SOUTH AFRICA: TOUCHED BYTHE VENGEANCE OF AIDS...[1]
Responses to the South African Epidemic.

The South African HIV/AIDS epidemic defies description. It is characterised by three main features - a) the rapid and unchecked growth of the epidemic b) a lack of any coherent policy documents on crucial issues and c) the failure of public prevention campaigns to have an impact. It is at one and the same time, the most fascinating and the most depressing of sagas. Recently it was claimed that 'it simply does not seem that the government can get it right on AIDS' [2] an accusation all the more telling in the light of the fact that South Africa now has the fastest growing epidemic in the world. With over 1500 new infections a day, South Africa has one tenth of the total daily infections and more infections a day, than some countries have in a year.
An estimated 4 million people are living with HIV and many people have died from AIDS related illnesses.

Well into the second decade of the epidemic, very few South Africans could claim not to have heard of AIDS. Few could claim to be entirely ignorant of its mode of transmission and its effects, and increasingly families and individuals are experiencing the infection, illness and death of family and friends. South Africans are a largely AIDS aware population, but not one that has not seen the necessity to turn this awareness into personal behaviour change and support and care for those who are infected.

Part of the reason for the growth of the epidemic is the failure on the part of government and NGOs involved in prevention work to persuade a sceptical population that AIDS is a real disease and not some part of some other more devious agenda.[3] The campaigns also largely failed to get a general appreciation that infection with HIV can cause AIDS a decade or so later and that this is overwhelmingly a sexually transmitted disease. So despite a great deal of money and many initiatives people with HIV and AIDS are still treated as social transgressors and the change in behaviour required to turn such an epidemic around has not happened.

Recently, in an absolutely bewildering move, the president has thrown the AIDS debate back years by his public musings as to whether HIV is the cause of AIDS, or whether there is not perhaps some other causal connection for the deaths that are called AIDS. It may be co incidental that this debate is coming just as the country is to host the 13th international conference on AIDS in Durban 2000. These international conferences throw the spotlight on the host country. Over 10 000 people attend and the response of the host to their own

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[1] Vera Ngowi a woman from Tanzania who gave a posting on an email forum - we have been touched by its vengeance - referring to AIDS.
[2] Edwin Cameron; acting judge of the Constitutional Court - in an address to the Second South African Conference of People with AIDS, Durban, South Africa, March 10.
[3] There have always been ideas that AIDS came in from outside as part of a plot - such as The American Intention to Destroy Sex; and that it was a myth or not a real illness.

epidemic is scrutinised. By raising an AIDS 'red herring' it may be hoped that the attention will move from what South Africa has not done, to the view of 'AIDS orthodoxy' vs. the 'AIDS dissidents'.

Despite having an out of control epidemic, the South African Government, announced on Feb. 28th that it is to convene a panel of international experts to amongst other things determine 'local evidence regarding the causes and diagnosis of AIDS and opportunistic infections' as well as review the evidence that HIV causes AIDS and allegations that the AIDS drug AZT is poisonous.

Given the reality of HIV/AIDS in South Africa this is an extraordinary move. It is extraordinary, not only because of the rate and pace of the epidemic, but also because it has completely ignored the voice and expertise of local scientists and AIDS NGOs. It is also extraordinary that in an attempt to find an 'African response' to AIDS, outside experts are called in and local experiences ignored. The newly established National AIDS Council (which is quite distinct from this expert committee) also lacks any representation from the experienced AIDS World.

The magnitude of the problem, the escalating costs of dealing with the epidemic and the failure adequately to address the AIDS crisis and to ensure care and support for people with HIV and AIDS has led to some desperation and some way to make the picture look less desperate.

What this public questioning has done, is to reinforce in the minds of the population the doubts and denial that have caused the lack of behaviour change. If, as the dissidents claim, HIV neither causes AIDS nor is infectious, then the safe sex message, the message of responsible sexual decision making, gender issues and domestic violence along with the seriousness of the epidemic fall away. It means that the vexing questions of culture, race, sexual behaviour need ***not*** be addressed. It will be unnecessary to deal with patterns of male sexual behaviour, with gender imbalances in vulnerability to infection and to changing peoples attitudes to behaviour change. HIV infection now will be seen as the 'logical' outcome of poverty, malnutrition and poor socio economic conditions, and hence there is very little that the government can, or need do, to try to combat it.

However, whatever the government might decide as the cause of AIDS, they will still be required to treat people who are ill and dying, so avoiding HIV as the cause of AIDS offers no release from their obligations.

Where have we come from?

In 1993, Schneider, Steinberg and Isselmuiden wrote;

> South Africa is in the early phase of a rapid and exponential growth in the HIV/AIDS epidemic. By the end of 1992, 2.4% of antenatal clinic attenders nationally were HIV-positive, almost double and treble the figures for 1991 and 1990 respectively ... Based on the behaviour of the epidemic in South Africa so far, it is very probable that

> our HIV/AIDS epidemic might follow a similar pattern to ... other African countries.

AIDS, they continued, constitutes one of the biggest challenges facing South and Southern Africa. AIDS has been shown elsewhere to have a devastating impact on individual families and communities. Those infected are only a proportion of those finally affected by the loss of breadwinners, parents and children.[4]

By 1994, South Africa had a National AIDS Plan developed through NACOSA[5] This Plan was underscored by the understanding of what an AIDS epidemic might do to South Africa. It recognised the socio economic determinants of the epidemic, the effects of discrimination and prejudice, and the economic realities of the epidemic. It highlighted the need for legal reform and legislation and research, all underpinned by prevention strategies and planning for care.[6] The plan was imbued with the notion of effective AIDS prevention being closely aligned to Human rights

In other words, South Africa, in 1994, with an infection rate below 5% was ready for the epidemic - ready in the sense of having information about the epidemic in the USA and Europe, ready in the sense of having seen the epidemic in other African states, and Latin America. Ready in having a group of highly literate AIDS specialists in prevention, care and research that could drive the programme. We knew about the links between poverty, migration, unemployment and the effects of poverty on general social well being.

No one could claim that the country did not know what it was facing. The National Plan was accepted and endorsed by the Minister of Health, Dr Nkosazana Zuma and the Cabinet and supported by the many AIDS NGOs and CBOs, religious groups, trade unions and business representatives that had helped to shape it. Its crucial recommendation, ignored in the end, was to have the final authority for AIDS rest in the president's office to ensure that there was enough weight thrown behind its implementation. The crucial role of People with AIDS was recognised by establishing the principle that PWAs should be involved in all stages of policy and programme planning and implementation. Although not located within his office AIDS was declared a Presidential Lead Project, and as such able to access funding from a variety of sources.

It was very clear that AIDS would have a dramatic effect on development and on the future hopes and promises of the new democracy. It was clear that it would fuel the economic crisis - through skills loss, unemployment, loss of productivity and shrinking of markets. It was clear that education, health,

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[4] Schneider H et al, 1993, Understanding the possible: policies for the prevention of HIV in South Africa. University of the Witwatersrand; MRC; p 1

[5] NACOSA drew together a wide spectrum of players - the old regime, the ANC, unions, religious groups, AIDS organisations in a unique consultative process. Working groups were established to develop the components of the National Plan and the plan was a reflection of years of experience.

[6] The Plan has six key areas, with priorities for immediate attention. The bulk of the plan could have been effectively implemented in less than two years.

transport and welfare would all suffer greatly as the epidemic started to take its toll. There were both the doomsday predictions as well as the more carefully researched projections to guide policy makers and to allow for proactive planning. It was already clear in 1994, that AIDS was likely to be devastating on the countries growth and future hope unless swift action was taken.

We knew about AIDS - this was not some new unfolding mystery that we were the first to experience. We had a time lag of infection, the oft-repeated 'window of opportunity', a committed government, an excellent plan and the relative wealth and advanced infrastructure to set our response apart from that of the rest of the continent. And there was a strong NGO sector committed to Partnership.

But this was a plan that did not come together and instead South Africa has been touched in many ways by the vengeance of AIDS.

Failed plan or failed planning?

Given what we knew then and know now, it is quite extraordinary that the Minister of Health can ask for an expert panel (largely of non South Africans) to explore all aspects of prevention and treatment strategies and review areas (in which South Africa has internationally recognised experts) such as

Treatment of HIV/AIDS and opportunistic infections
General prevention of the disease
Prevention of mother to child infections
Prevention of infection after rape or needle stick injuries
Local evidence, [7]

The fate of the National AIDS plan is well documented [8]. It was heralded as one of the first major breakthroughs of the new regime and confidence was high that it would be implemented. In the same way that South Africans had confounded the world with the transition to democracy - so too would they confound the world with the way in which they would deal with HIV and AIDS.

But it was not to be. Almost a decade later the plan remains unconsulted, un implemented and largely ignored. From what was the most creative plan, loudly praised by the international community, it has become the most condemned plan - condemned to being ignored and accused even by those who wrote it as 'having problems' [9]

It seemed as if the knowledge generated and the expertise that went into the development of the plan suddenly ran out when faced with the reality of implementation. For there was sufficient funding and despite claims to the

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[7] Statement issued by the Minister of Health, Dr Manto Tshabalala-Msimang, 2 March 2000.
[8] See Marais H 2000, On the Edge: Review 2000, University of Pretoria and Crewe M 1999, Siyaya! Issue 6 Summer 1999, Idasa.
[9] Almost immediately people responsible for the implementation of the plan began to undermine it - it became the fault of the plan, rather than of Govt. or NGOs that the plan was not used nor implemented. This failure is another South African 'AIDS scandal'

contrary there was sufficient will and capacity to get substantial parts of the plan implemented and a response to the epidemic underway. There was a basic infrastructure through which this could be done - the previous government had created a network (albeit in mainly white local authorities) of AIDS centres which had amassed a wealth of experience and training. These could have been transformed, expanded and developed satellite operations.

There were HIV clinics in some of the main hospitals with Drs and volunteers who had been watching the epidemic unfold and had a real understanding of what services were needed. There were programmes of change and transformation in many government sectors that created an ideal opportunity for the integration of HIV/AIDS work. There was too, a body of researchers with experience in trials and in running services. And there were many local and national NGOS and ASOs who had developed significant responses to AIDS and mechanisms for prevention and to some degree care.

But not for the first time, the government at both national and provincial level turned its back on this experience and expertise. Their understanding of the epidemic was denied and expertise was sought from else where - from Thailand, from Zimbabwe and from the donor agencies. What could have been a creative synthesis of different realms of experience with the outsiders being able to sharpen up the thinking and responses of the insiders - there seemed to be a belief that it was necessary to start again. New plans, new strategies, new posts, delayed appointments and a creeping epidemic.

In part the failure to implement the plan stems from the political settlement in 1994, which allowed for a national government and nine provincial governments, making it possible to have 10 different policies in key areas. There are in effect 10 different AIDS plans as each province vies for autonomy and control. What this has meant is that much energy has been spent in feuding and in arguments over ownership, policy and programmes, rather than looking for shared vision and policy and programme developments. This has allowed for an uneven response to the epidemic and the response will as often depend on individuals who have commitment to the epidemic, rather than on a coherent plan of action.

Where are we going?

Within a year of the new plan - the new strategies and the desire for an effective response the AIDS programme was in disarray. This was due to the Sarafina debacle in which the excellent idea of a national youth based AIDS drama developed into Sarafina 2 with irregularities of funding and dubious granting of tenders. While the ZAR14 million allocated to the play was actually not a great sum given that the play was destined for over 8 million young people (less that ZAR2.00 per child) the money became the focus of public dissent. Although the government was intransigent at the time Mandela was later to cite Sarafina as one of the ANC's key mistakes.

In some ways AIDS in South Africa has never recovered from the vengeance of the Sarafina response - it brought to the surface the simmering tensions

between the government and AIDS NGOs and CBOs. Criticism, in every way valid, of the content of the play and of the processes that had shaped it was construed as an attack on government and as an attempt to undermine the response.

This criticism led, correctly, by the AIDS consortium and echoed by NACOSA, was the turning point in the response of the govt and the NGOs. For now, the NGOs were forced to choose between matters of principle and their old comrades in the AIDS struggle - many of whom like Minister Zuma were holding high positions. Defending the government became almost impossible and made worse when the message from govt was clear - are the NGOs with us or against us?[10]

Sarafina introduced the beginnings of AIDS orthodoxy - the 'govt line' was the one orthodoxy and the 'NGO (or PWA) line' the other. It was extremely difficult to be outside of either of these. Independence was likely to ensure that either the govt. or the NGOs rendered that position untenable. So far from having - as the NACOSA plan so optimistically had suggested - A United Response to AIDS, there was developing quite the opposite - Govt and civil society were not united and there was little true unity in the NGO world.

This division came at the time when a united response could have worked to shift public perception about the disease and about people who were living with HIV. Instead, the general public was largely excluded from the AIDS world - instead of creating a climate of inclusiveness, the AIDS orthodoxy drove people away.[11]

AIDS became a world of exclusion - both by the government who shunned at all times local expertise and experience - looking to outsiders to generate an 'African response' and by the AIDS organisations who fiercely guarded who was 'in' and who was 'out' who could talk and who could not.[12]

This rigour was important. It is important how people with HIV and AIDS are treated, talked about and challenges must be made to prejudice or stigma. But what happened was that people focused too much on the images and not enough on the substance – and for many other people who wished to be included they felt alienated and intimidated by this. In its turn government was not prepared to concede that there was a wealth of experience behind each criticism, that such criticism was not driven by racism or funding constraints. The attempts made by the powerful AIDS NGOs such as NACOSA, the AIDS Consortium, the AIDS Law Project to defuse the situation were rebuffed and attempts at constructive engagement were taken as hostile criticism.

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[10] Question asked by the Director of the National HIV/AIDS and STD Programme to one of the co chairs of the AIDS Consortium, after the Consortium had given a submission to the Public Protector.

[11] The language of AIDS seen to be important for creative a positive response, has the effect of excluding people who may not have been introduced to the need for sensitivity - they feel undermined by the response to their language as well as to their grappling with certain issues

[12] It was clear that certain people and NGOs were able to speak on behalf of PWAs or on AIDS issues and their comments were valid, whereas others were dismissed if they asked different questions or gave a different view. The media and government alike were able to exploit this.

Why was government so jumpy about AIDS criticism? It is true that the AIDS response has been a litany of mistakes and disasters. But the extent of the response, the hostility from the government was ill considered in the world of AIDS and the depth of the anger and hostility is difficult to understand.

After Sarafina 2 came Virodene, 1997 -the 'miracle' South African cure for AIDS - fully supported by the Cabinet and indeed in the media by Mbeki himself. Criticism of Virodene, which was later shown to be a toxic industrial solvent, was again regarded as unfair and hostile. It was even alleged that people working in AIDS did not wish for Virodene to succeed, as they then would be out of a job![13] Still in 1997 came, the decision to make AIDS a notifiable disease, announced in contradiction of the findings of the expensive and time consuming review. The recommendations of this review have never been implemented.

In 1988 came the firing of the AIDS advisory committee. In 1999, came the decision not to supply AZT or latterly Neviropine to pregnant women and survivors of rape and in 2000 the creation of the National AIDS Council, Mbeki's stance on HIV and AIDS and the pending appointment of the expert committee. And throughout this was the failure of government and of the Ministers in particular to support the National HIV/AIDS and STD Directorate, which suffered as a consequence a rapid turn over of Directors and a lack of capacity as well, most crucially a lack of autonomy.

Balancing the chaotic government response, which seemed 'never to get it right on AIDS', was the response from the NGOs. These have grown into a powerful lobbying and advocacy group with the AIDS Consortium having a membership of over 100 organisations, and NACOSA extensive community based networks and organisational affiliations. NAPWA - the National Association of People Living with AIDS, has recently gone through a difficult time as the competing demands of various PWA groups and expectations tore it apart. The AIDS Law Project and most recently the Treatment Action Campaign have been fighting for the rights of people with HIV as well as together with international activist groups been lobbying for free (or significantly reduced in price) treatment for people with HIV and AIDS.[14]

These organisations are mainly concerned with lobbying and advocacy and have ensured that the issues facing people with HIV and AIDS and their families and communities are constantly in the public debate. They ensure that the government is constantly 'on guard' in not being able to be complacent or neglectful of its AIDS response. The government is certainly feeling beleaguered and uncertain, but this seems to be driving it into a hostile and defensive position, rather than into one that tries to find effective and speedy interventions.

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[13] Person communication from a high placed official to a person using Virodene. Mbeki fully supported Virodene, a known toxin but later rejected AZT as being 'too toxic' - no one has questioned him on this.

[14] A major drug company announced April 3 free distribution of an AIDS drug. The actual details of this offer have still to be published, as well as the current status of this drug vis a vis new treatments.

Whilst these NGOs are strong on advocacy they are not geared up for delivery of services. For this there are many NGOs and CBOs who are active in offering services to people with HIV and AIDS as well as running prevention programmes. The National database on AIDS organisations cites more than 600 organisations that are active in HIV/AIDS work. Many of these have modest operations and are small community based programmes. Most are competing for funding and often cannot compete with the large better known national NGOs.

They are also at the mercy of the ongoing funding cuts in government support for NGOs a fate made worse by the failure of the health department to spend up to 40% of its HIV/AIDS budget, whilst funding for NGOs has been cut[15].

These smaller organisations tend not to get involved in the macro political struggles of AIDS. They struggle with the consequence of the failure of leadership within the government and the failure of government to provide adequate services and support. In many instances they are doing work that should be covered by government programmes and they experience first hand the pain and suffering, the poverty and desperation which so many people and communities are facing in this epidemic. They are supported in some areas by the AIDS training and Information Centres (where these have not been destroyed through the provincial/local authority power struggles) and they get some support from provincial structures. These NGOS and CBOs are mainly concerned with the development of community based education and prevention programmes, with counselling and counselling training and increasingly with home based care and legal rights support and social welfare.

While they tend neither to get embroiled in the disputes with government, nor to challenge the state they reap the consequences of a unchecked and unco-ordinated response to the epidemic. Lack of security in funding allows for a high turn over of such NGOs with communities being left to pick up the pieces.

The response of both government and the NGOs accounts for where we are in the country and the present time. The adversarial relationship has soured the AIDS field and discord, disunity and a lack of trust underpins the players in the AIDS world. Although recognition is given to a 'common enemy' in the virus, this does not create a united vision or shared resources. This is also a feature of the AIDS orthodoxy mentioned earlier, with a growing intolerance from both sides of voices of disagreement. Squeezed in-between this are the PWAs, their partners, families, children and communities. They are the ones who suffer from the infighting and the division between civil society and the state, but they are the ones most used by them to justify such disharmony.

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[15] Pretoria News, March 9th 2000.

The vengeance of AIDS seems to have created a deep seated inability to accept difference of opinion, to include as many people in the combating the epidemic as possible[16]. There is a pattern of distrust and undermining of other programmes that feeds into the governments belief in a dogmatic AIDS world, that refuses to even consider other approaches or possibilities. By the same token the government remains unaccountable, intransigent and unable to get an effective response from the drawing board and into communities.

The history of the epidemic world wide has shown just how difficult it is to deal with an epidemic of this nature raising as it does all the difficult questions of culture, sex, death and social patterns of behaviour. It has been shown to be especially difficult in South Africa with the added complexities of race and culture, class and levels of illiteracy and unemployment. AIDS raises all kinds of questions about cultural beliefs and practices and it feeds into all the existing prejudices and stereotypes.

In our racially insecure and still racially raw society it also feeds into all the racial pain of the past years. So much so that in the debates on Virodene, Minister Zuma could suggest that the DP do not care about blacks - they would be happy if they all died.[17] Likewise as much of the AIDS criticism and activism was initially led by white people they were dismissed racially as whites feeling aggrieved by not being listened to. There are also the conclusions that are drawn about the racial categorisation of the epidemic, fuelling white perceptions that this is a black epidemic and evoking a response from blacks about AIDS being a white created ploy to kill off Africa. While these may now seem less important and less obvious than they were a few years ago, they still surface and are still obstacles to be overcome.

This situation continues because of the lack of understanding about why our society reacts in the way that it does, how it is created now, post apartheid and how intervention programmes could be informed and enhanced by a theoretical understanding of the epidemic. The response to AIDS has been overwhelmingly populist and as such is not underpinned by any real understanding of what the interventions are doing. There is little understanding of what works and what does not, and when programmes are seen not to work, more money is allocated or another outside external agent - poverty, migration etc is brought in as justifications. Linking AIDS to poverty is a descriptive explanation. It is not an explanation that is based on a real understanding of what the forces that have shaped where we are now or determine how a population comes to understand a particular phenomenon such as AIDS.

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[16] It I often remarked upon how the AIDS world in South Africa fights itself, and that differences of opinion become sites of destruction rather than site of constructive engagement. This is in part, because there are too few players in the AIDS world, it is too 'closed'.

[17] See Marais H, 2000, To the Edge, AIDS review 2000, University of Pretoria

The determinedly anti intellectual stance and the refusal to take theoretical explorations and explanations seriously means that we have no tools to describe our failure and decide on new and creative programmes of action.[18]

Is there a way past this?

There has been one programme where an attempt, informed by theory, to move past the common understandings and responses has been tried. An area in which the difficult cultural, racial, moral and ethical issues of AIDS were addressed and a programme implemented.

This has been in the National HIV/AIDS and Life skills programme, which has aimed to get HIV/AIDS education into all schools through teacher training and curriculum innovation. While this has not been a uniformly successful programme, it has explored ways in which diverse groups of people can overcome suspicions and tensions and work together to develop an appropriate effective and dynamic response.

It was clear that getting HIV/AIDS education into schools should be the work of the education departments (all 10) This was achieved through collaboration in the first instance between the National Departments of Education and Health. In a unique move the Department of Health raised the money and gave education the authority to spend it. A national committee was established with representatives from all the provincial education and health departments, as well as representatives from national NGOs, youth organisations and teacher unions.[19]

This committee has to grapple with the fears of the education department and of the parents of how AIDS work - dealing as it must with sex - would be integrated into schools. After a great deal of debate and often-acrimonious exchanges a training programme and a basic curriculum was agreed upon. Teachers were trained throughout the country and by the end of 1999, just on 14, 000 teachers were trained both to be able to design and run effective AIDS programmes themselves but also to train other teachers.[20]

In some areas this hope was instantly dashed as the education authorities refused teachers the kind of time they would need to develop and run programmes. In other areas teachers were redeployed, or even retrenched. Nevertheless, through the work of the life skills programme a National AIDS Policy Act for schools was developed and finally passed into law. This act determined that all children must receive HIV/AIDS education in schools, that children and staff with HIV will be treated in a just and humane way and that schools will lay down the basis for a non discriminatory response to HIV and

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[18] See Crewe M, Nov. 1999 They Roam the Landscape like packs of leaderless dogs; paper presented to Commonwealth Heads of Universities, Durban.

[19] This is the National Project Committee for HIV/AIDS and Life-skills, which is responsible to the Minister of National Education. It has been in operation for 5 years.

[20] Whilst the numbers trained has been impressive, it is how they use this training that is crucial.

AIDS by ensuring that the pupils are well taught in terms of compassion and understanding.

Immediately, the life skills programme was attacked as being 'out of touch', run by people who do not understand the epidemic' and doubts were cast (mainly by medically trained people) as to whether teachers should and could do AIDS education.[21] The people raising these concerns seldom questioned their role in similar activities!

Clearly there are some teachers who are, like some nurses and doctors and community workers, quite unsuitable for HIV/AIDS education. There should be sufficient checks and balances to ensure that they are not trained and asked to do such work. Despite the criticisms, which are in some cases valid, there are now many places where effective and dynamic HIV/AIDS education is taking place in schools. This is being done in collaboration between two government departs as well as with the full involvement of many NGOs.

What the life-skills programme has addressed is how to deal with the complex issues of race, class, culture and attitudes through the introduction of school based programmes. These debates and difficult decisions have generated a new and refined understanding of the process of education and the ways in which such radical diversity as we have in south Africa can be addressed and challenged. In essence it was found that there are far greater similarities between families and communities than generally believed. Many of the difficult moral and ethical issues can be dealt with in a multi-cultural and racially diverse way, with the aim of uniting young people around the common hope of a united South Africa that can defeat the AIDS epidemic.

The programme has been extended to primary schools. The ultimate hope is that all young people will have comprehensive HIV and AIDS education that will enable them to remain uninfected, support those who have been infected and know how best to deal with HIV and AIDS in their communities.

The TV soap drama SOUL CITY is another positive example of how really difficult racial, cultural, gender and violence issues are tackled unflinchingly through the medium of a television soap drama. In addition to dealing with the difficult cultural issues and having a dramatic story line, SOUL CITY effectively introduces understanding about social issues such as AIDS through its dramatic medium. It is a highly effective and successful programme and highly complementary to the life skills programme.

What both of these examples - one driven by the government and one driven by an NGO show is that it is possible to transcend the historical barriers as well as to unite people around a common theme. Both of them highlight the possibility to intervene in such a way that many people from diverse and various backgrounds and experiences can be reached in creative and

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[21] The attacks on the Life skills programme began almost before it was launched. There was suspicion of the education departments and a refusal to 'widen the response'. It was believed that NGOs should carry this work - despite the logistical nightmare of dealing with an education system of the size and complexity of South Africa.

effective ways. The formal life skills programme requires the ongoing commitment from the government, schools parents and communities - this will be forthcoming as long as the programme is allowed to be creative and try for new methods of education and curriculum innovation. The TV drama and the workbooks that accompany it are high in the ratings and will be a part of the South African response for a long time.

The way in which AIDS will finally play itself out in South Africa, like the South African response, defies description. It is too late to halt the effects of a major epidemic - it is not too late to avoid a catastrophe. To do that we need to focus on the real issues, forge unity and put aside government and NGO differences to forge a new and common understanding of how we can respond in a way that is mutually respectful, critical and challenging and ultimately effective.

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THEY ROAM THE LANDSCAPE LIKE PACKS OF LEADERLESS DOGS
(ANTONIO GRAMSCI – SELECTIONS FROM PRISON NOTEBOOKS)

AIDS; ACTIVISM AND THE ROLE OF THE UNIVERSITIES

(Paper presented to the Heads of Commonwealth Universities; 8/9 November 1999, Durban)

The notion of Universities responding to the crisis generated in the society by HIV and AIDS, is a relatively new one. For a long time, AIDS has been recognised as something that could be incorporated into the traditional services offered on campuses through the campus health clinics and student support services. This response was seen as one of counselling and care, coupled with sporadic attempts at education and awareness through safer sex campaigns, World AIDS Day events, dramas, marches and through the distribution of condoms and pamphlets.

This is essentially a conscience driven, largely passive, response. It recognises that students will be concerned about HIV and AIDS and will need support to address these concerns. It recognises that they will also be at risk of being infected with HIV and will need support through this risk and condoms to minimise it.

This answered the classic question phrased (pre AIDS) by Lenin of 'what is to be done' regarding students and the HIV epidemic.

But the idea of an HIV/AIDS response being institutionalised in Universities is a new one and there are few examples where it has happened. There are HIV/AIDS research programmes that aim to foster multidisciplinary research, or to generate research in the field. These are not an answer to the question of what is to be done, - they are a classic status quo response – there is a problem, a fascinating set of complex issues and the solution is to research them.

Institutionalising HIV and AIDS as a university response is far more complex than offering counselling services or establishing research programmes. It involves turning the whole University around to recognise the threat of HIV and AIDS both to the University and the society in which it is located, and to respond to it in a holistic and complete way. It involves addressing the essence, culture and power of the institution and it challenges the relationship between the institution and the society.

In the past, Universities have been able to respond quite effectively to social and political injustices. Some South African universities have a rich history of their opposition to Apartheid and the political repression of the previous

regime. The fact that this in and of itself no longer confers a legitimacy on their current operation and practice is something that these institutions are having to confront. Likewise the credibility of some of the Universities with the new regime, who were considered to be pillars of the previous dispensation, should be cause for reflection. It indicates how quickly institutions can transform themselves when the social forces require it, but also how fickle is the political imagination and how success comes as much from how one positions oneself as it does from any ideological identification or political rhetoric.

The history of AIDS, throughout the world, has been and is a history of anger, protest, despair and activism. The activists' movements of gay men in America and Europe largely fuelled this. Much of that form of activism has been taken, in the main uncritically, into the anger and activism of Southern Africa.

The history of AIDS activism accounts in part for the reason why the AIDS response has been so fractured, so divisive and why the society at large have felt excluded from the experience of this epidemic. In many respects AIDS has become integrally tied up with notions of 'identity and difference', and in a conscious attempt to create an identity of difference.

Our constitution defines AIDS as a disability and therefore people with HIV and AIDS ought, the argument goes, to be treated like all other people with all other disabilities. The work of activists has therefore increasingly come to centre on campaigns for equal treatment and access to resources that would enable disabled people to participate fully in social and economic life. But it has also involved an active renegotiation of identity.

This is a narrative framed in the conventional 'identity politics' terms in which an oppressed group who perceive themselves to share a common identity press for recognition and equity. What needs to be addressed is how to deal with the politics of disability without losing touch with the materiality of impairment, or how to speak of the diverse capacities and skills and the characters of the 'disabled' without sliding into a righteous politics that eclipses suffering. Can there be a positive image of suffering? This issue certainly bears heavily on the perceptions of and the representations of AIDS. {1}

The most common representation is that AIDS comes from outside – whether this be from Africa to the USA, from a lover to a partner, or to the University community from the communities out there. But it is this very representation that has made AIDS such a difficult area of social responsibility to deal with. For the AIDS activists have constructed a web of representation that has belonged inside rather than outside the affected groups. The language of

AIDS at all levels is the language of exclusion.
People with AIDS have been and are excluded from social and medical benefits, from occupations as well as from basic rights, recognition and acceptance. But it is also true that people with AIDS seek ever increasingly to exclude people without AIDS from their structures and organisations. Activists will tell you that only people with AIDS can understand and therefore run PWA organisations

How do we move from the exclusive images of those affected to a condition that might affect anyone? How do we acknowledge the reality of AIDS and the tragedy of AIDS deaths without stripping it of its aura of exclusivity and of exclusion of all those outside of direct experience? The language of AIDS activism may eclipse important aspects of the experiences of individuals concerned.

The public language of HIV/AIDS is too narrow and too tightly focused. It circulates powerfully in the AIDS community – so powerfully that outsiders can seldom find a way into it – but it does not circulate as strongly outside the boundaries of the AIDS community – in the broad public from which our staff and students are drawn and the communities that we largely represent. The AIDS world believes that what they say is understood by the wider community, but this is not true. What an outsider hears is AIDS people talking to themselves – and what they see is the huge gap between people on the inside and those on the outside. It appears that people with HIV/AIDS are protecting themselves, and it is that, in part, which makes them the represented, stigmatised object. {2}

The weight of signification that AIDS still carries is important when looking at University responses. A common trope is to compare AIDS to the holocaust and indeed some of the more intransigent literature in the USA links the casualty figures to those of Vietnam. Those who wish to downplay AIDS also engage in this kind of comparison – here AIDS is demeaned by being described as less significant than the deaths on the road.

Rather than comment on such facile and pointless jostling for importance we could ask a more serious question – just how does disease and bodily suffering come to be collectively imagined and experienced? Cancer - an illness often compared with AIDS – as in the borrowed slogan 'living with AIDS' – is an experience that is individualised. In AIDS the experience is collectivised. Unlike AIDS the diversity of individual experience permits no hegemonic cultural constructions to be developed or maintained in illnesses like cancer, or malaria.

As Edmund White has so eloquently put it AIDS is central in the construction of self and the construction of community – through the friendship networks

that framed the early collective conscious of the epidemic. This collective conscious has stayed with the activists, though in dealing with a widely infected and quite diverse and heterogeneous population, this collective conscious may no longer be possible.

But people with AIDS who assume leadership positions and the AIDS activists who are often not positive themselves regard this collective conscious as the way forward for mobilisation of people with AIDS and for creating social and political conditions that will allow for representation of people with AIDS in all forums as well as ending the stigma and prejudice. It's as if the argument goes – when they recognise how many there are of us they will join us, -, and the categories of exclusion and inclusion are strengthened and maintained.

So whilst it is important to have identity, it is this identity that constructs the notion of difference. And the denial of participation of the 'general population' (other than as potential threatened sites of infection) ensures that they remain sceptical about the cause and alienated from the emerging social movement.

This has moved into the terminology of AIDS as well – there is a long list of taboo words that are associated with the epidemic and descriptions of it.The 'wrong use' of these words has assumed a signification far beyond the semiotic meaning of the word. In their discourse AIDS activists frequently portray people with AIDS as 'victims' of the state, the pharmaceutical companies, the private sector and families whilst at the same time trying to dispel this notion. So we have the rhetoric of the 'poor people with AIDS who need a voice' vs the 'rich people with AIDS who can have not only a voice but also a treatment'.

It is this categorisation of AIDS as a disease of poverty, disadvantage and discrimination, that allows the 'AIDS Struggle' to be equated with the political struggle. Without much critique or reflection the same conditions and terms are said to apply. The logical consequence of this is the expectation that the experience from the political struggle will apply to the AIDS struggle and that Universities should take it on board as a serious social and political issue, as they have done in the past, with political struggles.

Clearly AIDS is very different from other life threatening illnesses despite the pretence that it is not – this difference can most simply be seen in terms of numbers alone. The personal experiences of people with AIDS differs enormously, as did the personal experiences of people under apartheid. The Apartheid struggle was, like the AIDS struggle formed around collectivities, - groups of affected people and less around the individuals. AIDS activists try somehow to both define the disease as an individual issue – people with HIV

and AIDS should come forward and reveal their status and be seen, be public and be seen to be seen; and at the same time, these individuals must also be seen to be part of the collective conscious, when it may be precisely their individual response that puts them apart from the collective experience.

We need a new language, a new text and recontextualisation if you like, a new way in which both the epidemic and the people infected can be seen, talked about, understood, and acted upon.

It is this recontextualisation and new language that is the activist role for the universities. But how should universities deal with this, and how should the Universities position themselves in relation to this broad social movement of AIDS activism? In the first place Universities have to address both the complex issues of the individual vs the collective. What should a University be doing about staff and students with AIDS and should this be the same or different from staff or students with other life threatening illnesses. So we talk about the university having an association of staff and students with AIDS, but not of one for staff and students with cancer, TB or malaria – these diseases in which the death toll is also high are private and seen to be private. AIDS is seen on necessity to be public. Must we create a space for people to disclose when we can create a space where it is safe for people.

But universities also have to look at AIDS as a problem – it is clearly a problem if there are 25% of the students infected. This is not to diminish the personal but maybe the political/social and economic effects of this epidemic are of more immediate concern than the actual staff and students who are infected. In the life of a University for there are hard choices to be made, and dealing with AIDS will highlight many tough and difficult choices.

The collective response underpinned by the strong human rights ethos means that it is problematic merely to address AIDS in these terms. For the problem of AIDS is too readily read as the problem of people with AIDS, and all too soon we are accused of making the people with AIDS, the problem! And yes the problem of AIDS means in a society of few resources, that decisions will have to be made about those students or staff with HIV or AIDS.

In developing its AIDS programme, the University of Pretoria, looked carefully at the rage and rhetoric of AIDS activism and of how best to position a programme that would recognise their legitimate concerns and angers, but would also address the more complex issues that a disease of this nature and magnitude raises. In this we looked at five key areas –

The culture of critique – this is the role the University will play in providing intellectual leadership that will develop an understanding of the epidemic

and why it is that in South Africa we have one of the fastest growing epidemics in the world. It addition it will challenge the state, the private sector as well as the NGOs and the activists to be more accountable.

This leadership will also operate to inform and educate the wider public in terms of the issues at large and the facts and values that go with them.

Part of the failure to address AIDS in South Africa has been that much of the response is based on populism rather than on a rigorous and theoretically informed social understanding of our society. We need to challenge this through a ferment of new ideas, the creation of a new social conscious and explanation and through the ways in which we understand, explain and change the world.

It will and should generate a new recontextualized language of AIDS – one which is inclusive of the whole society and one which allows people affected, though not necessarily infected to feel part of a shared programme of action, debate, discourse and action.

Professional training – we are convinced that unless students have a very clear professional understanding of this epidemic and what it is likely to mean in terms of their future careers, we will have failed both the students and the wider society. In this professional understanding much of the critique and theoretical understanding we have generated will be incorporated into student curricula. The students will grapple with AIDS as a professional intellectual issue in the same way that they do with many other issues pertinent to not only their discipline but to South African society.

This professional understanding will have another component, which is that as many graduating students as possible will have been fully trained in the management, political, social, economic and legal aspects of AIDS in the workplace. They will be able to generate workplace programmes, that include peer education and counselling. as well as an understanding of the relevant legislation, and the effects of large numbers of sick and dying colleagues.

Through this we are sure that a major change in attitude in the society will occur and it really will be possible to end the prejudice and discrimination and the social hostility. However, this can only be achieved when people with AIDS are seen to be, and see themselves to be part of the society and not outside of it or a special category.

Student services – this has a number of components

The first is that AIDS will be incorporated into all the community outreach programmes of the University. Students participating in these programmes will be trained in AIDS outreach work and will also be twinned with and placed in outside community based organisations

and NGOs as that they are able to learn from them how such organisations operate and run within their communities.

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-) The second is that student volunteers (currently just on 500) will be recruited into the programme. They will be trained as peer educators and counsellors and will give support to the university AIDS response through the libraries, health services, hostels, student support and in all the faculties. They will establish faculty based student support counselling in which students and their families will be counselled and supported.
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-) The third is that students will form the University association for students infected and affected by the epidemic. Whether this becomes a group that contests student elections or remains as a society remains to be seen.
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-) Fourth, students who require counselling as a component of their degree programmes will supervise volunteers and run counselling services themselves.
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-) Fifth, the students are responsible for the extensive media campaign on Campus. This started with an awareness campaign for the establishment of the AIDS centre and continues with regular articles regularly in the student newspaper and talk shows on the student radio. They are also responsible for the new posters and the welcoming poster for all registering students.

There will be special aspects of the programme, that address the areas of concern for staff. This will be in the training of key personnel to deal with AIDS in the workplace as well as staff to ensure that there is peer education and support staff. Staff in student support services, the campus clinic, the library and the key members of the unions are all currently being trained.

An extensive research programme is planned, in collaboration with the CSIR and other tertiary institutions. This will generate research not only at the University of Pretoria, but also in collaboration with other institutions. This research will be part of the culture of critique and will have to address the role of the state, private sector, NGOs and the ways in which the activities of these (despite their individual successes) have often, unintentionally, undermined the development of a coherent, united, informed and successful programme. The Universities are ideally placed to be part of the new language and context of AIDS that we have to find if we are to be successful.

This programme developed at the University of Pretoria has the full support and commitment from the Rector, Vice Rectors, all the Deans and the student

leadership. In its vision and design we believe it is unique in the world and we believe that it is offering and will offer a fascinating way in which the entire epidemic can be addressed, challenged and worked upon. In the immortal words of the Italian social theorist, Gramsci, the players in the AIDS world '***roam the landscape like packs of leaderless dogs'*** on the loose, reacting rather than leading, fighting for power and turf creating a social movement based on exclusion and an identity of difference. The general public has identified that there is no leadership and that they are excluded even while being accused of being disinterested. They retreat into defensive and silent passivity as the epidemic unfolds about them.

The Universities acting together, as Pretoria and Natal have shown, can give leadership in policy, in theory, in programmes, in practice through the partnerships they develop with the communities from which the students are drawn, in partnership with the government and in recognising the ways in which the epidemic will impact on their functioning and on their staff and students.

Each university should not try this alone, but in the Southern African region should commit to working together to ensure that the rate of infection among the youth is dramatically reduced and that the impact on the sector is lessened and that all people with HIV and AIDS and all of us affected by it, feel united and supportive of each other so that we roam the landscape like a hunting pack assured of our direction and purpose and committed to success.

NOTES:

1. Woodward K (ed) 1997 Identity and Difference, ch. 1 and 3
Sage/Open University Press

2. Morphet T 1996, AIDS – The Social Test
Summary comment on the Continuum of Care Conference, AIDS Consortium

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HOW DO WE MAKE SENSE OF MBEKI?

President Mbeki's first foray into the AIDS arena came, in 1997, when as deputy president he supported Virodene, the alleged cure for HIV. He was a member of the Cabinet who heard the presentation and who applauded at the end. He was supportive of Dr Zuma, and even went as far as writing an article for the newspapers on the need for creative responses and support for the process. The Virodene creators claimed that they were not heard by the 'AIDS establishment' and that their work was blocked. Mbeki was possibly encouraged in this support for Virodene by the fact that not one of the (Black) intelligentsia or scientists was prepared to speak out against Virodene. The editor of the SAMJ Daniel Ncayiyana even went as far as to publish a plea 'Give Virodene and the Minister a Break'.[1] The people, who did criticise Virodene, were (white) HIV/AIDS researchers and doctors. It was only months later when the politically appointed MCC (appointed when the previous MCC refused to support Virodene trials) finally decided that Virodene could not be tested at all, that William Makgoba by then head of the MRC supported the anti Virodene stand. Mbeki has never distanced himself from Virodene or corrected his previous stance.

He next supported Dr Zuma in her duel with the drug companies, saying that the fact that South Africans did not have access to treatment was not the fault of the government but the fault of the pharmaceutical companies that priced their drugs too high.

His next major stand was on the refusal to provide AZT for pregnant women with HIV. Despite all the convincing arguments that AZT had shown efficacy in reducing maternal transmission and favourable cost analyses, he was steadfast in his refusal to even consent to trials. His main argument was that, in surfing the web, he had found evidence that AZT was highly toxic and dangerous. He showed a concern about the side effects and dangers of AZT that was startlingly absent from his support of Virodene.
Mbeki claimed that there was evidence (from 5 trial sites) that AZT was dangerous, and that the 'consensus' view ignored such dangers.[2] He also refused to consider AZT for women who had been raped, with the minister of health arguing that it would be unethical to give possibly uninfected women AZT due to the toxicity and side effects.[3] The case of Thalidomide was given as an example of 'consensus that went wrong'.

His AZT investigations also led him to the Duesberg debates about the causes of AIDS. The so-called AIDS 'dissidents', who dispute that HIV causes AIDS, have gained the sympathy of Mbeki. While stopping short of saying that HIV did not cause AIDS, Mbeki cast enough doubt on this to give the impression that he was a dissident supporter. This was also demonstrated in his manner of addressing the dissidents as cruelly victimised by the so-called 'orthodoxy' of the AIDS world. He said that in order to sanction AZT and to

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[1] South African Medical Journal Vol. 87 No 3, March 1997 (editorial)
[2] Mbeki digs in his heels over HIV/Aids Independent on Sunday 26/3/00
[3] Truth and Lies about AZT, Mail and Guardian website, 1/12/99.

develop an appropriate South African response he was determined that the other voices be heard. To this end and at great expense he has convened an expert panel, which includes very few South Africans, to meet early in May to discuss the causes of AIDS, prevention and treatment.

This is an extremely elaborate way to get around the AZT controversy and the failure adequately to address the AIDS epidemic in South Africa. It also allowed for a delay on a decision on Nevarapine (an effective and cheaper drug than AZT) and indeed five deaths on a local trial were immediately (and incorrectly) attributed to Nevarapine as part of the discrediting process against cheap and effective drugs.

There are a number of contradictions in Mbeki's stand. The first is that in seeking an African solution and to ensure that Western drugs are not relied upon, he will confer with mainly non-Africans for his answer. Indeed many of the panel are already collaborators with local programmes and scientists and could give their input via local expertise. Second, his Government is committed to the development of an HIV vaccine, a full acknowledgement that HIV is the causal connection with AIDS. Third, he is aware of the thousands of people who are infected and dying, but refuses to sanction treatment that could reduce this toll.

His contact with the so-called dissidents is curious - he has spent time on the phone, and claims that through the propaganda machines of the orthodox position 'an entire regiment of eminent scientists is wiped from public view.' However, he did not find the time to call up the local HIV/AIDS experts and get their impressions on the debate and their understanding of the issues, or even meet with them in committee, to get himself well informed before his full committee would meet.

The use of the political term 'dissidents' for the doubters of HIV as the cause of AIDS is interesting. It introduces a political dimension to the controversy that shows a misunderstanding of the way in which scientific controversies are resolved. His view that he through committee can reach a 'consensus view' is similarly misguidedly drawn from politics. Science does not operate through committees that reach consensus.

His behaviour on the causal effects of AIDS is consistent with the Virodene saga. Support for the underdog and disdain for the established and internationally renowned scientists who work in his own country, and a refusal to entertain any criticism or challenging counter debates. Only this time, with a couple of minor exceptions, the entire scientific world, black and white seemed ranged against him. His critics included Ramphele Mampele, as well as Dr William Makgoba. The head of the Durban 2000 organising committee and a range of prominent people joined them.[4] Without exception they called on him to recognise that HIV is the cause of AIDS, to recognise the effects of AZT in reducing transmission and to ensure that the AIDS programme is not damaged.

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[4] Mbeki was sent a joint letter from Judge E Cameron, Dr H Coovadia, Arcgbishop N Ndungane, Bishop M Dandala and Ms M Makhalamele requesting amongst other things AZT for pregnant women

He refused to hear them, and the expert committee will meet to answer his concerns, which in effect could have been answered in a memo from the health department. His concerns are - the causal links between HIV and AIDS, how it is that HIV/AIDS started in SA as a typical western gay/IV drug using epidemic and moved with terrifying speed to a heterosexual one, and how to deal with this 'African epidemic'? This was the gist of the letter he sent to heads of state in other countries. A letter that his advisors and health ministry should have prevented, a letter that serves only to highlight that even as President, one can be woefully ignorant of the basic facts on HIV/AIDS and its development implications, and shows how even the best prevention education campaigns can fail.[5]

But what has not been answered is why he is doing this? Why is the President of a country being involved in debates that really are of little concern to a head of state? The consequences of an epidemic such as AIDS are certainly a matter for his concern and attention. But engaging in this debate is rather like standing by when a fire is engulfing a building and killing those inside whilst asking whether the fire is caused by an electrical fault or paraffin, or indeed if the fire exists at all.

It is difficult to give answers. Why dredge up a decade old discredited debate to justify holding out on crucial decisions about treatment access and care?. Why in a country with the most rapidly growing epidemic in the world and a disbelieving and prejudiced population, raise the possibility that HIV does not cause AIDS and allow for the undermining of years of patient and difficult work?.

It is possible that there is a senior member of government or the ANC who is living with AIDS and at a point where the information could be made public, and this is a desperate attempt to find a non sexual i.e. an non transgressing reason for infection - the idea that HIV lies within us all from the polio campaigns and that something - (this committee could tell us what) - will trigger off an AIDS response.

It is possible that the hosting of the 13th International AIDS conference in Durban has highlighted the fact that South Africa's response will be harshly placed under the spotlight and it will be found to be seriously lacking. One way is to deflect the attention away from policy and (failed) practice onto the debate that challenges the very premise on which the conference is based.

Another is that dealing with AIDS raises all kinds of social, racial and cultural issues that have not been dealt with - such as the sexual behaviour of men, the position of women in society, patricharcial behaviour and domestic violence. All of these together with poverty, unemployment and a failure to provide housing fuel the epidemic. If it were possible to show that HIV did not cause AIDS and was indeed was not sexually transmitted, then the difficult

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[5] see comment Mbeki's Aids letter defies belief by Michael Berger, Mail and Guardian April 28 - May 4, 2000, pg. 32.

issues of class, race, culture and gender and sexual behaviour need not be addressed.

It all defies explanation and understanding. But as worrying as Mbeki's stance, is the support that he seems to be getting from his Minister of Health and his party, as well as from members of the public. This support is couched in the rhetoric of open debate - though interestingly there has been no open debate with the academics and scientists who accept the current thinking on HIV and AIDS - just attacks on their scientific integrity. And as worrying is the effect this has on an already sceptical and disbelieving population, who see in Mbeki's doubts confirmation of their own doubts, and confirmation that they do not have to change behaviour.

When calls have been made for intellectual leadership, they have not been calls for obstructive, red herrings, but calls for bold and unambiguous ways to gain popular support for AIDS campaigns.

What Mbeki has failed to recognise or indeed understand is the nature of science. Science does not operate on consensus, but on the basis of weighing up evidence and fact and on peer review and understanding. The 'dissidents' can not produce scientific evidence to support their claims. Much of what they say has been proved wrong. Contrary to the Mbeki belief they have been given ample 'air time' with their work being published and subjected to peer review as with all other scientists. And on the balance of evidence, discarded.

It would be hard to imagine that Mbeki would wish to question the theory of evolution, and host a meeting of the creationists and the evolutionists. It is hard to imagine that he would wish to open the debate on eugenics and racially based assumptions of IQ. Would he entertain allowing Jensen to air his views on the genetic intellectual inferiority of black people? And yet why not - in creationism, in theories of racially determined intelligence, in eugenics there is an 'orthodox' position and there are the 'dissidents'. But in all cases the body of evidence - the scientific facts have convinced us that the 'dissidents' are wrong and the current 'orthodox' understanding is correct. And in the Soviet case of genetically engineered wheat, acceptance of the views of the 'dissident' Lysenko over the views of the 'orthodox' agricultural scientists led to the destruction of the wheat crop, starvation of the population and even the death of people who opposed the use of science for political ends.

What Mbeki is doing is again raising the dreadful spectre of using scientific findings to suit his own political ends. The failure of his government to provide basic and treatment and care cannot be explained away by doubting the cause and nature of the African epidemic of HIV and AIDS much as he seeks for such explanations. The heterosexual disease in Africa is no different, except on measurement of scale from that in Europe and America - there social stability, employment, housing and access to treatment contain it. The African epidemic is not different in terms of transmission and the pattern of the disease. But what is starting to characterise the difference is a failure to act

boldly and decisively and to understand and believe all the evidence about HIV and AIDS that lies before us.

The expert committee has six Internet weeks to discuss the issues and answer the questions. Six weeks brings us close to the Durban 2000 conference. Something dramatic will be announced just before Durban - either a reinvigorated AIDS programme based on the best understanding there is of the epidemic there is at present with creative new ideas and programmes, or at worst a pronouncement on the 'African' causes of the epidemic at odds with the scientific evidence and our current understandings.

It is hard to make sense of Mbeki and his quest for answers in AIDS that will satisfy his personal doubts, but it may be even harder to get South Africa back on track in fighting HIV/AIDS and all its effects.

Mary Crewe
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SADC HIV/AIDS STRATEGIC FRAMEWORK AND PROGRAMME OF ACTION: 2000-2003

MANAGING THE HIV/AIDS PANDEMIC IN THE SOUTHERN AFRICA DEVELOPMENT COMMUNITY

PREPARED BY SADC HIV/AIDS TASK FORCE

APRIL 2000

Participating Sectors/ Commissions:

- Culture Information and Sports
- Employment and Labour
- Health
- Human Resource Development (Education and Training)
- Mining
- Tourism
- Transport, Communication and Meteorology

SADC Health Sector Coordinating Unit
Private Bag X828
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April 2000

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ACKNOWLEDGEMENTS

This Strategic Framework aims at strengthening the response to the HIV/AIDS epidemic in the Southern African Development Community (SADC). It has been developed under the leadership of the SADC Health Ministers whose vision of a multi-sectorally driven strategy has given impetus to and seen the birth of this seven-sector framework. The Ministers set up an HIV/AIDS Task Force made up of Health Focal Points which was later expanded into a multi-sectoral Task Force to include the seven sectors involved in this Framework.

The framework seeks to build on the efforts of the many sectors that have been involved in the HIV/AIDS response within the framework of SADC. It is recognized that much of the work in HIV/AIDS has been spearheaded by the National AIDS Coordination/Control Programmes (NACPs) in Member States. The guidance of these NACPs will continue to be desirable in strengthening the response in other sectors, and in providing technical leadership in the implementation stage of the Framework. The Strategic Framework has also benefited from the efforts of many international agencies, whose work has provided insights into options available to Members States' HIV/AIDS responses.

Sector Coordinators from the seven SADC Sectors as well as the SADC Secretariat have participated in the design of this framework and have invested much time in developing this Framework. The coordination in the development of this framework has been spearheaded by the Health Sector Co-ordinating Unit and the overall technical leadership has been provided by the HIV/AIDS Task Force.

Further technical support has been provided to the Multi-Sectoral Task Force by consultants from Ziken International of Harare, who have synthesised inputs from various sectors into this Strategic Framework and Programme of Action.

This work would not have been possible without generous financial support provided by the European Union and UNAIDS, as well as funding from Member States who released Senior Officials to work on the Framework.

3-4 April 2000

1. Introduction

The SADC HIV/AIDS Task Force in December 1999 adopted the vision of ***"A SADC Society With Reduced HIV/AIDS"*** to guide the work of the seven sectors participating in the development and implementation of a multi-sectoral SADC HIV/AIDS Framework for the period 2000 - 2004. The elaboration of this vision led to development of the overarching goal of ***"decreasing the number of HIV/AIDS infected and affected individuals and families in the SADC Region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of Member States"***. This goal provides guidance to all SADC sectors in the formulation of their responses to the epidemic.

The health sector has over the last two decades provided much of the leadership in the HIV/AIDS response and has advocated a strategy that addresses the HIV/AIDS epidemic through the efforts of health care system, communities, youth, the private and public sector and other stakeholders in society. This multi-sectoral HIV/AIDS Framework recognizes that the wider participation of all sectors and communities (including youth, women and children) in the HIV/AIDS response is likely to lead to enhanced synergism and complimentarity of effort for achieving greater impact.

The main strategy being pursued in this Framework is to promote the re-allocation of responsibilities for planning, coordination, implementation and monitoring and evaluation of the HIV/AIDS response across the social and economic sectors of SADC, consistent with the specific mandates and comparative advantage they enjoy. In this manner, the response will become increasingly multi-disciplinary and multi-sectoral in character and take on a more regional flavour.

Overall, the Strategic Framework is guided by Article 10 of the SADC Health Protocol within which all SADC sectors use their comparative advantage to address the needs of those sectors and communities they serve - Transport, Mining, Tourism, Human Resource, Information, Culture and Sports, Labour and Employment, and Health. The underlying strategy of this Framework is to assist each sector build its capacity so that it can develop, implement and monitor an effective HIV/AIDS programme – supported by the Health Sector Coordinating Unit. In working towards that goal, the Strategic Framework provides the context for, and seeks to build capacities in the seven sectors for an accelerated and robust response to the epidemic.

2. Process of Development of the SADC HIV/AIDS Strategic Framework

This Strategic Framework aims to address the HIV/AIDS epidemic in the SADC region using a multi-sectoral approach within the regional grouping of SADC. It is the product of consultations among the seven sectors comprising a multi-sectoral Task Force on HIV/AIDS in SADC. The Task Force met in Pretoria, South Africa, during 6-7 December 1999. Each of the seven Sector Coordinators conducted extensive consultations within their sectors to arrive at strategies that best reflect that sector's response to the HIV/AIDS epidemic.

In keeping with this consultative process, each sector was encouraged to:

1. Identify those HIV/AIDS activities that it needs to integrate into its overall strategy, and then seek support from Health and other sectors.

2. Use relevant Sector Coordinating Units, to facilitate the sharing of lessons between member states within the sector.

3. Share its lessons with each of the other six sectors.

4. Adopt innovative and relevant strategies that have been tested by other sectors.

The Health Sector Coordinating Unit in this period performed the following functions:

1. Identification of those activities that are best carried out by the health sector and then assist health sector focal points in member states with implementation.

2. Synthesis of inter-sectoral experiences for wider dissemination based on work carried out by the seven sectors involved in this framework.

3. Undertaking and stimulating HIV/AIDS awareness in all other sectors not participating in this multi-sectoral HIV/AIDS Framework, and using experiences from 1 and 2 above to disseminate information on good practices in intra-sectoral HIV/AIDS work.

It is envisaged that in the implementation phase of this Framework, each sector will strive to integrate HIV/AIDS strategies into its overall sectoral strategy whilst the health sector will assist in coordination and technical support. During the five-year life span of this Framework, the SADC Health Sector Coordinating Unit is to be strengthened with expertise that can coordinate work within the following:-

(a) The three social sectors involved in the programme (Health, Human Resources Development, and Culture, Information and Sports);

(b) The three economic sectors (Mining, Tourism, and Transport and Communication) forming part of the programme; and

(c) The integrative sector of Employment and Labour, whose work on HIV/AIDS can provide useful strategies for more effective linkages between social and economic sectors at the national and regional levels.

3. SITUATION ANALYSIS OF HIV/AIDS IN THE SADC REGION

The SADC Region faces a very severe HIV/AIDS epidemic. The current extent of the pandemic has affected virtually every aspect of the lives of the people in the SADC region and has now reached crisis proportions. Since the mid-80s when HIV/AIDS was identified in most countries of the region, there has been a rapid increase in the numbers of adults

and children infected with, and dying from HIV and AIDS, with a corresponding adverse impact on the socio-economic development of the region. HIV/AIDS is now arresting or even reversing the major socio-economic gains of the past two decades in such areas as health, agriculture and education. Health care systems are overwhelmed with HIV/AIDS patients with the result that health workers are overburdened, health care costs are escalating and acute conditions are being "crowded out". Conditions such as tuberculosis (TB) which were almost being brought under control in the 1970s have re-emerged as a result of the HIV/AIDS epidemic, further straining the overstretched health care systems.

The demographic impact of HIV/AIDS in the region has also been serious: life expectancy has dropped significantly to around 40-50 years, child and adult mortality have risen while the number of orphans continues to increase at an unprecedented rate.

From the epidemiological surveillance of HIV/AIDS in the region, it is not uncommon to find HIV seroprevalence rates in excess of 20% or more in the adult population in most urban areas of the SADC region. This in essence means that a large number of productive and skilled men and women will lose their lives prematurely to HIV/AIDS, with dire consequences for the socio-economic development of the region. Yet the full impact of HIV/AIDS is yet to come because of the prevailing high levels of HIV infection in the communities which will ultimately translate into AIDS patients requiring care and social support.

The characterization of HIV/AIDS "as a disease of sub-Saharan Africa" is aptly demonstrated by the following facts available from UNAIDS:

- The region has registered a total of close to 4 million deaths, which have left behind nearly 3 million orphans.
- The estimated total number of AIDS cases in the region is 4 million, leaving another estimated 6 million who are HIV-positive and likely to develop AIDS.
- There are about 10 million citizens living with HIV/AIDS (5% of the total population) in the region.

According to the Joint United Programme on HIV/AIDS (UNAIDS), it is estimated that the region has an average adult prevalence rate of 12% (which would mean close to 10 million people affected by HIV/AIDS in this region).

HIV/AIDS is therefore a major burden and challenge to the health, social, and economic development of the region. There can therefore be no meaningful development in the SADC region as long as HIV/AIDS is not addressed on an **urgent** and **emergency** basis, and justifiably so, the SADC Ministers have identified HIV/AIDS as a crisis that requires a multi-disciplinary and multi-sectoral approach. This entails forging strategic partnerships and alliances across public, private and NGO sectors.

3.1 Health status in the region

The HIV/AIDS epidemic has begun to adversely affect the health status of people in the SADC region. The health indicators have also begun to deteriorate. While the region has

registered a steady improvement in the provision of safe water supplies and sanitation facilities during the last decade, the challenge of high morbidity and mortality remains. Infant Mortality Rates in the 1980-97 period only dropped from 109 to 92 deaths per 1,000 live births, while Maternal Mortality Rates in the same period remained at 634 per 100 000 live births. Prevalence of malnutrition among the under-fives was around 25% during the 1990s decade, and under-fives Mortality Rates were 146 per 1,000 live births. The population in the region, with a relatively heavy burden of illness and poor health, is now faced with an even more menacing and growing AIDS/TB co-epidemic.

Regional averages of selected health indicators

	1997
Population with access to safe water (% total)	55
Population with access to sanitation (% total)	51
Access to sanitation in urban areas (%)	75
Public health expenditure as % of GDP	2.7
Infant Mortality Rates, per 1,000 live births	94
Total fertility rate (births per woman)	5.0
Contraceptive prevalence (% women in 14-49 age group)	30
Prevalence of malnutrition among the under-fives	25
Under fives mortality rate, per 1,000 live births	146

Source: World Bank Development Report 2000

The prevalence of communicable but preventable diseases is high in the SADC region and the advent of HIV/AIDS has further complicated the prevention efforts of these diseases. Of particular importance and significance is the emergence or re-emergence of tuberculosis as a major public health and socio-economic problem that threatens the lives of hundreds of thousands of people in the SADC region. Despite efforts by governments in the region over the last decade to address HIV/AIDS and its effects, the epidemic still constitutes the single biggest threat to health within the SADC.

3.2 Socio-economic setting

The SADC has a total population of 191 million people, with an average of GNP per capita of US$1,096. This average GNP figure masks great inequalities within the region, with Botswana, Mauritius and South Africa having a figure of over US$3,000; while countries like the Democratic Republic of Congo, Malawi, Mozambique, and Tanzania have less than a figure of US$200. This gap in GNP per capita for the region (US$80-3,380) has major implications on the availability of resources to support development efforts, including the financing of health services and various measures needed to combat the impact of HIV/AIDS.

Although the region has a low rate of population growth (2% per annum in the 1995-2000 period), this is offset by the very low rates of economic growth for most of the member states, especially for those countries with low GNP per capita figures. This poses a major challenge in the allocation of resources to HIV/AIDS programmes for member states.

Macro-economic stability and the challenge of resource allocation to HIV/AIDS programmes and activities is complicated further by the high levels of ***external debt*** in the region – which in 1997 averaged at 93% of GNP according to the World Bank

Development Report 2000 (WBDR 2000). Only Botswana had an external debt less than 10% of GNP – with the highest being Angola at 206% in 1997. In the 1990-97 period, the region only received a total of US$2.7 billion in foreign investments, most of it going to South Africa. In the same period, the per capita Official Development Assistance to the region dropped from US$63 to US$45 - a drop from 16% of GNP to 10% (WBDR2000). Thus, for countries with a high dependence on external assistance to finance the social sector, the challenge of resource constraints will remain for some time to come.

Regional averages of selected economic indicators

	1990	***1997***
Direct foreign investments ($b)	-6	2.7
Total external debt ($b)	43	76
External debt as % of GNP		93
Official Development Assistance $/capita)	63	45
Official Development Assistance (% GNP)	16	10
GNP per capita (value in US$)	1 6	11
GNP per capital annual growth rate (%)		0.3
Food production index (1995-7; 1989-91=100)	69	84
Arable land (hectares per capita)	0.4	0.3

Source: World Bank Development Report 2000

With the establishment of SADC and COMESA and the end of apartheid in South Africa in 1995, the region has shown signs of increased economic integration. In the period 1996-98, South Africa invested a total of US$4.2 billion in eleven of the fourteen member states according to a survey by *Focus on Africa 2000*. Increased economic integration and intra-regional investment flows have the effect of opening up possibilities for the increased allocation of private sector finance to HIV/AIDS programmes.

The overall difficulty of registering high economic growth figures in the region will pose the greatest challenge to the allocation of adequate resources to programmes aimed at enhancing the HIV/AIDS epidemic in the region.

All member states have literacy levels above the 40% mark, with Mauritius, Seychelles and Zimbabwe registering over 80%; and the bottom three being Angola, Malawi, and Mozambique (UNESCO, 1998). Due to disadvantages suffered by women, illiteracy rates are generally higher among women than men, and this has implications on the range of communication strategies that can be used to deliver information to the population, especially women. High enrolment rates in primary schools is conducive to the provision of health education to this population, but low secondary school enrolment is a major handicap in reaching the teen age group that is usually in Secondary Schools. For higher education, the figures are even lower, less than 5% in the region, and the use of non-visual communication in the region has limitations due to this pattern of educational levels. This issue poses major challenge to all sectors involved in the implementation of the multi-sectoral activities.

4. HIV/AIDS Response Analysis in the SADC Region

Member States in the SADC region have been implementing HIV/AIDS programmes since the mid-80s in order to (i) prevent or reduce the transmission of HIV and other STDs and (ii) reduce the socio-economic impact of HIV/AIDS among individuals, families and communities.

In the early stages of the epidemic, many countries were guided in the implementation of HIV/AIDS Programmes by the WHO's Global Programme on HIV/AIDS (GPA) which was later supplanted by UNAIDS in 1996.

The early HIV/AIDS response was mainly centered around raising awareness on HIV/AIDS through IEC and communication for behaviour change (abstinence, mutual faithfulness), condom promotion, treatment of STDs as well as clinical and home-based care. These early approaches were predominantly medical and health-focused in nature and largely neglected the participation of other sectors in the response. In addition, it emerged that there was (and there still is) the challenge of narrowing the gap between knowledge and behaviour.

As the epidemic continued to evolve in the 1990s and its effects became increasingly cross-cutting, there was a realization that the health sector alone could not respond to, and cope with the wide-ranging socio-economic consequences and manifestations brought about in its wake. Therefore, there was a shift in the programming paradigm from a medical to a more multi-sectoral, participatory and inclusive approach.

The main actors in the HIV/AIDS response in the region are:

i. The Governments, through National AIDS Coordination/Control Programmes (or AIDS Commissions, Councils) which provide overall leadership, guidance, policy formulation and coordination.
ii. The Non-Government Organizations (NGOs), Community-Based Organizations (CBOs) and Religious Organizations which have increasingly been playing a bigger role in prevention, care, social support and other forms of impact mitigation, thereby complementing Governments' efforts
iii. Private Sector working mainly through work place programmes are also beginning to take ownership for responding to the epidemic
iv. Regional Organizations and Cooperating Partners who have provided resources and technical support in the HIV/AIDS response

The extent to which interventions have been successful in averting the further spread of HIV in the region is extremely variable across countries of the region, depending on the maturity of the epidemic and the intensity of the response. There are reports of a stabilizing epidemic in some countries, albeit at extremely high levels while some countries have reported declines in the rate of new infections, particularly in the age group 15 to 19 years. Notwithstanding these isolated favourable changes, the rising trend of HIV infection in the southern part of the SADC region is worrying, particularly in parts of South Africa over the last five years.

It is clear therefore that the HIV/AIDS epidemic remains serious in SADC and many of the "effective" interventions have remained small, fragmented and remain stuck in pilot mode.

In addition, the strategies have largely been single-sector efforts (health) and efforts to develop and catalyze a concerted multi-sectoral approach have not yielded the desired results. Many sectors outside health have inadequate technical expertise and capacity to 'internalize' the HIV/AIDS problem through their policy frameworks, institutional arrangements and service delivery.

In order to produce a greater positive impact on the HIV/AIDS situation in the region, it is desirable to broaden and expand the number of sectors participating in the response and to considerably scale up the interventions. This will have the effect of improving and widening coverage - both in terms of geography and in relation to populations and clients served.

Consistent with the lessons learnt thus far in the epidemic, there is now greater movement towards developing multi-sectoral and regional approaches in the response to the HIV/AIDS epidemic

5. Guiding principles

The development of this Strategic Framework has been guided by the following principles:

1. The 'comparative advantage' of each sector should be identified and utilized in the implementation of strategies aimed at addressing the epidemic and its effects in the sector

2. The SADC Strategy seeks to complement on-going National Responses to HIV/AIDS epidemic as outlined in the respective National HIV/AIDS Plans and Programmes.

3. The recognition that there are other international, regional and national organisations/bodies already participating in the response to HIV/AIDS pandemic in the region.

4. Respect for rights of individuals and promoting partnerships and respect.

6. SADC VISION, GOAL AND OBJECTIVES OF THE SADC HIV/AIDS STRATEGIC FRAMEWORK

Vision
SADC society with reduced HIV/AIDS

Overarching Goal

To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of Member States

Main Objectives

1. To reduce and prevent the incidence of HIV/ infection among the most vulnerable groups in SADC.
2. To mitigate the socio-economic impact of HIV/AIDS/AIDS.
3. To review, develop and harmonise policies and legislation aimed at prevention and control of HIV/AIDS/AIDS transmission.
4. To mobilise and co-ordinate resources for the HIV/AIDS multi-sectoral response in the SADC region.

OUTPUTS

1. Reduced incidence and prevalence of HIV/AIDS in SADC region;
2. Strategies for responding to the socio-economic impact of HIV/AIDS are developed and implemented in all SADC sectors;
3. Adequate regional and international resources mobilised and efficiently utilised in a coordinated manner for the region;
4. Harmonised and coordinated SADC policies on HIV/AIDS

7. Institutional Framework

The organization of SADC programmes in Sectors has the potential to mobilize the region to successfully tackle the HIV/AIDS pandemic - using coordinated and effective strategies as outlined in the SADC Health protocol, Article 10. This initiative for a multi-sectoral HIV/AIDS strategy brings together seven Sectors in the fourteen member states, creating 98 (7x14) sector national points where HIV/AIDS can be tackled through coordinated strategies. The potential to mobilize other institutions in the region using these 98 national sector points is enormous, and it is this organizational capacity that the multi-sectoral plan seeks to exploit.

The SADC framework also provides for mechanisms to coordinate the use of resources available from the budgets of member states and from contributions by the international donor community. It is planned that the multi-sectoral HIV/AIDS plan will tap into these resources to ensure that all available resources are deployed in an efficient and cost-effective way.

This plan will have a number of country-based and sector-specific projects for implementation under the guidance of the Health Sector Coordinating Unit in Pretoria to ensure that lessons can be shared, results disseminated, and efficiency promoted between various projects. The reporting mechanisms will primarily be output-based to ensure that the deployment of resources can be justified by the outputs each project produces.

Three technical officers will be deployed at the SADC Health Sector Coordinating Office in Pretoria to provide support to all the national Sector Coordinating Units working on this programme. The work of these officers will be to facilitate the documentation and dissemination of best practices from the various sectors, to follow-up on administrative and technical issues identified by sectors involved in the plan, and to prepare inter-sectoral progress reports – highlighting successes, constraints, and lessons learnt.

The three programme officers to support coordination will require strong management backgrounds, and should have the following experiences:-

1. For the economic sectors, should be someone with knowledge in the economic sectors.

2. For the social sectors, the person should be knowledgeable in social sector concerns and work.

3. The most senior person should have experience in inter-sectoral work, and be able to use the Employment and Labour Sector to synthesise the work of economic and social sectors.

The three programme officers would be contract posts (funded by project funds) and answerable to the Health Sector Coordinator.

8. SECTORAL STRATEGIES

8.1 Culture, Information and Sports Sector

Background

The history of Southern Africa has been characterized by movements of populations in response to labour demands by mining houses, especially in South Africa, during the colonial period. Although this demand for migrant labour has declined in recent decades, this movement of people in search of employment opportunities has continued into the post-colonial era, followed by substantial internal movements of people from rural to urban areas. In many of these countries, there is evidence that migration (both internal and inter-country) is on the decline, and permanent communities and settlements have taken root on mines and many other enterprises. The resulting culture and socio-economic formations in Southern Africa have had a significant impact on HIV/AIDS, and people in the region have much in common (be it clothes, food, family structures, education, health systems, entertainment, and other aspects of life).

Another important feature of the region is its common history in the struggle against colonialism and apartheid. Even the origin of SADC, as the Southern Africa Development Coordination Conference (SADCC), was to reduce the economic dependence of free states on the then Apartheid-ruled South Africa. A consequence of this struggle against colonialism in Southern Africa is war – which has persisted in some countries (principally Angola) with devastating consequences. Further instability in the Great Lakes Region has led to war in the Democratic Republic of Congo, affecting other member states in various ways. Over the last four decades, there has been either a war of liberation or violent conflict in some part of the region – causing great disruptions in people's lives. For HIV/AIDS, these wars and violent conflicts have created refugees and internally-displaced persons; and both population groups are prone to the spread of HIV/AIDS and other diseases due to high mobility, poor nutrition, and general vulnerability.

Anecdotal evidence suggests that there have been many changes in traditional practices (medical and social) and these (like polygamy and use of cutting instruments) have been associated with the spread of HIV/AIDS. This sector of Culture, Information and Sports tries to harness the socio-economic and cultural ties resulting from the above processes to support regional integration, and its work is expected to have a major impact on the region's response to HIV/AIDS.

The availability of appropriate media for the communication of information to populations in the region will greatly affect the success of this programme. While there are 266 newspapers per 1,000 population in high-income countries, the region has a low rate of 13. Similarly, there are only 146 radios per 1,000 population compared with a figure of 1,300 for high-income countries. Figures for TV sets per 1,000 people are 43 in the region and 664 for high-income countries. In the region, there are wide variations in the availability of communication media. Malawi, South Africa and Tanzania for instance have the highest ratios of radios per population, while Botswana and South Africa have the highest figures for newspapers. The availability of TV sets is quite low, except for South Africa, which has 125 TV sets per 1,000 people – all the other countries are below a figure of 100. Alternative communication media will need to be developed for the effective communication of HIV/AIDS strategies.

Sector mandate: To strengthen, promote and consolidate the long-standing historical, social, and cultural affinities and links among the people of Southern Africa.

Impact of HIV/AIDS: There are positive (to be enhanced) and negative (to be minimised) impacts of HIV/AIDS in relation to the following areas:

- Labour movement and trans-border trade increases vulnerability (historical)
- Youth yielding to peer pressure (sports)
- Size of labour force (artisans, musicians, artists, sports-persons, youth, media workers, etc.).

	Indicators	Assumptions/ Risks
Overall Goal To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS/AIDS is no longer a threat to public health and to the socio-economic development of the member countries.	- Annual trends in HIV/AIDS infections within SADC region. - Trends in cost of HIV/AIDS for each sector.	Assumed that the quality of available data will improve to accurately reflect the situation within the region.
Sector Objectives 1. To mobilize and empower relevant organisations working with Artists, Media, Entertainers and Sports-persons (AMES) in the fight against HIV/AIDS in the region. 2. To ensure a co-ordinated and systematic sharing of information on HIV/AIDS in the region.	- No. of organisations mobilised. - No. of actors, media workers, entertainers, and sports-persons mobilised. - Sharing mechanisms established and working.	Assumed that most are already sensitised from work done by health sector.
Outputs 1. AMES in at least two-thirds of member states mobilise and equipped with knowledge on HIV/AIDS 2. At least two-thirds of member states to link their data bases on those AMES active in HIV/AIDS/AIDS/AIDS activities.	- No. of AMES mobilised and empowered. - No. of AMES on data-bases in member states. - No. of AMES promoting HIV/AIDS through electronic, print, and other media.	Assumed that member states already have data-banks. Risk is that not all member states will be electronically linked.
Activities 1. Regional Orientation workshops; 2. National Orientation workshops; 3. SADC Day Commemorations; 4. Production and distribution of print materials; 5. Compilation of Database of AMES active in HIV/AIDS activitiesin the region.	**Inputs**	

AMES = Actors, Media, Entertainers, and Sportspersons

CULTURE, INFORMATION AND SPORTS : BUDGET

code	Activity	Inputs required	Measure	Total inputs	Unit cost (US$)	Subtotal	Total (US$)
CIS1.1	Regional orientation workshops	Participants	Numbers	78			
		Travel	Trips	50	900	45 000	
		DSA	Days	312	150	46 800	
		Venue hire	Days	2	600	1 200	
		Translators	Numbers	4	200	800	
		Interpreters	Numbers	4	200	800	
		Honorarium translators	Days	4	300	12 000	
		Honorarium interpreters	Days	4	300	12 000	
		Administration	Days	4	10 000	40 000	
		Communication	Numbers	1	10 000	10 000	
		Subtotal				***168 600***	***168 600***
	National orientation workshops	Participants	Numbers	280			
		Travel	Trips	250	100	25 000	
		DSA	Days	560	150	84 000	
		Venue hire	Days	14	200	2 800	
		Administration	Days	2	10 000	20 000	
		Materials	Numbers	14	500	7 000	
		Subtotal				***138 800***	***138 800***
CIS1.2	SADC Day Commemorations	AMES	Numbers	420			
		National music shows	Numbers	14	2 000	28 000	
		Regional sports tournaments	Numbers	14	5 000	70 000	
		Appearance fees	Numbers	42	5 000	210 000	
		Advertising	Numbers	14	5 000	70 000	
		Venue hire	Numbers	14	600	8 400	
		Equipment hire	Numbers	14	1 000	14 000	
		Security services	Days	2	1 000	2 000	
		Communication	Numbers	14	500	7 000	
		Subtotal				***409 400***	***409 400***
	Production & distribution of print materials	Message design workshop	Days	5	30 000	150 000	
		Designers	Days	5	2 000	10 000	
		Editor	Days	10	500	5 000	
		Translators	Numbers	10	300	3 000	
		Journalist	Numbers	4	300	1 200	
		Communication	Numbers	1	10 000	10 000	
		Subtotal				***179 200***	***179 200***
CIS1.3	Compilation of data-base	Interpreters	Numbers	4	300	1 200	
		Data collection	Days	10	100	1 000	
		Data coding	Days	5	50	250	
		Data entry	Days	5	50	250	
		Computer equipment	Numbers	1	100 000	100 000	
		Computer programme	Numbers	1	10 000	10 000	
		Subtotal				***404 600***	***404 600***
		TOTAL					**US $ 1 300 600**

EMPLOYMENT AND LABOUR SECTOR: BUDGET

OUTPUT	TARGET	ACTIVITY	TOTAL INPUT	UNIT COST	TOTAL COST
Increased Capacity of Government, Worker and Employer to Implement HIV/AIDS Code	2000 Institutions in SADC	Printing and Disseminating the SADC Code on HIV/AIDS and Employment	2000	US$20	US$40,000
	2000 Institutions in SADC	Preparation, printing and dissemination of explanatory leaflets on the background and implementation of the Code	2000	US$4	US$8,000
	50 Trainers from SADC Sectors	Workshop SADC Sector Coordinating Units (SCUs) to implement the provisions of the HIV/AIDS Code	150	US$900	US$135,000
	420 People (30 persons per Country)	National workshops for Government, Workers and Employers organisations on implementation of the Code in all Member States. Formation of National HIV/AIDS Tripartite and Bipartite Committees	840	US$300	US$252,000
	14 Member States	Implementation of National HIV/AIDS and Employment Projects	14	US$30,000	US$420,000
	14 Member States	Training Seminar on Monitoring, evaluation and impact analysis	14	US$30,000	US$420,000
	14 Member States	Develop national mechanisms to monitor the impact of HIV/AIDS on the labour market	14	US$30,000	US$420,000
OUTPUT	**TARGET**	**ACTIVITY**	**TOTAL INPUT**	**UNIT COST**	**TOTAL COST**
Audit of Member States on implementation of HIV/AIDS Code/Regional situation analysis on HIV/AIDS and Employment	10 Persons (Working Group)	♦ Workshop to establish audit teams within the Employment and Labour Sector. ♦ Develop a standard audit and reporting format on HIV/AIDS and Employment	20	US$900	US$18,000
	1 Center	Create a Database on HIV AIDS and Employment at the ELSCU in Lusaka, Zambia	2	US$7000	US$14,000
	14 Centers	Create Databases on HIV/AIDS and Employment in each Member State	14	US$5,000	US$70,000
	14 Member States	Survey and report at the end of each year on Best Practices on Implementation of the Code	294	US$1,800	US$529,200
	14 Member States	Preparation and Printing of the Annual regional analysis on HIV/AIDS and Employment for each year (3 Years)	2100	US$5	**US$10,500 TOTAL 2 569 600**

8.2 Employment and Labour Sector

Background
The HIV/AIDS epidemic has had a tremendous impact on the demand and supply of labour in the SADC Region and has affected the sector in several ways:

(a) Trends of employment figures and the impact of HIV/AIDS;

(b) Identification of any particular labour practice that persists and is considered an obstacle to the tackling of HIV/AIDS pandemic;

(c) Trends in labour productivity in the region and the impact of HIV/AIDS; and

(d) Costs of managing HIV/AIDS at the workplace (absenteeism, medical costs, funerals).

Regional integration in the context of the global economy is also influenced by the availability of labour, and SADC has a history of large-scale labour migration and a relatively free movement of people. One benefit has been that there are fairly common labour practices in the region, which should make it easier to share strategies – be it in the organization of labour or in the provision of services to workers. This is the context within which the HIV/AIDS Code is being approached, and a major strategy for the Employment and Labour Sector is the effective implementation of this Code in all member States.

Even before the advent of AIDS, the region had a relatively high proportion of children in the 10-14 age group active in the labour force (30% of the population in this age-group was part of the labour force in 1980 and has only dropped to 24% by 1998 – WBDR 2000). The proportion of women active in the labour force has over the last two decades remained at 44%. The major change in this region has been the growth in urbanisation – with the population living in urban areas having risen from 22% in 1980 to 37% in 1998. These changes have had major impacts on the way the HIV/AIDS problem has developed in the region.

Sector mandate: To co-ordinate all matters related to employment and labour in the region with a view to enhancing labour productivity for sustainable economic growth and development.

Impact of HIV/AIDS
Increased use of child labour due to loss of adults.
- High attrition and loss of labour force
- Reduced labour productivity.
- Increased costs to employer and State.
- Increased use of child labour due to loss of adults

8.3 Health Sector

BACKGROUND
The Health Sector has been providing leadership and technical guidance in the HIV/AIDS response in many Member States, but there is recognition other sectors need to increasingly take ownership for addressing the epidemic. In the past, the health sector has attempted to do too much in articulating the multi-sectoral response. Consequently, this sector will shift its focus and emphasis from implementing HIV/AIDS interventions that lie outside its comparative advantage to specific activities within the realm of its mandate. It will therefore concentrate on the following:-

(a) Developing and implementing improved clinical management standards and strategies (clinical care and nursing, treatment, drugs procurement and supply, laboratories support, etc.)

(b) Improving HIV/AIDS disease surveillance systems and disseminating epidemiological information to the other sectors;

(c) Providing health-related technical assistance to the other sectors as these plan, implement, and monitor their strategies aimed at addressing the epidemic.

(d) Catalyzing and creating opportunities for other sectors to become creative, innovative and take ownership for the HIV/AIDS response

Sector mandate: Attain an acceptable standard of health for all citizens by promoting, co-ordinating and supporting the individual and collective efforts of member states.

Impact of HIV/AIDS
- Over-burdened and overstretched health care systems leading to dilution of care
- Rising costs associated with provide health care, leading diverting resources from critical needs (national and household) to health care.
- Negative demographic trends – reduced life expectancy, increased morbidity and mortality, orphans
- Creation of new demands in training, services without corresponding resources
- Low morale among health workers due to burn out and helplessness
- Increasing health workers' attrition rates due to deaths.

OBJECTIVES	ACTIVITIES	OUTPUTS
1. To prevent HIV/AIDS transmission among the youth in SADC	1. Promote and support the establishment of youth friendly services as part of reproductive health services at district level	A 10% reduction in HIV/AIDS prevalence among the 15 –19 year age group, as measured by antenatal surveys
2. To improve the clinical management of HIV/AIDS, including management of opportunistic infections and MTCT, and access to affordable drugs	1. Review existing standards and protocols for treatment of opportunistic infections and for MTCT, and reach national and regional consensus on them	National standards and protocols on management of HIV/AIDS exist Regional consensus on standards and protocols exists.
	2. Support implementation of the standards and protocols at all appropriate level of health care	All levels of health care implement standards and protocols for management of HIV/AIDS
	3. Periodic review and information exchange on standards and protocols	Regular information exchange mechanisms and fora exist
	4. Harmonisation of drug registration procedures in region	Drug registration procedures in Region harmonised
	5. Adopt the best drug procurement practices	Optimum procurement practices adopted by sector
	6. Advocate for grant support for supplies, where the need exists	Grants available where needed
3. To improve care offered to HIV/AIDS affected through strategic partnerships	1. To establish strategic partnerships with key partners with competencies in providing care	Strategic partnerships for care of those affected by HIV/AIDS exist, with clear role definitions
	2. To support the delivery of quality home-based care programmes.	Home based care available to the community
	3. Establish standards for home based care	appropriate standards and supplies for home based care available

BUDGET

code	Activity	Inputs required	Measure	Total inputs	Unit cost (US$)	Subtotal	Total (US$)
HLT3.1	Establish national youth friendly rep health services	Consultants	Numbers	28	300	8 400	
		Travel	Trips	14	900	12 600	
		DSA	Days	28	150	4 200	
		Subtotal				***25 200***	***25 200***
	Develop guidelines and stds on youth friendly rep health services	Consultants	Numbers	10	300	30 000	
		Participants	Numbers	28			
		Travel	Trips	30	900	27 000	
		DSA	Days	420	150	63 000	
		Training materials	Numbers	1	10 000	10 000	
		Subtotal				***224 000***	***224 000***
	Orientation workshop on youth friendly rep health services	Participants	Numbers	28			
		Travel	Trips	28	900	25 200	
		DSA	Days	180	150	63 000	
		Stationery	Numbers	1	10 000	10 000	
		Translators	Numbers	10	200	2 000	
		Interpreters	Numbers	10	200	2 000	
		Honorarium for translators	Days	10	300	3 000	
		Honorarium interpreters	Days	10	300	3 000	
		Subtotal				***108 200***	***108 200***
HLT3.2	Review stds/mgt protocols for opportunistic infections and MTCT	Consultants	Numbers	12	300	3 600	
		Participants	Numbers	28			
		Travel	Trips	30	900	27 000	
		DSA	Days	180	150	27 000	
		Translators	Numbers	12	200	2 400	
		Interpreters	Numbers	12	200	2 400	
		Honorarium for translators	Days	10	300	3 000	
		Honorarium interpreters	Days	10	300	3 000	
		Administration	Days	5	2 000	10 000	
		Communication & postage	Numbers	1	10 000	10 000	
		Stationery	Numbers	1	10 000	10 000	
		Subtotal				***98 400***	***98 400***
	Harmonise national drug registration procedures	Participants	Numbers	28			
		Travel	Trips	28	900	27 000	
		DSA	Days	180	150	27 000	
		Facilitators	Numbers	12	300	3 600	
		Translators	Numbers	12	200	2 400	
		Interpreters	Numbers	12	200	2 400	
		Honorarium translators	Days	10	300	3 000	
		Honorarium interpreters	Days	10	300	3 000	
		Administration	Days	5	2 000	10 000	
		Communication & postage	Numbers	1	10 000	10 000	
		Stationery	Numbers	1	10 000	10 000	
		Subtotal				***98 400***	***98 400***
	Develop best drug procurement procedures	Participants	Numbers	14			
		Travel	Trips	14	900	12 600	
		DSA	Days	84	150	12 600	
		Stationery	Numbers	1	5 000	5 000	
		Administration	Days	3	2 000	6 000	
		Communication & postage	Numbers	1	5 000	5 000	
		Subtotal				***41 200***	***41 200***

HLT3.3	Develop stds/guidelines on quality home based care programmes	Participants	Numbers	14			
		Travel	Trips	14	900	12 600	
		DSA	Days	84	150	12 600	
		Communication & postage	Numbers	1	5 000	5 000	
		Stationery	Numbers	3	2 000	2 000	
		Communication & postage	Numbers	1	5 000	5 000	
		Subtotal				***41 200***	***41 200***
	Compilation of best practices on home based care	Consultants	Numbers	15	300	4 500	
		Participants	Numbers	28			
		Travel	Trips	30	900	27 000	
		DSA	Days	200	300	6 000	
		Stationery	Numbers	1	10 000	10 000	
		Subtotal				***47 500***	***47 500***

TOTAL **US$ 684 100**

8.4 Human Resources Development Sector (Education and Training)

BACKGROUND

All sectors have a common concern for the development and availability of human resources and how HIV/AIDS has affected the production, deployment, management and other issues related to the efficiency of labour in the region. As most HIV transmission in the region is due to heterosexual contact, many of the infected persons are THOSE who are sexually active. Unfortunately this is also the economically active age group. HIV infection is on the increase among the 15-29 age group. This means that the "window of hope" is immensely reduced and shrinking and that young people are contracting HIV at a very young age. The HIV/AIDS pandemic is making serious inroads into the education and training sector in the region, and some of the main issues are:-

- HIV/AIDS negatively affects the supply of skilled personnel providing educational services and reduces the efficiency in the sector by raising costs of service delivery (e.g. payment for sick leave versus payment for actual work undertaken, increased output regarding teacher training to fill vacant posts, etc.). The sector is experiencing significant losses in teacher numbers due to HIV/AIDS. Many teachers are themselves, like other families, taking on the orphans of those who have died of AIDS, and increased time is spent going to funerals, and caring for the sick. This is seriously undermining member States' efforts to increase the pool of trained teachers in a bid to improve both the quality and quantity of education.

- Alarming is the growing numbers of orphans as a result of HIV/AIDS. Many of these risk the danger of not attending or completing school. This has implications on future generations and the development of the region as a whole.

Children who have lost one or both parents, 1997-98

Country	Number	Per 1 000 people
Botswana	25 000	13
Democratic Republic of Congo	310 000	6
Lesotho	8 500	4
Mozambique	150 000	9
Namibia	73 000	36
South Africa	180 000	4
Tanzania	520 000	16
Zambia	360 000	36
Zimbabwe	360 000	30

Source: ***Newsweek*** *January 17, 2000*

- The number of children who have lost both parents is particularly significant for those countries with small populations (Botswana and Namibia) and those countries with high HIV/AIDS prevalence rates (Zambia and Zimbabwe). This has a number of

implications in terms of schooling, entry into the labour market, and quality of life for these children (many of whom are likely to join the growing number of children living under difficult circumstances created by economic and political hardships).

- Due to illness and death in the family, many children of school-going age have to carry out adult responsibilities, which include taking care of their sick parents and/or taking care of their siblings. Such children also lack financial support. This may affect their attendance and performance in school.

- Both students and teachers encounter problems of stigmatisation and discrimination due to lack of knowledge on how to deal with people living with HIV/AIDS. The school children also suffer psychological effects due to peer pressure and exposure to AIDS related death. This creates demand for teachers to provide counseling services to children to mitigate poor performance.

It is thus imperative that concerted effort is made to reduce the spread of HIV/AIDS and mitigate its impact on this and other sectors.

These strategies will give the sector additional tools for addressing the wider issues of curriculum reform in formal and vocational training, and offering advice to any sector involved in programmes that contribute to Human Resources Development. The research will also allow the sector to develop appropriate and sensitive indicators on the relationship between the AIDS pandemic and developments within the sector and its contribution to overall development indicators.

Sector mandate: Provide skills, knowledge and attitudes that build the necessary human capital vital for economic and social development.

Impact of HIV/AIDS

- Increased numbers of orphans needing education.
- Children leaving schools to undertake adult responsibilities due to loss of parents.
- Stigmatization and discrimination in schools.
- Need for better integration of HIV/AIDS education and life skills in the school curriculum.

	Indicators	**Assumptions/Risks**
Overall Goal To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of the member States	- Annual trends in HIV/AIDS infections within the SADC region - Trends in cost of HIV/AIDS for each sector	Assumed that the quality of available data will improve to accurately reflect the real situation within the region
Objectives 1. To create a supporting environment for the fight against HIV/AIDS within the education and training sector 2. To impart knowledge on HIV/AIDS and skills which are life-enhancing to both learners and educators 3. To co-ordinate, at regional level, research in order to inform policy and decision-making in the fight against HIV/AIDS	- Trends in the HIV/AIDS infections among learners and educators - Trends in attitude and behaviour change within the SADC Region - Regional databank on HIV/AIDS in the sector	- Religious and traditional leadership are supportive - Support and technical inputs from the health and other sectors is available - Co-operation from all institutions/organisations that are involved in research is forthcoming
Outputs 1. Revised education/training policies 2. Revised curricula incorporating HIV/AIDS 3. Regional database on HIV/AIDS in the education and training sector in place, and mechanism for exchange of such data and information established and in operation	- Number of revised policies in the region - Number of member States with curricula integrating HIV/AIDS in the education system - Regional database on HIV/AIDS in education and training	- Resources are available and member are willing to commit them to the strategy - Differing priorities of member States - resistance to policy change - resistance to curriculum change - confidentiality of information on HIV/AIDS

Activities	Inputs	
Policy Development		
1. Review existing education and training policies regarding HIV/AIDS 2. Develop and disseminate appropriate regional policy guidelines 3. Facilitate the development and implementation of national policies to address HIV/AIDS 4. Monitor the development and implementation of national policies	1.1 Recruit a programme co-ordinator (PC) 1.2 Organise a sectoral mobilisation workshop 2.1 Following Workshop, the TA to develop regional policy guidelines 2.2 Convene another workshop to agree on the regional policy guidelines 3.1 Finalise and disseminate regional policy guidelines to member States 3.2 Undertake training of policy developers –1 regional training workshop 4.1 The PC will develop a monitoring tool and undertake periodic monitoring visits; day-to-day monitoring to be undertaken by existing national structures. 4.2 Impact assessment of new policies may be necessary after a reasonable length of time	
Curriculum development		
5. Set up a curriculum development committee to develop a regional curriculum framework 6. Conduct national curriculum reviews to ensure adherence to regional standards 7. Monitoring and evaluation of programmes	5.1 Convene a meeting of curriculum experts to review existing situation and develop guidelines or a regional curriculum framework, along with teaching/learning materials standards. 6.1 National curricula centres to undertake curricula reviews using regional guidelines to incorporate HIV/AIDS education. 6.2 Implement curricula – national structures. 7.1 Regular monitoring to be undertaken by national structures; a regional feedback meeting to take place to evaluate impact and recommend improvements after 2 years of implementation	
Co-ordination of Regional Research		
8. Undertake a study to establish the current position with regard to HIV/AIDS in the sector and to determine research needs 9. Establish a regional database on the impact of HI/AIDS in	8.1 Engage a team of 1 regional 14 national consultants to undertake study. 9.1 Equipment and short-term consultancy to establish database and develop a tool for maintenance and regular updating of database. 12.1 Provide funds for research based on identified research needs	

the sector 10. Develop a regional mechanism for research 11. Undertake impact assessment of previous research activities 12. Undertake joint research activities		

HRD4.1	Review education & training policies on HIV/AIDS	Participants	Numbers	33			
		Travel	Trips	31	900	27 900	
		DSA	Days	124	150	18 600	
		Stationery	Numbers	1	5 000	5 000	
		Administration	Days	5	2 000	10 000	
		Communication & postage	Numbers	1	5 000	5 000	
		Subtotal				***66 500***	***66 500***
	Develop policy guidelines	Consultants	Numbers	10	300	3 000	
		Participants	Numbers	18			
		Travel	Trips	16	900	14 400	
		DSA	Days	72	150	10 800	
		Communication & postage	Numbers	1	5 000	5 000	
		Stationery	Numbers	1	2 000	2 000	
		Subtotal				***35 200***	***35 200***
HRD4.2	Regional curriculum development	Participants	Numbers	36			
		Travel	Trips	36	900	324 000	
		DSA	Days	180	150	27 000	
		Stationery	Numbers	2	2 000	4 000	
		Administration	Days	2	5 000	10 000	
		Communication & postage	Numbers	2	5 000	10 000	
		Printers	Numbers	2	20 000	40 000	
		Translators	Numbers	10	300	3 000	
		Subtotal				***418 000***	***418 000***
HRD4.3	Situation analysis of HIV/AIDS in the HRD sector	Researchers	Numbers	90	300	27 000	
		Travel	Trips	28	900	25 200	
		DSA	Days	90	150	6 750	
		Subtotal				***32 850***	***32 850***
	Establish regional data base on impact of HIV/AIDS on the sector	Computer equipment	Numbers	2	7 000	14 000	
		Data entry clerks	Numbers	15	300	4 500	
		Subtotal				***18 500***	***18 500***
	Monitoring and evaluation	Programme coordinator	Numbers	1			
		Travel	Trips	28	900	25 200	
		DSA	Days	90	150	13 500	
		Subtotal				***38 700***	***38 700***
		TOTAL					**US$ 609 750**

8.5 Mining Sector

BACKGROUND

Mining has been described as the backbone of economies in the region, usually competing with agriculture as the major earner of foreign exchange and provider of employment opportunities. Towards the end of the 1990s, it was estimated that mining on average contributed to 60% of foreign exchange earnings, 10% of GDP and 5% to formal employment in the region. Declining investments in the sector, combined with unstable world prices for most minerals, has contributed to a fall in the importance of the sector relative to service sectors (tourism and finance for instance). Nevertheless, mining remains an important sector for socio-economic development in the region.

The region is a major producer of such minerals as asbestos, cobalt, copper, chrome, diamonds, gold, and others needed by industrial process.

Available evidence suggests that this sector has been hard-hit by HIV/AIDS because most miners work away from home as migrants and are therefore likely to have multiple sexual partners. With the movement of labour between mines and rural homes, there are many opportunities to spread diseases between rural and urban areas, and HIV transmission has followed this movement of labour. Most information on these issues has come from work carried out by the health sector and its NGO partners; but there has been few mine-led initiatives to tackle the HIV/AIDS pandemic. It is for this reason that the immediate plan for this sector is to establish the size of the problem, to provide support to the infected/affected, and to draw up long-term plans.

Regional averages of selected mineral production figures, 1997

Asbestos (tons)	236 492
Coal (tons)	223 165 372
Cobalt (tons)	5 305
Chromite (tons)	6 449 191
Copper (tons)	523 019
Diamonds (carats)	34 482 004
Gold (kgs)	519 772
Lead (tons)	83 619
Nickel (tons)	65 121
Zinc (tons)	143 878

Source: SADC Progress Report, 1999

The Mining sector has organised its work under six sub-committees, and some of them could make significant contribution to the tackling of HIV/AIDS. In particular, sub-committees dealing with marketing, information, and human resources development might find it relatively easy to link HIV/AIDS management strategies to sector strategies once this multi-sectoral HIV/AIDS management plan is implemented.

Sector mandate: Facilitate the transformation of mineral resources into wealth at

regional level.

Impact of HIV/AIDS
Reduced productivity (through absenteeism, sickness, deaths, etc.).
Increased direct and indirect costs

Strategies for 2002

- To establish the extent of HIV/AIDS in the SADC mining sector.
- To minimise the spread of HIV/AIDS in mining sector.
- To provide adequate care for the already infected and affected in mining sector.

The implementation of these strategies will assist the better definition of the sectors work by:-

(a) Providing documentation on the status of HIV/AIDS on mines;

(b) Giving an indication of the link between mine productivity and HIV/AIDS;

(c) Making it possible to assess the economic impact of HIV/AIDS on mines (be it on labour, financial returns, social services, etc.).

(d) Providing arguments for a better understanding of how mine investments in HIV/AIDS programmes impact on the economy and national tax regimes.

PROGRAMME FRAMEWORK

PROGRAMME STRUCTURE	VERIFIABLE INDICATORS	SOURCES OF VERIFICATION	ASSUMPTIONS AND RISKS

Overall Goal To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that it is no longer a threat to public health and to the socio-economic development of member states	Annual trends in HIV/AIDS infections within SADC region; Trends in cost of HIV/AIDS in each sector	Ministries of Health Reports Reports from international Organisations (WHO, UNAIDS etc) Sectoral reports on impact of HIV/AIDS	The quality of available data will improve to accurately reflect the situation within the region
Sector Objectives 1. To establish the extent of HIV/AIDS in the SADC mining sector 2. To minimise the spread of HIV/AIDS in mining sector 3. To facilitate provision of adequate services for the already infected and affected in the mining sector	Status of HIV/AIDS in mining sector established Spread of HIV/AIDS in mining communities minimised Adequate care for infected and affected persons provided	Number of HIV/AIDS status reports on the mines Reports on trends in HIV/AIDS infection rates on the mines Number of infected and affected persons receiving care on the mines	Mining houses fully co-operate
Outputs 1. HIV/AIDS situational analyses on infected and affected numbers completed 2. Mining communities reached with HIV/AIDS awareness programmes 3. Mine facilities providing effective care to the infected and affected increased	Number of national and regional situation analyses reports Number of mining communities reached Number of mine health facilities participating in the programme	Reports Reports Mine Reports	Data already exists and most work will be in analysis Resources available Mining houses fully co-operate

Activities			
1. Conduct situational analyses 2. Establish mechanisms to collect and analyse existing data and collect where none exists 3. Identify trends and design interventions for implementation 4. Design and implement awareness programmes for mine managers, employees and mining communities 5. Train AIDS counselors and Educators 6. Facilitate the increase of condom availability on mines, including Small Scale Mines 7. Monitor and support the HIV/AIDS intervention activities 8. Facilitate establishment of HIV/AIDS Kiosks in mining areas 9. Promote intensification of treatment of STDs on mines 10. Facilitate support of existing facilities and identify new ones where HIV/AIDS related illnesses can be treated 11. Provide 2 scholarships per year for training in HIV/AIDS data collection and analysis 12. Develop Follow-up strategies			Assumed that Mining Houses are willing and able to contribute resources to the programme Small scale Miners willing to participate in the Programme

MNG5.1	Situation analysis on HIV/AIDS in the mining sector	Researchers	Number	360	300	108 000	
		Travel	Trips	12	900	10 800	
		DSA	Days	360	150	54 000	
		Subtotal				172 800	
	Orientation seminars	Consultants	Numbers	60	300	18 000	
		Participants	Numbers	336			
		Travel	Trips	336	900	302 400	
		DSA	Days	1 680	150	252 000	
		Administration	Days	60	2 000	120 000	
		Communication & Postage	Numbers	12	2 000	24 000	
		Training of AIDS Counsellors and Educators.	numbers			160 000	
		Subtotal				***876 600***	***876 600***
MNG5.2	HIV/AIDS awareness campaign	Consultants	Numbers	60	300	18 000	
		Participants	Numbers	336			
		Travel	Trips	336	450	151 200	
		DSA	Days	1 680	150	252 000	
		IEC materials	Numbers	12	5 000	60 000	
		Journalists	Numbers	60	300	18 000	
		Subtotal				***499 200***	***499 200***
MNG5.3	Establish HIV/AIDS kiosks	Building materials	Numbers	240	500	120 000	
		Furniture	Number	240	400	96 000	
		Supplies	Number	5 760	500	2 880 000	
		Counsellors	Months	432	200	86 400	
		Subtotal				***3 182 400***	***3 182 400***
	Procure and distribute condoms	Condoms	Numbers	24 000 000	0	1 200 000	
		Postage & courier services	Numbers	1	120 000	120 000	
		Subtotal				***1 320 000***	***1 320 000***
	Management of STIs	Drugs	Numbers	60	40 000	2 400 000	
		Laboratory equipment	Numbers	60	50 000	3 000 000	
		Laboratory supplies	Numbers	1 440	10 000	14 400 000	
		Subtotal				***19 800 000***	***19 800 000***
	Establishment of HIV/AIDS scholarship	Funds	Numbers	4	20 000	80 000	
		Subtotal				***80 000***	***80 000***
	Follow-up meetings	Participants	Number	56			
		Travel	Trips	56	900	50 400	
		DSA	Days	280	150	42 000	
		Stationery	Numbers	2	5 000	10 000	
		Subtotal				**102 400**	
		TOTAL					**US$ 25 758 200**

8.6 Tourism Sector

BACKGROUD

Tourism is a major earner of foreign exchange and provides both direct and indirect employment opportunities. The region has set aside nearly 10% of its land as protected areas – where tourist resorts are found in the form of national parks. In the latest available figures (WBDR 2000), each tourist brought US$384 to the region, although there are wide variations between countries with low volume and those with high volumes of tourists. Of the 10.6 million tourists who came to the region, half went to South Africa and 20% to Zimbabwe. Thus, nearly three-quarters of all tourists to the region have South Africa and Zimbabwe as the destination.

Regional averages of selected tourism indicators

	1997
National protected areas, as % of total land	9
Value added, % of GDP (Services)	41
Arrivals (millions)	10.6
Receipts, $ billions	4.1
Receipts per tourist (US$)	384

Source: World Bank Development Report 2000

With a population of 190 million, the region attracts a tourist for every 19 people living in the region. Thus, there is potential for extensive social interactions between tourists and visitors in the exchange of services, and community and eco-tourism are on the increase. It is in this context that those agencies involved in the marketing and coordination of tourism have become active in the development and implementation of this strategic plan.

A major argument advanced by those working in this sector has been that tourists (regional and international) are concerned over the quality of health services in member states, especially over the quality of blood and blood-related products. An inspection of recent figures on modes of HIV transmission in the region shows that over 86% of all cases are due to heterosexual behaviour, and only 4% is due to blood products. Most cases of contaminated blood were reported from Angola and Mozambique, where large parts of the country have been inaccessible due to war, and therefore should be insignificant in a regional context. The other significant cause of transmission has been mother-to-child, with a regional average of 7%. Homosexual and intravenous drug-use make very small contributions to HIV transmission in SADC member states.

The second concern by the Tourism Sector is over the transmission of HIV between tourists and the local population. Given the high incidence of heterosexual transmission and the relative ease of sexual contacts between local and tourist populations, this issue is particularly important. In the proposed sector strategy for 2002, this problem will be addressed by promoting improved preventive measures in community-based tourism.

In line with evidence from available statistics, the message to tourists and the local population will be 'avoid unprotected sexual encounters – and preferably avoid sex altogether'. For this reason, the strategy will involve regional tourism bodies (SATA, RETOSA, etc.) in mounting campaigns aimed at: -

(a) Educating tourists on the availability of health facilities that are of acceptable standards in the region.

(b) Equipping tour-operating companies with skills and information to promote safe sex among tourists and local populations.

(c) Promoting safe sex awareness among all workers in this sector.

Sector mandate: Promote sound and efficient development of the sector to increase the welfare of the SADC population; and remove all possible obstacles to the development of tourism.

Impact of HIV/AIDS

- Fear among tourists that health facilities are inadequate.
- Interaction between tourists and local population can lead to transmission (both ways).

	Objectively Verifiable Indicators	**Assumptions/Risks**
OVERALL OBJECTIVES To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that it is no longer a threat to public health and to the socioeconomic development of the member countries	- Annual trends in HIV/AIDS infections within the SADC region. - Trends in cost of HIV/AIDS for each sector.	Assumed that the quality of available data will improve to accurately reflect the situation within the region.
OBJECTIVES 1. Formulate HIV/AIDS policy for the tourism sector in the SADC region	- Number of tourism related programmes with integrated HIV/AIDS programmes	1.1 Lack of political and instability may hamper implementation of policies. 1.2 Governments give incentives for industry to invest in HIV/AIDS programmes 1.3 Divergence between nation and regional priorities and different context and national sector priorities in the SADC region may hamper the formulation of common policies
2. Reassure tourists on the availability of high quality health care in the SADC region.	- Trends of HIV/AIDS infections within the sector. - Number of information material produced	2.1 Lack of quality health services in some member states could hamper the production of a comprehensive directory 2.2 Medium of communication may delay the production of promotional materials
3. Support community based tourism in the SADC region through HIV/AIDS prevention activities	- Cost saving trends from HIV/AIDS prevention - Number and types of prevention activities.	3.1 Red tape could delay the appointment of team conducting the needs assessment

OUTPUTS 1. Policy on tourism and HIV/AIDS developed and implemented. 2. Regional directory on health services available in the SADC region and Promotional materials produced. 3. Needs assessment conducted.	Number of revised policies in the region.	
ACTIVITIES 1. Policy on tourism and HIV/AIDS developed and implemented. 1.1 Request member states to submit information on HIV/AIDS concerning the tourism sector and how they are tackling the problems, prior to the study 1.2 Recruit the services of a consultant to prepare a policy paper on HIV/AIDS for the tourism sector 1.3 Organise a workshop to discuss the paper 1.4 TCU to follow-up and ensure the implementation of the strategy paper 2. Regional directory on health services available in the SADC region and Promotional materials produced. 2.1 Production of a regional directory on health care especially on HIV/AIDS met for tourists travelling in the SADC region and other promotional materials 2.2 Distribution of promotional materials through travel agents and tour operators. 2.3 Mobilize regional and national tourism organizations and bodies (private and public) for efficient coordination between them and ensure regular consultation on the HIV/AIDS issues.	The services of a consultant would be required to prepare the policy paper on HIV/AIDS on Tourism. Directory produced (Number) Number of promotional materials distributed	Inputs to be received from member states Framework to implement these policies Proper coordination mechanism between these organisation Quality of health information on HIV/AIDS therein Originality of message and means of disseminating information

2.4 Involvement of RETOSA which is the promotion arm of the SADC tourism sector in the fight against HIV/AIDS 2.5 Mobilize regional and national tourism organizations and bodies.		
3. Needs assessment conducted. 3.1 Conduct a region-wide needs assessment in all member states and conduct a KABP (Knowledge, Attitude, Belief and Practice) survey to obtain information which can be used for orientation of future IEC(Information, Education and Communication) strategies. 3.2 Identify ways and means to assist and support the local resident population 3.3 Work in close collaboration with RETOSA in the promotion community based tourism in the SADC region 3.4 Identify institutions and other bodies, including NGO which are actively working on the field for disseminating information appropriately 3.5 Develop training courses for trainers or NGO's or other active recognised groups working on the fields to assist the local population 3.6 Formulate any sensitisation programme apart from formal training to support the local population	The services of a consultant would be required to conduct the need assessment. Number of training courses organised Number of sensitization programme conducted	Cluster of regions may hamper assessment Standards norms and registered community Training budgets and identification of trainers

TSM6.1	Policy review	Consultants	Numbers	45	300	13 500	
		Participants	Numbers	50			
		Travel	Trips	65	900	58 500	
		DSA	Days	350	150	52 500	
		Administration	Days	5	10 000	50 000	
		Communication & postage	Numbers	1	10 000	10 000	
		Subtotal				***184 500***	***184 500***
TSM6.2	Publish directory of available health care services in the region	Consultants	Numbers	45	300	13 500	
		Printers	Numbers	2	20 000	40 000	
		Postage	Numbers	2 000	15	30 000	
		Subtotal				***83 500***	***83 500***
	Production of promotional materials	Communication consultants	Numbers	10	300	3 000	
		Printers	Numbers	2	20 000	40 000	
		Subtotal				***43 000***	***43 000***
TSM6.3	Conduct a KAPB survey	Researchers	Numbers	45	300	13 500	
		Travel	Trips	12	900	10 800	
		DSA	Days	270	150	40 500	
		Printers	Numbers	2	20 000	40 000	
		Subtotal				***104 800***	***104 800***
	Orientation workshop	Participants	Numbers	28			
		Travel	Trips	28	900	25 200	
		DSA	Days	166	150	24 900	
		Administration	Days	5	2 000	10 000	
		Communication & postage	Numbers	1	5 000	5 000	
		Honorarium translators	Days	10	300	3 000	
		Honorarium interpreters	Days	10	300	3 000	
		Subtotal				***71 100***	***71 100***
		TOTAL				***US$***	***486 900***

8.7 Transport and Communication Sector

BACKGROUND

With a region as vast as the SADC and given the historical migration of populations in search of economic opportunities, transport is an important sector for socio-economic development. The importance of railways is for instance even captured in popular music describing the role of trains in bringing people together. With several members of SADC being land-locked, there is a particular importance attached to roads, rail and air travel in the region. For those countries with a coast-line, transport has had the added impact of maritime trade (with sailors from all over the world having used these ports over the last five hundred years). Disease and trade have come with travel, and this sector is particularly important in promoting trans-national awareness on measures aimed at curbing the spread of HIV/AIDS. This sector also deals with telecommunications, an important avenue for disseminating information in a world becoming increasingly integrated by information technology (radio, TV, computers, satellites, newspapers, etc). The availability of telephone lines in the region is less than one-twentieth of that available in high income countries, while cell phones, Personal Computers, and internet hosts are even lower. This low level of technological development (except for South Africa) poses a major challenge for those designing communication strategies in this programme.

Regional averages of selected transport and communication indicators

	1997
Paved roads (% of total)	23
Goods transported by rail (tone-km million)	830 771
Air passengers (million)	9.7
Main telephone lines per 1,000 people	25
Mobile telephones per 1,000 people	4
Personal Computers per 1,000 people	11
Internet hosts per 10,000 people	5

Source: World Bank Development Report 2000

Sector mandate: The SADC Protocol on Transport, Communications and Meteorology entered into force on 6 July 1998. The mandate of the Sector has been defined as "To establish transport, Communications and Meteorology systems which provide efficient, cost-effective and fully integrated infrastructure and operations, which best meet the needs of customers and promote economic and social development while being environmentally and economically sustainable".

Impact of HIV/AIDS

- There are no comprehensive reports on impact, but labour productivity has been reduced in railways, maritime, civil aviation, road transport, postal, telecommunications, and meteorology services.
- High rate of attrition among young and skilled labour.
- Increasing direct and indirect Cost

LOGICAL FRAMEWORK MATRIX FOR SATCC

NARRATIVE SUMMARY	ACTIVITIES	**RESPONSI-BILITY**	**RESOURCES / INPUTS**	**TIME-FRAMES**
Programme Goal: To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio –economic development of member countries	As contained in Sectoral Plans	SADC Health Sector Coordinating Unit (HSCU)	HSCU, Culture, Information & Sports, HRD, Mining, Tourism, SATCC USD 30 million	2000-2001
Programme Purpose/Objective: 1. Sectoral Programme to contribute towards the decrease of the number of HIV/AIDS infected and affected individuals and families in the SADC Region.	SATCC-TU	SATCC-TU	SATCC-TU, Consultants, All Member States	2000-2001
OUTPUTS				
1.1 Funds available	1.1.1 SATCC to source funds through HSCU	HSCU, SATCC	HSCU, SATCC, All Member States USD 3 million	2000 - 2001
1.2 Situational Assessment carried out				
1.3 Sectoral Orientation Workshop conducted	1.2.1 Prepare Terms of Reference for the Study	SATCC-TU, HSCU		End of April 2000
1.4 Coordination and Implementation Machinery established and functional	1.2.2 Search for Potential Consultants to undertake the Study	"		Early May 2000
	1.2.3 Evaluation of Tenders		SATCC-TU HSCU, Subsectors	"
1.4.1 Recruitment of Programme Personnel	1.2.4 Award contract to a successful bidder (Consultant)	"	"	Study Report
1.4.2 Training of Trainers	1.2.5 Consultants to undertake the following:	Consultants, SATCC-TU	"	
1.5 Community and Work-based programmes carried out	1.2.5.1 Design and prepare methodology for data collection and information	"	Consultants, HSCU,	
1 6 Information sharing and Exchange of	1.2.5.2 Collection of data and	"		

Experiences 1.7 Monitoring and Evaluation	information 1.2.5.3 Identify high-risk areas 1.2.5.4 Identify all the stakeholders i.e. institutions and individuals 1.2.5.5 Analyse data and information	 " " "	SATCC-TU, other sectors	
	1.2.5.6 Prepare study report, with recommendations on actions and appropriate coordination machinery and elaboration of a Sectoral Policy Document 1.2.5.7 Present the report to a Sectoral Workshop 1.3.1 Prepare documentation for the Workshop 1.3.2 Decide on dates and duration of Workshop 1.3.3 Send invitations for the Workshop, together with relevant documentation 1.3.4 Convene workshop, reviewing Study Report etc 1.3.5 Provide Secretarial Services to the workshop 1.3.6 Preparation of outcomes and recommendations of the Workshop	" " " SATCC-TU, Consultants SATCC-TU " " Consultants		
	1.3.9 Agreement on a Sectoral Plan 1.4.1.1 Draft Job Descriptions for Programme Coordinator and Administrative Assistant 1.4.1.2 Advertisement of positions. 1.4.1.3 Recruitment exercise 1.4.1.4 Mobilisation of personnel 1.4 2.1 Identify potential trainers, peer educators and counsellors 1.4.2.2 Prepare trailer-made TOT courses to create a cadre of professional HIV/AIDS Trainers	Workshop Participants SATCC-TU, HSCU " " " Consultant SATCC-TU Consultant		

	1.4.2.3 Mount TOT courses 1.4.2.4 Evaluation of TOT courses 1.4.2.5 Use of Trainers in designing and developing tailor-made courses and training materials/media for communities and work places to create awareness and instil responsibility at public and personal levels.	 " Consultant, SATCC-TU "		
	1.4.2.6 Review and evaluate reach-out programmes to assess impact levels. 1.4.2.7 Establish Programme (Project) Steering Committee to oversee implementation. 1.5.1 Direct interventions or teach-ins at various levels involving all subsectors (i.e. railways, maritime, civil aviation, road transport traffic, telecoms, postal and meteorology) and SATCC-TU itself. 1.5.2 Addressing hig-risk areas, such as transit border areas, ports, etc. Publicity and campaign activities 1.5.3 Support to national focus groups and SATCC-TU on the implementation of HIV/AIDS Programme. 1.6.1 Ongoing exercise but could involve consultative fora/meetings 1.6.2 Regular interaction with HSCU 1.6.3 Consultations among subsectors to ensure harmonised approaches and efforts, avoiding	Consultant, SATCC-TU SATCC-TU, Workshop, Consultant, HSCU Consultants, Trainers, SATCC-TU Trainers, Consultants Trainers, Consultants SATCC-TU, Consultant SATCC-TU, Consultant "		
	1.6.4 Liaison with other Sectors 1.7.1 Monitoring and evaluation of implementation and assessment of impact levels of programme	SATCC-TU, Consultant Consultant, SATCC-TU		

Selected references

IPA (1999) "A bulk purchasing study on the procurement of anti-TB drugs among 11 SADC countries" report to SADC Health Sector Coordination Office, Pretoria.

RETOSA (1999) "Tourism statistics and general information for Southern Africa: the essence of Africa – beyond your wildest dreams", report by the Regional Tourism Organisation for Southern Africa (RETOSA), Midrand, South Africa.

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_____ (1999) *Finance and Investment*, Lusaka, Zambia, 10-12 February 1999

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_____ (1999) *Mining*, Lusaka, Zambia, 10-12 February 1999

_____ (1999) *Tourism*, Lusaka, Zambia, 10-12 February 1999

_____ (1999) *Transport, Communications, and Meteorology*, Lusaka, Zambia, 10-12 February 1999

UNAIDS (1999) "Working in partnership: intensifying national and international responses to AIDS in Africa: A framework for action", Draft discussion document.

World Bank (2000) *Entering the 21st Century: World Development Report 1999/2000,* Oxford University Press, Washington.

	activities, using short-term consulting services and Programme Coordinator.			

ACTIVITY	COST ESTIMATES IN USD	TIME FRAME
1. Situational Assessment	200 000	May - June 2000
2. Sectoral Orientation Workshop	300 000	June - July 2000
3. Implementation		
3.1 Establishment and functioning of a Coordination machinery	950 000	September 2000 and on going
3.2 TOT - Design & Development of campaign and training materials	300 000	September-October 2000
3.3 Programmes/ activities	850 000	November 2000-2001
3.4 Information Sharing and exchange of experiences within and among sectors	150 000	Regular feature in the programme implementation, using visits, electronic mail etc.
3.5 Monitoring & Evaluation - Consultation - Steering Committee	250 000	Mid-tern and end of programme
TOTAL	**3 000 000**	**2 YEARS**

Annexure 1. Article 10, SADC Health Protocol (1999)
HIV/AIDS and Sexually Transmitted Diseases

1. In order to deal effectively with the HIV/AIDS/STDs epidemic in the Region and the interaction of HIV/AIDS/STDs with other diseases, State Parties shall:

   (a) harmonise policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of STDs and HIV infection;

   (b) develop approaches for the prevention and management of HIV/AIDS/STDs to be implemented in a coherent, comparable, harmonised and standardised manner;

   (c) develop regional policies and plans that recognise the inter-sectoral impact of HIV/AIDS/STDs and the need for an inter-sectoral approach to these diseases; and

   (d) co-operate in the areas of:-

      (i) standardisation of HIV/AIDS/STDs surveillance systems in order to facilitate collation of information which has a regional impact;

      (ii) regional advocacy efforts to increase commitment to the expanded response to HIV/AIDS/STDs; and

      (iii) sharing of information.

2. State Parties shall endeavour to provide high-risk and transborder populations with preventive and basic curative services for HIV/AIDS/STDs.