration

The SADC Secretariat should:

1. Promote and support public debate on the Maseru Declaration on HIV and AIDS
2. Facilitate the development or harmonisation of a regional policy on HIV and AIDS related to migrant worker, mobile populations and commercial sex workers in the context of access to ART treatment, STI treatment and referrals between countries
3. Scaling up of the Cross Border project to cover all Member States.
4. Document and disseminate experiences, knowledge and best practices emerging from the cross border project to other Member States
5. Develop mechanism to monitor the implementation of The Business Plan by Member States
6. Develop strategies for facilitating effective network, information sharing and knowledge transfer between countries and in-country sectors
7. Document and disseminate best practices and experiences emerging from the implementation of the national response programmes
8. Strengthen advocacy work at national and regional level to address challenges associated with gender based violence, rape and uptake of treatment care and support programmes
9. Promote and support population based surveys for HIV and AIDS
10. Develop guidelines on how the SADC HIV and AIDS Trust Fund would be managed, how countries will contribute to the fund and equally how funds will be accessed
11. Strengthen National Coordination Mechanisms within the concept of 3-Ones. This would also include monitoring and evaluation
12. Develop a comprehensive policy on human resource development and retention in the region
13. Develop strategies for procurement of cheaper ARV

drugs or a plan on how drugs could be manufactured in the region

14. Promote and support distribution of female condoms as a strategy for women empowerment
15. Develop comprehensive policy on care and support for orphans in the region
16. Facilitate the mapping of migration patterns in terms of source, receiving communities, characteristics of migrants, causes and the impacts in relation to HIV and AIDS
17. Consider rolling out the “Cross Border Sites STI/HIV/AIDS” initiatives to other countries as part of the Business Plan activities

(b) Promoting treatment and care in the Region

The SADC Secretariat should:

1. Together with WHO explore and advise Member States on how best to access cheaper ART drugs or on ways the drugs could be manufactured in the region
2. Facilitate capacity building for Member States to strengthen their essential drugs systems for production, procurement, distribution and monitoring.
3. Publish and distribute all guidelines related to harmonisation of medicine regulations in the region
4. SADC Secretariat should facilitate the evaluation of the capacity of Member States in relation to managing the regulations on medicine and in particular the ARTs
5. Develop a regional (common) protocol on ART that will facilitate harmonisation of treatment in the region
6. Assist Member States in establishing effective systems for monitoring and tracking PLWHAs on ART in the region. This should include the development of appropriate tools and strategies that involves all stakeholders including civil society organisations and the private sector
7. Facilitate capacity building for improved coordination of care and support programmes for orphans at country and regional level
8. Support the development of guidelines for care of carers
9. Document and disseminate best practices (i.e. Baylor Centre of Excellency-Botswana) on care and support of orphans
10. In collaboration with UNICEF and WHO develop policy guidelines on the administration of ART for children under age (requiring parental consent).
11. Facilitate development of regional guidelines on the

criteria of supporting and building capacity for volunteers at community level

12. Support the development of policy and appropriate interventions for people with disability and HIV/AIDS
13. Promote and support applied research and analysis of systems costs, benefits, and opportunity costs to guide programme choices

Member States should:

14. Allocate resources equitably between ART and health care services
15. Adequately prepare communities for ART scale up as a strategy to ensure adherence
16. Provide adequate social support to families living with PLWHAs on ART, and living below the poverty datum line
17. In collaboration with WHO should develop a programme for care of carers. SADC Secretariat should ensure adequate monitoring of the implementation of the programme
18. Include role models from the community to promote prevention initiatives and consequently complement the efforts of eminent persons
19. Develop policy guidelines for fair allocation of resources between ART and other health services at national level

Recommendations for collaborating partners:

20. WHO should provide technical support in form of training more staff on ARV management to enable Member States achieve the goal of 3X5

(c) Promoting an expanded and multi-level response to HIV and AIDS through mainstreaming and decentralising the response

The SADC Secretariat should:

1. Together with UNDP document and disseminate country experiences in mainstreaming HIV and AIDS utilising the experiences of Lesotho in “core” streaming of HIV and AIDS
2. Together with UNDP conduct further training with a practical orientation for Member States on HIV and AIDS mainstreaming
3. Initiate and support a comprehensive study on “civil society response to HIV and AIDS” in the region with the aim of establishing their actual strategic niche, and expertise

Member States should:

4. Initiate programmes that address HIV and AIDS and people with disability
5. Develop more practical strategies for support to civil society organisations especially those working in district, rural and community levels

(d) Resource mobilisation for HIV and AIDS

The SADC Secretariat should:

1. Document and share the experiences of Member States in working with the Global Fund in the region
2. Develop guidelines on how the funds for the “SADC Trust Fund” will be mobilised from Member States, donors and how Member States will access the funds
3. Organise a workshop on funding opportunities for HIV and AIDS for National Coordinating Agencies and National Control Programmes (Ministries of Health)
4. Encourage and support Member States to initiate innovative strategies for local resource mobilisation by documenting and sharing information on such strategies
5. Facilitate training by IDASA and EQUINET on tracking resources for HIV and AIDS
6. Establish a database on HIV and AIDS funding and donor agencies from government, bilateral and multilateral donors and from civil society organisations. This should be analysed from different perspectives i.e. in relation to per capita income, as a percentage share of the total health expenditure, in relation to spending priorities by activity type, and efficiency and equity in HIV and AIDS spending
7. Develop systems and tools for tracking resources from government, donors and NGOs earmarked for HIV and AIDS

Recommendations for collaborating partners:

8. Delegates recommended that Global Fund should make the application process more efficient, less bureaucratic, and participatory

(e) Monitoring and Evaluation of the response

The SADC Secretariat should:

1. In collaboration with UNAIDS build and strengthen the monitoring and evaluation capacity of Member States as a matter of urgency
2. In collaboration with UNAIDS facilitate the development of a common M and E framework in the region

Recommendations for collaborating partners:

3. UNAIDS through its country network should promote and support networking and sharing of information and experience on M and E in the region
4. HSRC should compile and disseminate information on how countries can collaborate with it and SAHARA
5. HSRC should develop clear guidelines on how the project will assist individual member countries
6. HSRC should conduct training for the National AIDS Coordinating Agency on "Population Based Surveys". – (dependent on availability of resources)

(f) Ensuring a coordinated national and regional response

The SADC Secretariat should:

1. Together with UNAIDS facilitate the process of clarifying roles and responsibilities between National AIDS Councils, National AIDS Coordinating Agencies and Ministries of Health

2. Roll out technical support under the DFID project to support the capacity building of other Member States where necessary
3. Member States should establish Sector HIV and AIDS Coordinators in all government institutions as full time assignment and not as an added responsibility to an existing staff
4. In collaboration with UNAIDS should conduct a study on how some countries are managing to maintain low prevalence rates
5. Facilitate a study on how some countries have managed to maintain low prevalence and especially those countries in emergency situation

Recommendations for collaborating partners:

6. UNAIDS should facilitate the mainstreaming of 3-ones at country level and provide technical assistance to ensure that the institutions are effective and efficient
7. UNAIDS and WHO should develop strategies to assist countries in or emerging from emergency situations

Annexe 1 - Workshop programme

Draft Program for the Regional Workshop for the implementation of the SADC HIV and AIDS Strategic Framework, 26 – 28 July 2004, South Africa

Purpose of the Meeting

1. Facilitate information sharing on the HIV and AIDS situation and responses among Member States.
2. Provide input to the development of:
 - a. The SADC Business Plan on HIV and AIDS
 - b. The SADC Project Concept Notes on HIV and AIDS
 - c. The SADC HIV and AIDS Institutional Framework
3. Develop Mechanisms for sharing of best practices and lessons learnt
4. Establish strategies and mechanisms for networking and collaboration
5. Define processes for strengthening regional coordination and collaboration

DAY One, July 26, 2004		
Chair: SADC Secretariat		
Rapporteur: Botswana & Zimbabwe		
Registration (0800 – 0900)		
Official Opening		
Topic	Presenter	Time
Welcome Remarks	Chair	0900 - 0905
Statement by UNAIDS	UNAIDS Rep	0905 - 0920
Official Opening	ES SADC	0920 - 0940
Vote of thanks	CD - SADC	0940 - 0950
Tea Break (0950 – 1030)		
Setting the Scene		
Chair: Angola		
Rapporteur: Namibia and Zambia		
State of the epidemic in the SADC Region	WHO	1030 - 1100
The Major Findings and Recommendation of the UN Secretary General Task Force on Women, Girls and AIDS in the SADC Region	UNAIDS	1100 - 1120
SADC Response to the Epidemic: SADC Strategic Framework and Program of Action 2003 - 2007 and the Maseru Declaration on HIV and AIDS.	SADC	1120 - 1140
Update on the Harmonization of Drugs in the SADC Region.	SADC	1140 - 1200
Discussions (1200 – 1230)		
Lunch (1230 – 1400)		
Operationalizing the SADC Framework and the Maseru Declaration		
Presentation of the Draft Business Plan on HIV and AIDS		
Presentation of the Draft Project Concept Notes on HIV and AIDS		
Presentation of the Institutional Framework for facilitating the regional response.		
Overview of the DFID and EU Funded SADC HIV and AIDS Projects	SADC	1400 - 1500

Working Tea		
Group Work Group A: Discussing the SADC Business Plan Group B: Discussing the Project Concept Notes Group C: Discussing the Institutional Framework	SADC	1500 - 1630
Plenary: Presentation, Discussions and Recommendations Group A Group B Group C		1630 -1730

DAY Two, July 27, 2004

Chair: Mauritius

Rapporteur: Lesotho & Malawi

Topic	Presenter	Time
Recap of the Previous Day's Proceedings. (Prioritizing Strategic Issues for Follow-up)		0800 - 0820
Promoting Care and Support in the Region		
The 3 by 5 Initiative	WHO	0820 - 0840
PMTCT as an entry point for ART delivery	UNICEF	0840 - 0900
Country experience in rolling out Treatment	Botswana	0900 - 0920
Country Experience in promoting Universal testing	Lesotho	0920 - 0940
Health Systems Strengthening for treatment roll out.	EQUINET	0940 - 1000
Discussions and Recommendations to the Business Plan (1000 – 1030)		
Tea Break (1030 – 1100)		
Promoting an Expanded and multi-level Response to HIV and AIDS through Mainstreaming and Decentralizing response.		
Challenges in expanding the response	UNDP	1100 - 1120
Country Experience in Mainstreaming HIV and AIDS response.	South Africa	1120 - 1140
Decentralized response: Country Experience	Namibia	1140 - 1200
Promoting partnerships with the civil society, PLWHA, Private Sector, Parliaments etc.	Zambia	1220 - 1240
Discussions and Recommendations to the Business Plan (1240 – 1330)		
Lunch (1330 – 1430)		
Resource mobilizing for the HIV response		
Country Experience with the Global Fund	Malawi	1430 -1450
Steps towards meeting the Abuja Declaration Target of 15%	Angola	1450 - 1510
Innovative Resources Mobilization: The Case of the AIDS Levy	Zimbabwe	1510 - 1530
Mainstreaming AIDS Funds: Tools for tracking the resources.	IDASA	1530 - 1600
Tea Break (1600 – 1630)		
Discussions and Recommendations (1630 – 1730)		

Day Three July 28, 2004

Chair: DRC

Rapporteur: Swaziland and South Africa

Topic	Presenter	Time
Recap of the Previous Day's proceedings (Prioritizing Strategic Issues for follow-up)		0800 - 0830
Monitoring the response		
Mechanisms for monitoring Global, Continental, Regional and National commitments.	UNAIDS	0830 - 0850
Expanding mechanisms for monitoring the epidemic: Population based surveys	HSRC	0850 - 0910
Country experiences in M&E	Mozambique	0910 - 0930
Discussions and Recommendations to the Business Plan (0930 - 1030)		
Tea Break (1030 - 1100)		
Ensuring a Coordinated National and Regional Response to HIV and AIDS		
The evolution of the National Coordinating Mechanisms for HIV and AIDS: Experiences	UNAIDS	1100 - 1120
Experience and Challenges in coordinating a national response.	Swaziland and Tanzania	1120 - 1150
Observation from independent players	IDASA	1150 - 1210
Discussions and Recommendations to the Business Plan (1210 - 1300)		
Lunch (1300 - 1400)		
Special Topics		
Strategies for maintaining a low prevalence rate: Lessons from Mauritius	Mauritius	1400 - 1420
Strategies for address the HIV epidemic in an emergency Situation: Lessons from DRC	DRC	1420 - 1440
Discussions		1440 - 1500
Tea Break 1500 - 1530		
Way forward		
Networking and Collaboration on HIV and AIDS at regional level	Action AID ?	1530 - 1600
Outlining areas for Further Follow-up	SADC	1600 - 1630
General Discussions and Official Closing (1630 -1730)		
Meeting of the SADC Technical Committee on HIV and AIDS		1900 - 2000

Annexe 2 - List of Participants

“Regional Workshop for Implementation of SADC HIV/AIDS Strategic Framework, 26-28 July 2004, South Africa”

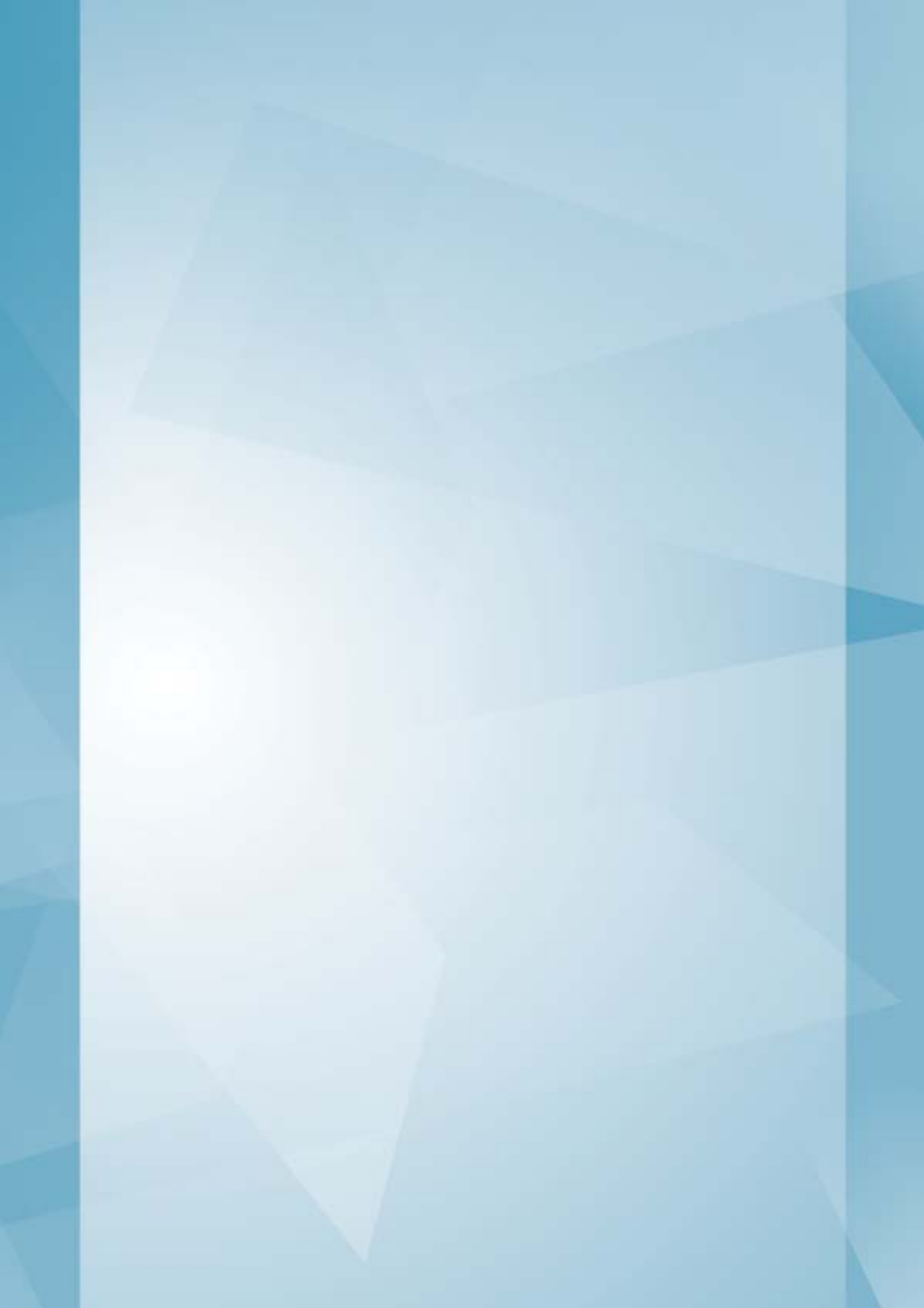
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