

AIDSPOLICY AFRICA

Issues for HIV/AIDS policy-makers

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The World Bank (WB) has formally approved US\$60 million as an International Development Association (IDA) grant to support programmes in Burkina Faso, Ghana and Mozambique aimed at scaling up treatment and care for People Living with HIV/AIDS (PLWHA). The deal, in partnership with Economic Commission for Africa (ECA) and the World Health Organization (WHO), will boost the Treatment Acceleration Programme, or TAP, in these countries.

TAP aims at assessing the scalability of decentralized, cost-effective equitable treatment in three countries which have small-scale treatment activities, supported by non-government organisations (NGOs) and/or by a public/civil partnership.

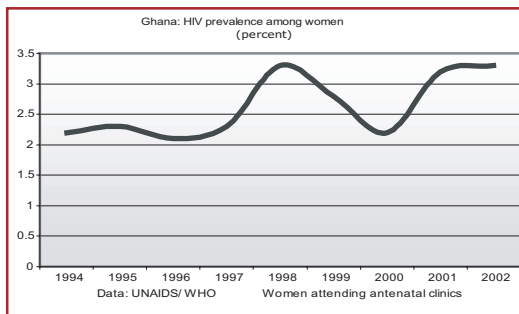
It has three components:

- country specific HIV/AIDS and mother to child transmission (MTCT)-plus treatment activities;
- cross-country learning via intensive monitoring and evaluation and the fostering of a community of practice; and
- influencing next generation programmes in decentralizing access to complex medication through public/private partnerships.

Costs of scale-up

TAP is designed to be a patient-oriented initiative that addresses the needs of PLWHA and their families. In broad terms, TAP has three dimensions with related costs.

The first dimension of the project (US\$38.82 million) will finance direct costs of scaling up ongoing care and treatment programmes with Burkina Faso, Ghana, and Mozambique receiving US\$13.48 million, \$9.86 million, and \$15.48 million respectively.



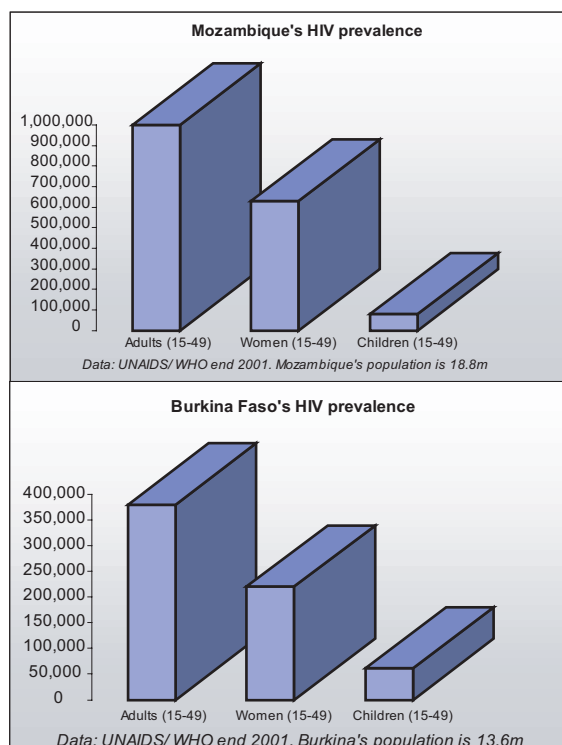
The second dimension (\$16.51 million) will strengthen institutional capacities for HIV/AIDS care and treatment allocated as follows: Burkina Faso, \$4.63 million, Ghana \$5.72 million, and Mozambique \$6.16 million.

These funds will help countries refine and adapt national treatment policy using WHO recommended standards, strengthen health facility response

capacity, train required staff and strengthen the drugs supply chain as well as institute effective monitoring and evaluation systems and promote information exchange on lessons learnt.

The third dimension (\$6 million) will be administered jointly by the WHO and ECA for technical support to the TAP countries and for regional learning facilitation. This will include assistance to countries in refining treatment guidelines and protocols, in developing curricula and pedagogical methods for training health and related staff, in establishing systems for managing patient compliance, and strengthening monitoring and evaluation.

Regional learning consultations, progress reviews and related operational »



research work will be supported by a small TAP unit within the Commission on HIV/AIDS and Governance in Africa at the ECA.

To support cross-country learning, the TAP will establish a regional multi-disciplinary advisory panel (RAP), with a sub-committee of clinical experts (CCE) recognized for their work in HIV/AIDS treatment in Africa, to enable Africans to share experiences, to review clinical results, and to recommend policy reforms in participating TAP countries and other Multi-Country HIV/AIDS programme (MAP) countries.

The RAP will meet periodically at the headquarters of the ECA in Addis Ababa to review and recommend improvements from lessons emerging from TAP countries.

A regional clinical coordination committee (RCCC), a sub committee of the RAP, will be established to work with the International Treatment Coalition (ITAC) and WHO to maintain regular review of treatment regimens and protocols as lessons from country treatment programmes are gathered and shared at the regional level.

The RAP will review and oversee operational research work under the TAP in collaboration with the participating countries, WHO and the World Bank. The RAP will promote the rapid incorporation of lessons from the TAP into MAPs and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donor funded programmes

Feasible AIDS care

Until recently, the option of treatment for the majority of people living with HIV/AIDS in Africa had seemed impossible - high costs, demanding treatment regimes and the lack of even basic health infrastructure in many heavily-affected countries were all cited as potential insurmountable barriers. Today, however, despair over unmitigated mass human suffering is

giving way to hope over the possibility of feasible AIDS care. The cost of antiretrovirals (ARVs) has already fallen, and it is widely assumed that it will fall further in the future.

In many African countries, however, access to antiretroviral treatment (ART) has been fragmented and uneven, with states in some cases having little control over the distribution or administration of the therapies. Furthermore, there are many areas, especially rural areas, where there is little infrastructure for delivering ART.

The question, then, is how to decentralize access to these treatments, away from the major cities and large hospitals in order to widen the access base. The benefits of decentralization would be first to widen access to ART and second to ease the burden on hospital infrastructures, so freeing them to undertake other tasks and preventing 'crowding out' of other forms of treatment.

Under the auspices of CHGA (the Commission for HIV/AIDS and Governance In Africa) within the ECA, a coordinating unit would be established as the secretariat for the RAP and the countries participating in the TAP to organize policy research on community-based initiatives; and disseminate lessons and provide public education by maintaining close linkage with the New Partnership for African Development (NEPAD), the Conference of African Heads of State and Ministries of Finance.

ADVOCACY

Impetus for treatment gathers, but problems are legion

A wave of public opinion in favour of HIV/AIDS treatment is sweeping the world and replacing hopelessness. On the continent, the mood is palpable in virtually every country as the prospect of AIDS care through access to life-saving drugs opens.

Until recently, that goal had not seemed possible. High costs, demanding treatment regimes and the lack of even basic health infrastructure in many heavily affected regions were all cited as impassable barriers.

Over the past three or so years at least a dozen pilot treatment programmes implemented by numerous actors have helped develop and form consensus around an appropriate treatment protocol for resource-limited settings.

Although there are still some medical issues to be improved and clarified - pediatric treatment protocols, the usefulness of structured treatment interruptions, and the efficacy of immune boosters such as vitamins - the results from the existing pilot studies are very encouraging. Crucially, they show that adherence and treatment results are equal to those in the developed world.

Simpler, cheaper

Three other important developments are worthy of note. The first of these is the emergence of simpler treatment regimes. In 1998, the typical daily intake for an individual on antiretrovirals was between six and fifteen pills per day. Today, it can be as little as between two and three per day.

The second development is the dramatic drop in the cost of ARVs. When ARVs were introduced in 1996, they were hugely expensive. Since then, they have dropped from between US\$10,000 - \$12,000 per person per year to between US\$600 - US\$900 per year in most countries in Africa.

The final development has been the increase in international funding for ARV in low-income countries. The

creation of the Global Fund to fight AIDS, Tuberculosis and Malaria has been a significant indicator of the international commitment for financial support for health related issues in Africa. Among numerous other players on the international scene, the World Bank, the Bill and Melinda Gates Foundation and US President George W Bush's initiative are allocating significant resources to the cause of AIDS treatment in Africa.

As a result of these crucial developments the international climate of opinion has now shifted firmly in favour of sharply expanding HIV/AIDS treatment in Africa.

Progress in scaling up has, however, not kept pace with rising demand. According to recent estimates ART was initiated for only an additional 70,000 patients during 2002, leading to only 300,000 HIV-infected persons in the developing countries currently receiving ARVs of any kind - nearly half of them in Brazil alone.

The WHO estimates that there are currently 100,000 people on antiretroviral therapy (ART) in Sub-Saharan Africa, a coverage of only 1%, whilst over four million people remain in need of immediate treatment on the continent.

The first funding commitments by the Global Fund made in 2002 will allow a two-fold increase in the total number of individuals receiving ART in developing countries, and a six-fold increase in Africa.

Constraints

In spite of these advances, the challenge of scaling up from current initiatives to the comprehensive treatment programmes needed in Africa will pose significant logistical and support problems. Among constraints are the low and declining number of health professionals; the inadequate laboratory and patient care infrastructure; cost reductions and fiscal unsustainability; and inadequate stakeholder buy-in.

An immediate imperative is to stabilize and replenish the existing human resource base that provides health care in Africa. In many countries, that base is under siege. Health providers themselves are getting sick at high rates, and many who are healthy are migrating in search of economic betterment. How to stem these destabilizing attrition rates is as yet poorly understood, but needs to be understood very clearly if ARV scaling up is to be effective.

ART is a complex process that requires close surveillance by care providers, careful adherence to the therapeutic regime, and access to laboratory facilities for continual testing so that the therapy regime can be adjusted. All of these facilities must be available if ART programmes are to be undertaken successfully.

In a recent Kenyan study, for example, it was shown that whilst doctors throughout the country were prescribing antiretroviral drugs, only 30% of these doctors had received any training in administering and monitoring ART, and outside Nairobi, no laboratory facilities were available for monitoring the progress of therapy.

Even with the reduced costs of ARV drugs the price is still prohibitive for most African countries. Take the example of Kenya, where even under the best case scenario of ARV drugs becoming available at \$1 per day, they would cost 100% of the average monthly income of \$30.

At the national level, treating 25% of all HIV infected individuals in Kenya would cost 6.3% of gross national product (GNP), more than seven times the current government spending on health. For up-scaling to be successful, the price of ART and related interventions will need to come down to the level where African governments can budget for them in a sustainable manner.

In the African context of limited resources and huge unmet demands for HIV care, efficient programmes clearly necessitate that ARV drugs be properly delivered through organized channels. This implies a strong involvement of governments to either promote access to ART in the public sector or to regulate their delivery and use by

the private sector.

In the absence of organized efforts by public health authorities to improve access to ART the alternative that will inevitably occur in Africa is 'antiretroviral anarchy' that will restrict availability of ARV drugs to the most privileged, and increase the risk of diversion to 'black market' sales, of irrational prescriptions and the consequent dissemination of resistant viral strains.

In Zambia, for example, some reports indicate that the current system of drug allocation, with high demand and long waiting lists, is open to abuse and favouritism. Those who can afford it jump the queue by paying bribes. The medication gets distributed, but those who receive it will most probably not be registered as receiving the drugs. Buying the drugs through the back door also means that treatment is not accompanied by the necessary advice and medical monitoring and follow-up.

Zambian health officials are now warning of the presence of drug-resistant strains of the HIV virus in the country. Resistance mainly results from poor adherence to an ARV treatment regimen, or from discontinuing treatment altogether.

An environment where erratic drug supply decreases adherence paves the way for drug-resistant strains of HIV. When, on top of erratic supply, people on ARV receive inadequate follow-up and counselling, this adds to the risk of poor adherence and development of resistance.

Poor information leads to misunderstandings, such as was reported from Zambia, where people stopped taking the ARVs when they felt better - why continue taking medication when you are cured?

Former Zambian health minister, Professor Sam Luo, tells IRIN PlusNews that the problem is "immediate and urgent" because of its implications for drug policies and the cost of health care.

"I am frightened," he says, "I heard President [Levy] Mwanawasa saying government would provide ARVs for a further 100,000 people this year. I am screaming 'Stop'. Look at what is happening with just 10,000 people on treatment. Drug resistance makes it difficult to treat patients. If people are not getting better we have to look at other options, which increases the cost of treatment. Zambia can barely afford to provide basic health care to its people - we do not need this additional burden."

GOVERNANCE

Botswana:

Foremost treatment programme still fails to hit mark

Botswana's President Festus Mogae was in 2001 among the first to announce a programme to provide free antiretroviral drugs to all HIV-positive people in the country. It has made great progress but has nevertheless failed to hit official targets.

The first antiretroviral drug site was opened in January 2002 with the help of the Bill & Melinda Gates Foundation, which pledged \$50 million, and pharmaceutical company Merck, which pledged \$50 million and free drugs for five years.

Since then, about 80,000 people have been tested for HIV, 21,000 of whom have tested positive. Of that group, about 15,000 have become ill enough to begin antiretroviral treatment.

This has been rated a remarkable success, but Mogae said that the government had hoped to have 60,000 people on treatment by now.

The scheme has thus exposed serious gaps and indicates that even the best-resourced programmes may

not be enough. In addition large-scale behaviour change is needed, say experts.

Botswana was the first country in Africa to have a national policy of routinely offering HIV tests, on a voluntary basis. It has nearly the highest HIV/AIDS prevalence in the world - by the end of 2001 the virus had infected 38.8% of the adult population (in the 15-49 age group), a total of 330,000 people.

"I do not believe Botswana have a death wish ..., but I am afraid there will be a lot more funerals before people really change their behaviour", Ndwapi Ndwapi, a physician working in the national treatment programme, told newspapers earlier this month.

'New Dawn' programme

Botswana's ART programme, 'Masa' ('New Dawn') provides ARVs in six sites - Gaborone, Francistown, Serowe, and Maun - and in two district hospitals. Four priority groups are targeted - pregnant women, children older than six months, TB patients, and all adult patients with AIDS-related illnesses.



Mogae

Initial results showed that many patients were sicker than anticipated, with CD4 counts around 50 or lower at the start of treatment.

The later people start treatment, the more difficult it is for therapy to be successful, and it causes an

extra burden to the already overwhelmed health system.

In spite of the offer of free treatment only a small number of people have come forward.

Misinformation and stigma about HIV/AIDS seemed to be discouraging people and health experts say much still needs to be done to overcome cultural constraints to treatment.

In a move to break the taboo one of Botswana's influential paramount chiefs recently agreed to take the HIV test. Bakwena Paramount Chief Kgosi Kgari Sechele III and about 30 headmen agreed at Molepolole, a village 50 km south of the capital Gaborone.

To increase the number of people being tested at earlier stages, from the beginning of 2004, the government made HIV tests part of the routine checkups at health centres, with the possibility for those who do not want to be tested opting out.

It is still too early to assess the impact of this measure, but it is expected to enlarge the numbers of people who can benefit from treatment.

Limited capacity

Still to be resolved is the issue of the limited capacity of the health system. Botswana's Ministry of Health blames in large measure the critical shortage of skilled personnel and this lack of human resources cannot be solved by money alone. It requires improving motivation of medical staff, provision of training, and working closely with organizations outside the public health system.

Last month the ministry of health announced its intention to expand its existing HIV/AIDS training programme to reach more health care professionals.

"Building on the existing KITSO AIDS training programme, the plan will ensure a comprehensive, standard-

ised and coordinated HIV/AIDS training, as well as bringing all existing and future HIV-focused training under the aegis and direction of the ministry of health, so the quality can be assured," Peter Navario, chairman of the KITSO planning committee and project coordinator of the Baylor-Botswana Children's Clinical Centre of Excellence, told the UN agency PlusNews.

KITSO includes the Botswana-Harvard Partnership, the Ministry of Health's AIDS/STD Unit, the African Comprehensive HIV/AIDS Partnership (ACHAP), the BOTUSA Project, the Baylor International Paediatric AIDS Initiative, the Nurses Association of Botswana and affiliated health training institutions.

One of the new courses on offer includes advanced training in paediatric HIV care, provided by leading paediatric AIDS experts from the Baylor International Paediatric AIDS Initiative.

Another addition is an HIV counsellor training course.

The KITSO AIDS training programme was established in 2001 since when more than 2,000 health professionals have completed courses.

The role of NGOs and communities in ensuring efficient delivery of systems is also key, say health experts. Innovative approaches, such as the 'buddy system', which helps patients to follow the treatment correctly, is proving successful.

• CHGA is holding an interactive meeting in Gaborone on July 26-27

COUNTRY FOCUS

Zimbabwe:

Resources for treatment still a drop in the ocean

The Zimbabwe government has made US\$2.8 million available for the purchase of antiretroviral drugs in public hospitals, Zimbabwean President Robert Mugabe said at the official opening of the first national conference on HIV and AIDS in Harare this month. However, this means antiretroviral drugs for only 10,000 patients, he said.

At the same time a local company has announced production of its first batch of generic anti-retrovirals, helping to cut the price of the drugs.

The country's economy is in a state of crisis, with growth declining for each of the last five years and the government desperate for foreign exchange. The UN also says Zimbabwe faces a serious food shortage, which the government denies.

Figures released last year by the ministry of health put the HIV prevalence rate among Zimbabweans aged between 15 and 49 at 24.6 percent, with an estimated 1.82 million people living with HIV/AIDS. Doctors at the conference believe that currently there are fewer than half that number being treated.

"It is estimated that about 5,000 patients are currently on ARVs in Zimbabwe, although this might be an underestimate," said Christine Chakanyuka, an HIV/AIDS clinician in the ministry of health. An estimated 166,000 new HIV cases were registered last year, according to Chakanyuka.

National emergency

The government two years ago declared the HIV situation a national emergency to facilitate the import of cheaper generic drugs and allow manufacturing by local companies and earlier this month a Zimbabwean pharmaceutical company said it had started manufacturing generics.

Varichem Pharmaceuticals, based in Harare, said in a statement that it was probably the first generics company to produce ARVs in Africa. The company is producing nine types of ARVs to be sold in Zimbabwe.

"All raw materials are imported from Europe and Asia," said a Varichem company official.

The local production of ARVs have already brought about a significant drop in the cost of the drugs, currently around ZD150,000 a month.

But Phineas Makurira, who spoke on behalf of doctors at the conference, said the government should help to bring down the cost of ARVs by scrapping duties on imported raw materials used in production and offering tax incentives to pharmaceutical companies.

Early this year, government started administering free ARVs at selected government hospitals in a pilot project and said it would roll out free ARVs to some 171,000 people by the end of next year. However, Chakanyuka, indicated that the it might be unable to meet that target as "we are limited by resources".

Harare Central and Mpilo Hospital in Bulawayo started rolling out ARVs in March this year to people living with HIV and AIDS and 14 more sites have been identified and have undergone initial assessment.

Laboratory staff have received training at Harare and Mpilo hospitals where equipment for testing CD4 count (the level of virus in the body) has been set up. Other centres that will soon offer ARVs are Pelandaba Clinic, Howard Mission and Triangle Hospital.

Delegates at the three-day conference stressed that poverty and malnutrition were undermining the country's struggle against HIV and AIDS.

"Malnutrition affects 90 percent of HIV/AIDS patients ... it is also responsible for 60 to 80 percent of AIDS deaths," noted nutritionist Percy Chipepera.

Mugabe told delegates that access to ARV treatment was one of the priorities of his government, but "has to be viewed in the context of comprehensive programmes for AIDS care that include access to counselling and treatment of opportunistic infections, community-based care, and orphan and psycho-social support".

He also said that expensive modern ARV drugs should be complemented with traditional medicines in AIDS care. "After all, the majority of our people still rely on, and could benefit from, traditional medicine, as long as the proposed remedies pass the necessary medicine control tests".

Although the prevalence rate in Zimbabwe appears to be stabilising, the number of AIDS-related illness and deaths will continue to rise as current HIV cases develop into AIDS. Around 70 percent of patients admitted to Zimbabwe's hospitals suffer from HIV and AIDS-related illnesses while 33 percent of pregnant women in the country are infected with HIV, according to health experts.

Politicians take HIV tests

Last month, in a rare show of unity, several lawmakers from Zimbabwe's two rival parties underwent

voluntary HIV tests in a bid to inspire others to do the same.

Five members of parliament from the opposition Movement for Democratic Change (MDC) and four from Mugabe's ruling Zimbabwe African National Union - Patriotic Front (Zanu-PF) turned up at one of the AIDS testing centres dotted around the city.

The public testing of the MPs came a day after the release of the Zimbabwe Human Development Report, which warned of a negative population growth rate by 2010.

POLICY

Social scientists network on impact of HIV/AIDS

A major conference in South Africa has brought together researchers in a continent-wide alliance to discuss the social aspects of HIV/AIDS.

Over 350 social researchers, doctors, representatives of national and international organisations, NGOs and donor agencies met in Cape Town for four days at the second African conference on Social Aspects of HIV/AIDS Research (SAHARA), organised by South Africa's Human Sciences Research Council (HSRC).

Olive Shisana, executive director of social aspects of HIV/AIDS and health at the HSRC said the gathering would serve as a catalyst for broader discussion.

Researchers from all over the continent were able to network and share notes and already it is apparent that preliminary results from different sites will help develop locally initiated HIV and AIDS control strategies

One of the aims, said the organizers, was to identify the barriers to interaction between researchers and decision makers in government ministries

Conference objectives were to brief researchers, policy and decision makers, donors and other interested stakeholders about the work of SAHARA, advised by a reference group of key stakeholders; to share emerging results from research sites in Africa on the social aspects of HIV/AIDS; to strengthen linkages, collaboration, and coordination of SAHARA to make it an effective broad-based research network, and a flexible alliance of research partners; and to issue policy briefs to policy makers, government representatives and inter-governmental bodies.



Shisana

120 contributions

The theme of the conference was 'Promoting an African Alliance to Mitigate the Effects of HIV/AIDS on a Sustainable Basis', and there were over 120 contributions made at the four-day meeting. The focus was on nine key themes - nutrition and food security, policies of access to care, stigma in relation to care, cultural and communal mobilisation, human rights, drug- and trade-related issues, the financing of AIDS, orphans and vulnerable children and HIV surveillance.

"The challenge is to take the research and turn it into practical action," said Dan Kaseje of the Tropical

Institute of Community Health and Development in Africa, a SAHARA partner.

The papers will be included in the alliance's inaugural journal SAHARA, which will be published four times a year in both hard copy and online.

Mbulawa Mugabe, UNAIDS country coordinator for South Africa, also welcomed the establishment of a network that focuses on the social aspects around HIV/AIDS.

"Social sciences help us explore where clinical science cannot. We require evidence that interventions are making a difference, and then we must scale up these interventions and make the finite resources work for us," he told the UN agency PlusNews.

Participants were asked to examine specific operational research questions, such as whether urban-based or rural-based programmes are more effective in reducing HIV infection in rural areas and what the information gaps are. Some questions were -

- Can bar-based and workplace peer education and condom distribution activities reduce the high HIV infection rates seen in young women?
- What are the implications of condoms for family planning in the era of HIV/AIDS?
- Do school education or membership of community groups help young women to avoid HIV?
- Do paternal and maternal orphanhood harm the educational opportunities of boys and girls?
- How effective are HIV intervention programmes in reaching marginalized groups such as disabled persons and street kids?

Researcher Lindiwe Majele Sibanda from the University of Zimbabwe said the challenge is for

SAHARA to develop a database that will keep running, of what researchers have done post-presentation of their papers.

In addition to linking up with key partners in the region, SAHARA is also building on existing initiatives (SAHARA West Africa, and SAHARA East and Central Africa) and starting new ones.



TREATMENT ISSUES

International:

Health chiefs boost cheaper ARVs

WHO member states last month unanimously approved measures to scale up the treatment of HIV/AIDS in poor countries and to supply them with affordable, high quality anti-AIDS drugs.

The move backs the 'three by five' initiative that aims to raise the number of people with AIDS being treated to three million by 2005, from 400,000 at the moment.

The resolution marks the first time that the 192 member states have backed the WHO's controversial 'pre-qualification' system for medicines.

The procedure cuts costs and speeds up supply by setting a minimum quality standard and international regulatory approval for generic and brand-name drugs that can be used by poorer countries and aid agencies.

The US - which has had qualms about the WHO quality approval scheme but backs boosted treatment

- did not oppose the scheme but Washington signalled earlier that it was setting up its own streamlined procedure to approve anti-AIDS drugs.

In the US, Randall Tobias, the Department of State's Global AIDS Coordinator, told the media last month that Washington wanted to get drugs reviewed by a "stringent regulatory authority" before treatment was scaled up in a "very, very massive way".

The capacity of the pharmaceuticals industry globally to produce the quantities of drugs that are going to be needed, as the programme was scaled up, was also an issue that would need to be addressed, he said.

The US 'Fast Track' process clarifies that there are provisions in the Food and Drug Administration (FDA) regulations for "tentative approvals" of drug registration application in certain circumstances and that those procedures would be made available to proprietary and generic producers on an expedited basis, particularly in the case of fixed-dose combination ARVs.

In procuring ARVs under the President's Plan for Emergency AIDS Relief (PEPFAR), the US has thus far refused to purchase generic ARVs pre-qualified by the WHO prequalification.

In contrast on May 20 the European Union passed new legislation permitting its drug regulatory authority, the renamed European Medicines Agency, to cooperate with the WHO and to issue a scientific opinion for medicines intended exclusively for markets outside Europe. This legislation would permit the European Union eco-management and audit standard (EEMA) to evaluate generic medicines, despite the EU's 10-year data exclusivity rules that might otherwise prevent proof of bioequivalence.

South Africa:

AIDS vaccine initiative gets R4m

Two of South Africa's biggest employers have committed themselves to supporting HIV/AIDS vaccine research and development by collectively donating R4-million to the South African AIDS Vaccine Initiative (SAAVI).

Impala Platinum Holdings will invest R2.5 million over five years while Transnet donated R1.5 million, a statement from SAAVI said.

SAAVI was established in 1999 by the South African government and power utility Eskom to coordinate the research, development and testing of HIV/AIDS vaccines in South Africa.

SAAVI's director, Tim Tucker, commented that "HIV vaccine research and development is an expensive, long-term undertaking, and will require ongoing support and partnerships such as this from all sectors to be successful."

Local research will be given a boost by the G8 summit's agreement this month to make an AIDS vaccine an international scientific priority.

Specifically it may begin a swing away from a focus on virus strains in the developed world. The research in South Africa is significant because until recently virtually all research on a vaccine was being done in the developed world, using the B strain of HIV that occurs mostly in North America and Europe.

However, most HIV-positive people in Africa are infected with other HIV types, including clades A, C and D.

The G8 plan calls for the establishment of HIV vaccine development centers throughout the world, the expansion of manufacturing capabilities, the creation of standardized measurement systems, the construction of clinics for trials and the creation of rules allowing regulatory authorities in different countries to recognize the results of foreign clinical trials. In addition, the initiative will encourage scientists from developing nations to play a larger role in the search for a vaccine, say AIDS experts.

MONITOR

Mozambique: First hospital for HIV-positive children

Mozambique's first hospital for HIV-positive children opened last month in the capital, Maputo, amid estimates that more than 30,000 children are born HIV-positive each year.

"The Paediatric Day Hospital will facilitate much more integrated support to children living with HIV/AIDS than up to now," said UNICEF representative Marie-Pierre Poirier in a statement.

It is estimated that there are currently 68,000 children under the age of five living with HIV/AIDS in Mozambique. Over 50 percent of them die within the first year and half of the remainder do not survive the second year, say AIDS experts.

Are you involved ...

Are you involved at any level in HIV/AIDS policy-making or administration in Africa? In government or civil society organisations? Are you an activist who is living with HIV/AIDS? We'd like to hear from you - your views and suggestions and experiences.

Please fill in the form below and mail (or fax or e-mail) it to:

CHGA Feedback, ECA, PO Box 3005, Addis Ababa, Ethiopia.

Fax: +251 1 512294

E-mail: chga_feedback@uneca.org

We'll send you alerts from our online newsletter on the fight against HIV/AIDS and on policy initiatives being taken in Africa.

NAME: _____

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POSITION/ FUNCTION: _____

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E-MAIL: _____

The primary mode of transmission of the virus is from mother to child. Only 34 percent of women in rural Mozambique deliver their babies with the assistance of a health care professional, compared to 80 percent in urbanised locations.

The new Paediatric Day Hospital was established in a rehabilitated wing of Maputo Central Hospital, with the support of Unicef and the government of France

Region: Focus on expectant mothers

Making HIV-positive pregnant women the focus of HIV/AIDS treatment programmes in Africa is the most effective way to battle the pandemic on the continent, African health ministers heard at a conference in Rome last month.

The Community of Sant'Egidio, a Roman Catholic organization dedicated to conflict resolution and assistance to the poor, described its pilot programme in Mozambique as "the best results obtained up until now in sub-Saharan Africa in terms of treatment" for HIV/AIDS.

The programme, called 'Dream', has since its inception two years ago offered free access to antiretroviral drugs to HIV-positive mothers-to-be to block the transmission of the disease to their babies.

The scheme is a model for others now being set up in Malawi, Tanzania and Guinea Bissau, and others in Angola and Guinea are soon to follow.

Some 500 people attended the Catholic charity's conference, including the health ministers of 11 African countries, AIDS activists and officials from the World Bank and the World Health Organization.

Zambia: Home-based care combats stigma

Zambian AIDS activists are turning to community projects in an effort to mitigate the impact of the disease and to combat its stigma.

In Chazanga township, north of the capital, Lusaka, a project called Bwafwano, meaning 'helping each other', has provided assistance to an estimated 2,000 township dwellers living with the virus.

So far the Bwafwano centre has trained 305 volunteers and recruited a further 250 people to form the HIV/AIDS support group. Volunteers visit almost 1,800 patients each day. Nursing the patients includes counselling, administering medication and bathing them.

An estimated 16 percent of Zambians aged between 15 to 49 years are living with the virus.

Lesotho: AIDS centre opens

Senkatana Centre, one of five community-based HIV/AIDS treatment support programmes in Southern Africa, was launched in Lesotho last month.

The launch coincided with the fifth anniversary of 'Secure the Future', Bristol-Myers Squibb's US\$100-million commitment to fight the pandemic in the region. The site was opened by Lesotho's Prime Minister Pakalitha Mosisili and John McGoldrick, executive vice-president of Bristol-Myers Squibb.

Secure the Future is a five-year initiative to support projects that help women and children affected and infected by HIV/AIDS. To date, more than 160 programmes in nine countries in Southern and Western Africa have been funded.

The new centre is an extension of Queen Elizabeth II Hospital in Maseru, and was given a three-year grant of R27.5 million from 'Secure the Future'.

In the past 18 months Secure the Future has worked with ministries and departments of health, private sector and non-governmental organisations in Lesotho, Namibia, South Africa and Botswana to develop a programme to support the provision of antiretroviral therapy in hard-to-reach areas.

The centre will serve as a learning base for Lesotho's National ARV programme. In the partnership are the Ministry of Health and Social Welfare, Lesotho Medical Association, People Living Openly with HIV/AIDS (PLOWA), Tsepong Counselling Centre and Christian Health Association of Lesotho (CHAL).

Swaziland: Rising number of HIV-positive truckers

Swazi authorities and health workers have expressed concern over the rising rate of HIV infection among the country's truck drivers.

The landlocked country is heavily dependent on road transport and there are fears that the spread of the virus could have a serious impact on the economy.

According to official statistics an estimated 38.6 percent of Swazis are living with the virus, and the country's health ministry has included truckers among the high-risk groups that are partly responsible for Swaziland's soaring HIV prevalence rate.

Two years ago sex workers operating at border posts were targeted by an aggressive HIV/AIDS awareness campaign aimed at encouraging them to engage in safer sex practices, thereby also reducing the rates of infection among truckers.

Swaziland: Project cares for AIDS orphans

Neighbourhood Care Points (NCP) providing services to Swaziland's growing population of orphans and vulnerable children (OVC) will be expanded 150 percent by the end of 2005 in the drought-stricken southern Shiselweni and eastern Lubombo regions, according to a

recent report released by the UN Children's Fund, Unicef.

"Neighbourhood Care Points are places for children to acquire [assistance with] their nutritional as well as emotional, educational and even spiritual needs. Importantly, they are places that allow for the socialisation of otherwise isolated children," said Unicef country representative Alan Brody.

In conjunction with the World Food Programme, which sees to the basic nutritional needs of OVC, 198 care points have already been established across the country. Eighty of these are located in the dry lowveld regions, where a third year of drought has led to acute food shortages. Some 200 NCPs will be operational next year. An estimated 20,000 children are orphaned by AIDS each year.

Meanwhile the Swaziland Vulnerability Assessment Committee (VAC) has predicted that the high HIV/AIDS prevalence rate will lower life expectancy to just 40 years by 2010. But some health officials have found fault with the survey, which does not factor in the effect of antiretroviral drugs on future life spans and AIDS mortality.

The ministry of health is planning a nationwide household health survey, beginning this month.

Zambia: Traditional healers called in

With less than two percent of HIV-infected Zambians under treatment with antiretrovirals, plans were announced last month to begin testing traditional medicines as an alternative treatment for the pandemic.

Patrick Chikusu, head of the department of pharmacy at the University of Zambia (UNZA), and chairman of the National AIDS Council (NAC) Technical Working Group on Traditional and Alternative Remedies, said orthodox medicines on their own had failed to contain the rising number of HIV/AIDS deaths, and it was time alternative medicines were tested for their efficacy in treating the disease.

The announcement ended years of debate and speculation in Zambia as to whether modern and traditional medicines could be combined in the fight against the pandemic.

Uganda: Distribution of free ARVs begins

Uganda this month began distributing free antiretroviral drugs to HIV-positive people, Minister of Health Jim Muhwezi said. The decision has been widely welcomed - but followed a surprise announcement by President Yoweri Museveni, reversing his earlier support for the use of condoms. He has attacked them as promoting promiscuity.

An estimated 100,000 of the 1.2 million HIV-positive Ugandans are in need of antiretroviral treatment, but as of December 2003 only 17,000 people had access to the drugs.

At the same time the government, backed by some faith-based organizations, has made an abrupt U-turn on the use of condoms, claiming that instead of saving lives they are promoting promiscuity among young people.

"When I proposed the use and distribution of condoms, I wanted them to remain in town for the prostitutes to save their lives," Museveni said last month.

In a separate news article in the New Vision (a government-controlled daily newspaper), Jackson Turyagyenda, spokesperson for the Church of Uganda, condemned the use of condoms among unmarried youth, saying it was a moral evil and militated against God's word on human sexuality.

Region: Church leaders at summit

Protestant church leaders from throughout Africa this month gathered in Nairobi, Kenya, for a four-day summit on religion and AIDS in Africa.

The All Africa Conference of Churches, which organized the summit, hopes to mobilize religious leaders on the continent to fight HIV/AIDS. AACC's 169 churches in 39 African countries have a total of 120 million members who could "form a formidable force for social mobilization" in the fight against AIDS, according to an AACC release.

About 40% of health facilities in Africa are run by churches, and leaders at the summit hope to explore ways of increasing the capacity of those facilities to treat HIV-positive people.

Kenya: AIDS education lowers refugee infection

A drop in HIV infection rates among African refugees was the result of intensive AIDS education and changed sexual behaviour, the UN refugee agency UNHCR has said.

Speaking at a recent workshop in Kenya's capital, Nairobi, UNHCR expert on HIV/AIDS Patterson Njogu, said, "The number of condoms being used in refugee camps has increased dramatically. At one time you could not talk about condoms in the camps. Now condoms are very much in demand."

Njogu said the number of sex partners decreased significantly, as had the incidence of transactional sex. While refugees were at greater risk of HIV infection - because of rape during conflicts, disrupted health care and the

trading of sex for food - this did not necessarily translate into higher infection rates, UNHCR added.

Nigeria: TV serial seeks behaviour change

TV serial debuts a 39-episodes television serial made its debut earlier this month on Nigerian television as part of a behaviour change communication strategy of the IMPACT project.

The television serial, titled 'Behind the Siege', is produced by Tade Ogidan of OGD Productions with funding from the US Agency for International Development (USAID) and technical support from Family Health International.

The serial highlights the moral and social problems posed by the HIV/AIDS epidemic in Nigeria and stresses behaviour that puts individuals at risk of infection.

Zimbabwe: Cross-border traders cash in on AIDS

Health experts have expressed concern over cross-border traders trafficking antiretrovirals (ARVs) for resale at lower prices to people living with HIV/AIDS in Zimbabwe.

The Ministry of Health and Child Welfare said the traders, who smuggle the drugs from South Africa, Botswana and Namibia were cashing in on the AIDS crisis and the unavailability of anti-AIDS drugs in Zimbabwe.

Christine Chakanyuka, an HIV/AIDS clinician in the ministry, said the selling of anti-AIDS drugs on the parallel market posed a serious health hazard to people taking the medications without professional medical guidance.

A local newspaper, The Zimbabwe Standard, quoted Chakanyuka as saying, "Constant contact with a health professional is essential to ensure that the drugs are working well and there are no serious side effects during treatment."

Niger: More are willing to take HIV tests

More people in Niger are volunteering to undergo testing for HIV/AIDS as acceptance and understanding of the disease improves, according to health workers in the capital, Niamey.

"The image of AIDS has changed. People no longer associate it with death, weight loss, incurability," Kadidiatu Gouro, the director of the Anonymous and Voluntary Testing Centre (CEDAV) in Niamey told the UN agency IRIN.

CEDAV is the only specialist testing centre in this poor West African country of 11 million people. Gouro and her colleagues from the local non-governmental organisation Living Better With AIDS, have been running the testing centre since it was set up in January 2002.

They have received support from Lutheran World Relief in the US and from the governments of France and Niger.

Djibouti: Media more active in fighting HIV/AIDS

Djibouti's communication and culture ministry has said it plans to involve journalists more actively in fighting HIV/AIDS despite the relatively low prevalence of the virus in the country.

Speaking at a seminar for journalists in the capital, Djibouti, Minister for Communication and Culture Rifki Abdoukader Bamakhrama said the seminar was the first step in his ministry's national programme to combat HIV/AIDS.

According to national health authorities, 2.9 percent of Djibouti's 600,000 population is HIV-positive - a figure, they said, which was low by African standards, but represented a generalised epidemic. The country, however, has a high prevalence of tuberculosis.

Upcoming Events –

Next CHGA Interactive to take place in Botswana July 26-27 in Gaborone, Botswana.

CHGA will organize the next CHGA Interactive in Gaborone, Botswana July 26-27, 2004 on the issues of treatment upscale and Prevention of Mother to Child Transmission. The meeting will bring a small group of thirty participants selected from Botswana's active civil society organizations, partners, donor agencies and UN partner organizations to engage in a focused and interactive dialogue around the thematic areas. The proceeding from the meeting will be synthesized and integrated into the Commissions Final Report. For more information contact CHGA secretariat at chga@uneca.org.