

CHGA will look beyond crisis management to HIV's long-term development challenge

Need to know ...

Mozambique:

Last chance

Mozambique faces a major HIV/AIDS epidemic but it can still avoid this outcome.

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Lesotho:

New laws

Two new laws will help deal with the impact of HIV/AIDS.

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Treatment:

Out of reach

There may be a six-fold increase in the number of people in Africa receiving ARVs - but even so the cost remains prohibitive.

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Administration:

Public sector crisis

The public sector faces collapse under the impact of HIV/AIDS in a number of states. But no country is addressing the planning issues.

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Region:

CHGA will be 'activist'

CHGA is going to be an 'activist' commission in the fight against HIV/AIDS, says KY Amoako.

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The special contribution of the Commission on HIV and Governance in Africa in the fight against HIV/AIDS is to help African policymakers understand the long-term development challenges of the epidemic. It will help in the formulation of policies that contain the pandemic in order to support development and foster good governance. This is because HIV/AIDS presents systemic challenges to Africa, beyond the need for immediate emergency responses, says CHGA's chairman, KY Amoako.

The reaction to HIV/AIDS has until now been to the immediate crisis – infection rates have increased from four percent to 20% or more in adult populations in less than a decade.

But after nearly two decades of seeking to change African sexual behaviour policy-makers now need to focus on the systemic characteristics of the epidemic.

The massively high infection rates relate not just to sexual behaviour but to poverty and wealth, disempowerment and influence, wellbeing and disease, deprivation and development, trust and bad faith - "the very way we as Africans live our lives", Amoako said in an interview.

HIV infection rates are bringing certain nations to the threshold of destitution. "Will there be global safety nets to allow nations rendered poor by the epidemic, and poor within nations to survive?" he asked.

Planning needs

HIV/AIDS is hitting societies' most productive sector of prime aged adults and this demands a strategic planning response. It means:

- Greater harmonisation of policies between donor governments, multilateral institutions of global economic governance and African countries. This will ensure that the fight against HIV/AIDS does not destabilise or impinge on longer term economic and development strategies;

- Better partnerships between NGOs and community groups responding to the pandemic and their national governments. This will ensure that the needs and knowledge accumulated by groups at the sharp end of service delivery and care

support are reflected in national strategic plans for confronting HIV/AIDS;

- Greater coordination of the efforts of multilateral agencies (particularly the UN system) within African countries. This will minimise duplication of efforts while ensuring that available resources are better utilised.

There is a final imperative, sustainability. New programmes of funder support have transformed the opportunities for developing effective responses. Current funding is only a fraction of what is needed and the long-term sustainability of the funding sources is uncertain.

"What for example, will happen to programmes currently funded by the Global Fund when that organisation comes to the end of its five-year mandate", Amoako



Amoako: More coordination needed



asked. "How will governments continue their treatment programmes?"

In this context CHGA's final report will focus on the challenges of governing a country – including maintaining essential public services, keeping economic development on track, maintaining rural livelihoods, mitigating the gender dimension of the epidemic, and ensuring national security – all despite the fact that a large number of the population is living with HIV/AIDS.

COUNTRY FOCUS

Mozambique:

Last chance to take the initiative as major epidemic looms

Mozambique faces a major HIV/AIDS epidemic given its high average prevalence level and structural factors such as poverty, gender inequality, cultural conditions and high levels of labour mobility. Its current infection levels appear low, but other countries in the region, like Botswana, Zambia and Swaziland, also had relatively low levels of HIV prevalence in the early/mid 1990s. Then the epidemic expanded with great speed.

Yet Mozambique may still have an opportunity to avoid this outcome, say CHGA researchers.

HIV prevalence among adults (15 – 45 years) was estimated at 12.2 per cent in 2001, which ranks Mozambique among the ten most affected countries in the world. There are currently 1.5 million people living with HIV/AIDS (PLWHA), with an estimated 500 new infections every day. An estimated 57% of HIV+ adults are women.

The national rate of prevalence masks considerable regional differences, with adult prevalence rates estimated at 13.2 per cent for the south, 16.5 per cent for the centre and 5.7 per cent for the north of the country.

Table 1 provides data on the regional distribution of HIV in 2001.

National response

The national response to the HIV/AIDS epidemic started in 1998 through the National Programme to Combat AIDS set up by the Ministry of Health. This programme focused mainly on health-related aspects of

the epidemic and the task was taken over in 2000 by the National AIDS Council (NAC).

This was set up as a government agency for coordinating, monitoring and evaluating all HIV/AIDS-related activities in the country, as well mobilising resources for a comprehensive and multi-sectoral response to HIV/AIDS. The board of NAC is composed of members of government as well as of civil society representatives.

In 2000, the National Strategic Plan to Combat STD and HIV/AIDS 2001 – 2003 (NSP) as well as an operational plan for its implementation in 2001 – 2003 was developed through extensive processes of consultation. Provincial HIV/AIDS coordinators were appointed in March 2000 and provincial plans were also developed.

So far about 15 line ministries have developed sectoral operational plans and have started implementing programmes and activities addressing HIV/AIDS.

The Ministry of Health (MISAU) has developed a National Strategic Plan for Health that comprises a cross-sectoral approach and which fosters partnerships for multi-sectoral interventions to respond to HIV/AIDS.

The community response has been stimulated by the work of national and international non-governmental organizations, faith-based organizations and community based organizations (CBOs) etc. These organizations are in part being used as implementing partners for various programmes and projects, with an emphasis on Information, Education and Communication (IEC) activities and promoting the use of condoms. At the present time activities are, to a large extent, focused on Maputo and a few other urban centres.

Impact mitigation activities, including orphanages, boarding schools for orphans, and support to PLWHA through home-based care and income-generating activities, are still limited in number and fall far short of the present and projected needs. The government has facilitated the formation of a number of organizations and associations, such as the Network of National Associations and NGOs working on HIV/AIDS (MONASO), the Business Against HIV/AIDS Group, and the Forum for Faith-Based Organizations.

In October 2001, parliament passed a law addressing HIV/AIDS in the workplace that specifically prohibits any discrimination against PLWHA.

Treatment

The number of patients who are presumed to be in immediate need of ARV is 54,000, but less than 2000 are currently undergoing treatment. Up to 2002, there was no mention of antiretroviral treatment. The new National Strategic Plan (NSP) covering the period 2004-2008 presents a more comprehensive list of services.

The prospect of increased resources coupled with the decreasing costs of antiretroviral drugs, provides an opportunity to scale up the national response but it also presents enormous challenges due to the lack of adequate financial, human, technical and institutional capacities at all levels.

Human Resources

There are 17,000 health workers of which 11,000 are trained. Only 6% are doctors, consequently less than 50% of the districts have a doctor. Up till now, a very small number of doctors are accredited to prescribe antiretroviral treatment.

The number of doctors and nurses per patient is very

HIV/AIDS prevalence rates by region

Region	Province	Provincial rate	Regional rate
South	Maputo city	13%	13.20%
	Maputo province	14.30%	
	Gaza	16%	
	Inhambane	9.60%	
	Sofala	18.70%	
Centre	Manica	21.10%	16.50%
	Tete	19.80%	
	Zambezia	12.70%	
North	Nampula	5.20%	5.70%
	Niassa	6.80%	
	Cabo Delgado	6.40%	
Mozambique national			12.20%

Source: Ministry of Health 2001

low compared with other countries in Africa. For instance, the number of nurses per patient is 1:1298 in Malawi, 1:704 in Zimbabwe, 1:610 in Zambia, 1:457 in Botswana and 1:215 in South Africa while in Mozambique it is 1:5000.

Annually the districts lose 7% of their staff, mainly due to transfers or death. One study showed that 10-15% of staff could die from AIDS between 2002 and 2010. Another important conclusion from the same study was that the level of knowledge about AIDS was very low in all ranks of health workers.

Funding issues

While budgetary allocations were made for the implementation of the NSP, in practice it has remained largely unfunded, and many planned activities have simply not been undertaken. As the MDG report [2002] concluded, *“Unless significant efforts and resources are invested to scale-up prevention, care and treatment interventions, the country will not be able to reach the MDG target. Based on recent data it is projected that the prevalence rate among adults could reach 16.3% by 2010.”*

The NSP is presently being revised, and there is a new commitment evident in government and among stakeholders to develop an expanded response to the epidemic.

More than US\$300 million is expected in the next five years from the Global Fund, from MAP from the World Bank and from the Bill Clinton Foundation.

The current NSP has been designed around this committed funding, which will allow provision of ART, and improve the national health service and systems.

The Strategic Plan from 2000-2002 was under-funded and few of the planned activities were actually implemented. The costs for implementation of the Strategic Plan 2004-2008 are estimated at US\$500 million.

Of the commitments made during 2003, only the World Bank Multi-Country AIDS Program (MAP) has already disbursed actual money. The first two years of the proposal submitted to the Global Fund have been approved. However, the agreement has not yet been signed. The Bill Clinton Foundation has raised \$9m through two donors, Canada and Ireland. Other donors and NGPs have provided smaller amounts.

Overall, up to US\$29 million of committed money has been allocated to AIDS interventions.

The possibility of actually using these resources will depend on the timely disbursement and the MOH's improved capacity for financial management. Nevertheless even this level of funding, while allowing for some services to be set up and managed, will be inadequate to produce the improvements in the health network and human resources needed for the system to be able to open and run the integrated networks planned for the Strategic Plan 2nd and 3rd phase. Sustainability of the program is a real issue.

While the funding problems may in the future not be the primary obstacle, what persists, and will almost certainly worsen as a consequence of the impact of HIV/AIDS, are constraints relating to organizational and human resource capacity.

At the present time there is a need for greater focus and prioritization both within government and among key stakeholders on the importance of sustaining human resource capacity as an essential element in **all** pro-

gramme activities – including those related specifically to HIV/AIDS. However, the Public Sector Reform Strategy of November 2002 left the development of a strategy to respond to HIV/AIDS until later, rather than ensuring its immediate development and integration across the whole of the public service.

GOVERNANCE

Lesotho:

New laws will strengthen HIV/AIDS action

Two new laws, on sexual offences and child protection, should help diminish the impact of HIV/AIDS in Lesotho. But the problem is how to provide public dissemination of information about the laws.

The Sexual Offences Act, passed into law last year, is still unknown to most people. There are no daily newspapers and the government-run television station broadcasts for only two hours nightly, so it is up to health organisations to spread the word about the law and its benefits.

“Because HIV/AIDS is undermining our social institutions and economy, it is crucial that the Sexual Offences Act be utilised now that it is law,” Limakatso Chisepo, director of social welfare at the Ministry of Health, told the UN news agency IRIN. “We also need to workshop and train chiefs about the law, because chiefs are the people's leaders at the local level,” said Chisepo.

The Act thoroughly defines sexual violations and contains revised definitions of rape, including within marriage,” said Sakoane Sakoane, counsel for the Lesotho Law Reform Commission. Before the Act, women could not refuse sex with their husbands.

Even if sex is consensual, if one partner withholds the information that they are HIV-positive it is a crime - this was a grey area before. It is also a criminal offence now to deliberately infect another person with HIV.

The Child Protection Bill is currently with the cabinet, and is expected to advance to parliamentary debate and passage by early next year. Although Lesotho is a signatory to the UN Declaration on the Rights of the Child, its points have yet to be enshrined in national law.

Adoption and custody issues, and child abduction, prostitution and labour, which are all prohibited, are covered by the Bill.

Street children, who are becoming numerous in urban areas, become the responsibility of the state, which must create institutions for them.

Primary education for all children is now free up to grade five, but some humanitarian workers feel that the government's current plan for financing primary education will stay incomplete until children no longer have the option of staying out of the classroom. Children - especially girls - are often pressed to stay home by families affected by AIDS and poverty.

South Africa:

Officials admit treatment programme is lagging

The South African Department of Health acknowledged this month that it was behind schedule in the rollout of its 'Operational Plan for Comprehensive HIV and AIDS Care and Treatment' and would not meet its initial goal of having 53,000 people on ARV drugs by the end of March.

The government in November 2003 approved a programme to provide antiretroviral drugs to 1.2 million people - or about 25% of the country's HIV-positive population - by 2008. About 25% of South Africa's economically active individuals are HIV-positive, with a total of about five million HIV cases in the country. About 5.3 million South Africans, out of a total population of 44.8 million, are infected with HIV.

But Dr. Nono Simelela, chief director of the health department's HIV/AIDS programme, said this month: "At present, there are no patients on AIDS medicines. The figures we gave for the end of March are not feasible because the plan was approved only in November." She could not say when the first patients would receive the drugs.

The health department's drug procurement team was planning to issue a request for proposals this month and then to develop specifics on drug procurement.

Health Minister Manto Tshabalala-Msimang said the staff needed to provide ARVs for HIV/AIDS patients were being recruited, and money for the ARV roll-out had been set aside. "Training guidelines have been developed and some provinces have started training" she said.

Deputy President Jacob Zuma has also defended the slow roll-out of the plan. He warned of the side-effects of anti-retroviral drugs.

"One of the factors that have been found in research is that casualties of people who are using these drugs without any scientific research are beginning to impact on the public sector. Because the side effects have not been monitored at all", he said.

Simelela said that the rollout plan recognized the role of traditional medicine in HIV care. The Ministry of Health is working with the country's Medical Research Council to research traditional medicines as HIV/AIDS treatments.

Kamy Chetty, acting director general of the Department of Health, said the plan includes prevention efforts, which "remain the cornerstone of fighting HIV and AIDS.

Tshabalala-Msimang said informing the public properly was "critical to the success of this programme". From this month, information leaflets and posters will be delivered, about R5 million has been set aside for radio and TV advertising, and R4 million is set aside for the procurement process and a further R6 million is budgeted for research.

Growth decline slowed

Without the AIDS prevention programme South Africa's growth rate in 2003/04 would have fallen half a percent lower than 1.9 percent, according to Treasury director-general Lesetja Kganyago.

According to the 2004 Budget Review, tabled by Finance Minister Trevor Manuel last month, growth in South Africa fell from 3.6 percent in 2002/03, to about 1.9 percent in 2003/04. Manuel announced that spending

on fighting AIDS would be boosted by R2.1 billion over the next three years. The bulk of this will go towards the cost of the provincially-administered ARV treatment programmes.

The additional spending will bring total spending on AIDS by the provinces and national government to R12.4 billion over three years.

POLICY/1

Full-scale treatment still out of reach of African budgets

The first funding commitments to the Global Fund in 2002 will allow a six-fold increase in the number of people in Africa receiving anti-retroviral therapy. But even so, and with much reduced ARV drug prices, the cost remains prohibitive.

For instance in Kenya, under the best-case scenario of ARV drugs at a dollar a day, treating a quarter of the cases would cost 6.3% of GNP, more than seven times current government spending on health.

But despite the prohibitive cost there should be strong government commitment to treatment programmes, says KY Amoako, CHGA chairman, who is also executive secretary of the UN Economic Commission for Africa. Without organized efforts by public health authorities 'antiretroviral anarchy' would develop, restricting availability of ARV drugs to the most privileged, and increasing diversion to 'black market' sales, with irrational prescriptions and consequent dissemination of resistant viral strains, he said.

Already the drop in the cost of ARVs has been dramatic, said Amoako. When ARVs were introduced in 1996, they were hugely expensive. Since then, the price has plummeted from between US\$10,000 - \$12,000 per person per year to between US\$600 - \$900 per year in most African countries. Although still beyond the reach of ordinary people, the general trend is for ARV prices to decline further.

The drop in prices was "a remarkable achievement" and the result of a complex process combining negotiations between the major pharmaceutical companies and the UN organization as well as governments, NGOs and competition from generic producers, he said. In particular he praised the "crucial" role of UNAIDS in achieving this remarkable turnaround.

The international climate of opinion has now shifted firmly in favor of sharply expanding HIV/AIDS treatment in Africa, he noted. The creation of the Global Fund to fight AIDS, Tuberculosis and Malaria was a significant indicator of this international commitment. He noted the involvement on the international scene of the Bill and Melinda Gates Foundation, US President Bush's initiative and the World Bank in putting extra resources into infrastructure to accelerate treatment.

Yet today in Kenya cost of the drugs would still soak up all of an average monthly income of \$30. So for scaling up to be successful, the price of anti-retroviral therapy (ART) and related interventions will need to come down further, to the level where African governments can budget for them in a sustainable manner, said Amoako.

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A simpler regime

There are other positive signs, one of which has been the emergence of simpler treatment regime: in 1998, the typical daily intake for an individual on anti-retrovirals was between six and 15 pills a day. Today, it can be as few as two or three a day.

At the same time there has been a simplification of the treatment protocols. 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 further improved and clarified, – such as pediatric treatment protocols, the usefulness of structured treatment interruptions, and the efficacy of immune boosters such as vitamins - the general 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.

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 World Health Organisation estimates that there are currently 50,000 people on antiretroviral therapy (ART) in Sub-Saharan Africa, a coverage of only 1%, whilst over 4 million people remain in need of immediate treatment on the continent.

Health professionals leave

One of the main constraints to developing treatment in Africa lies in the fall-off in health staff, said Amoako. "It is immediately imperative to stabilize and replenish the existing human resource base that provides health care in Africa" he said.

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 destabilising attrition rates is as yet poorly understood, but needs to be researched very clearly if ARV scaling up is to be effective on the continent, he said.

A further constraint lies in inadequate laboratory and patient care infrastructure.

Anti-retroviral therapy (ART) is a complex process which 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.

A recent Kenyan study showed 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.

Buying into the process

A further key element in moving treatment forward lies in fostering stakeholder buy-in said Amoako. Key to this was enabling and strengthening organisations of people

living with HIV/AIDS to own the issue, he said.

There needs to be strong government involvement for national ART programs and commitment on the part of national leadership and willingness to work with civil society organizations, he stressed.

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 maximize the risk of diversion to 'black market' sales, of irrational prescriptions and consequent dissemination of resistant viral strains.

POLICY/2

Keeping the public sector alive against HIV/AIDS onslaught

The public service and many government ministries in Africa may face collapse or be severely weakened as a result of HIV/AIDS mortality among their staffs. Yet no country has yet begun to address comprehensively the human resource planning issues raised and whether or not there is capacity to meet the needs for skills and training to replace those who die.

This is the conclusion of a new research paper from CHGA on the impact of the pandemic on African state capacities. It forecasts severe structural implications of HIV-related mortality on public services.

CHGA's work focuses on the challenges of governing a country where a large number of the population is living with HIV/AIDS. It focuses on maintaining essential public services, keeping economic development on track, maintaining rural livelihoods, mitigating the gender dimension of the epidemic, and ensuring national security.

Knock-on effects

HIV/AIDS's impact on the public service does not just relate to absenteeism. Death from HIV-related opportunistic infections usually occurs after a long period of illness and during this period, while the infected person is still considered as a staff of the sector, his/her work may either be left undone or may have to be done by other personnel in addition to their own work.

This is because, apart from the physical loss of the personnel who die, work output can seriously degenerate due to low morale as other personnel struggle to cope with the death of a colleague.

Mortality could result in the loss of experienced labour and low quality of work as inexperienced personnel step in earlier than would be normal in their careers to do the work of experienced staff.

Pressure on skilled staff for the public sector gets worse when, for example, the private sector begins to replace its lost labour from the public sector. This is already happening in the KwaZulu-Natal province in South

Africa where the private sector has started hiring teachers to replace staff lost to the AIDS epidemic.

In addition a new job market has been created by the UN, bilateral donors and NGOs who are recruiting staff specifically for HIV-related work. The public sector, and particularly the education sector, is believed to be the "poaching ground" for such recruitments.

The death of personnel in their prime is creating a pool of orphans who may be denied the quality education they would have received if their parents had been alive. This in turn could combine with the declining educational systems to reduce the number of qualified entrants to the public sector.

A number of studies have projected the future impact of the epidemic. In Swaziland, a survey of the education sector in 1999 predicted that from 2003 to 2011 there 13,000 teachers would need to be trained instead of 5,093, had there been no AIDS.

A survey in 2001 of Swaziland's Ministry of Finance, of Economic Planning and Development and of Public Service and Information showed that the three agencies will lose 32% of the work force to HIV/AIDS over the next 20 years and that will need to replace an additional 1.6% of the staff complement each year over the same period to maintain staffing levels.

A study on the impact of the epidemic on the public sector in Malawi showed that vacancy levels in government ministries had risen to as high as 58% in the Ministry of Education.

In Zambia, 30 percent of teachers are infected with the HIV virus. For the education system, HIV-related deaths in 2001 were equivalent to the loss of two-third of the annual output of newly trained teachers from all training institutions combined.

"We need to understand the deeper implications of the pandemic for the continual survival of African economies", say the CHGA researchers.

However, there remain major gaps in current knowledge and understanding what is actually happening. There is very little understanding in all countries about the distribution of the epidemic in terms of its impact on skills and experience across all major sectors, they say.

The challenge for CHGA is to provide the data, clarify the nature of the choices facing African governments today, and help consolidate the design and implementation of policies and programmes

The Commission will identify gaps in effective planning and responses to HIV/AIDS and provide information on its wider impacts., it says.

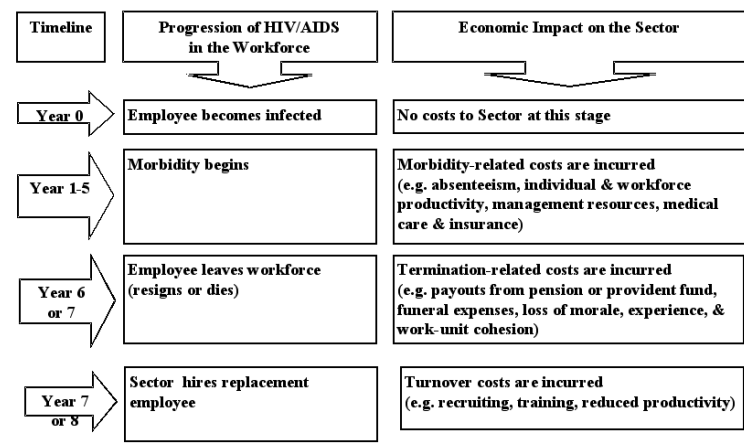
ADVOCACY

CHGA will be 'activist'

CHGA is going to be an 'activist' Commission engaging with policy makers and other stakeholders involved in the fight against HIV/AIDS in Africa.

Its core challenge is to get African policymakers to

Public sector costs



A stylised illustration of the progressive impact of HIV/AIDS on costs in a sector. Suppose, for example, a staff member is infected at year zero, there is no cost to the sector at this stage as the effects on the individual are not evident to the activities of the sector. From one to five years, as the infection begins to affect the health of the staff, absenteeism to seek medical care sets in, resulting in the reduction in productivity or increase in work load of other workers. The cost to the sector at this point could include medical care, insurance and the hiring of extra labour to avoid reduced productivity. By the sixth and seventh years, when the infected employee decides to resign or dies, the cost to the sector could include termination costs such as pension, provident fund, funeral expenses and any other retirement and/or termination benefits. Other costs which cannot be quantified include loss of morale, experience and work cohesion. From the seventh year onwards, the sector may have to meet turnover costs such as recruitment, training and other costs incurred to avoid decreased productivity (e.g. through the use of consultants).

"fully grasp the longer term development challenges posed by HIV/AIDS to their societies", KY Amoako, CHGA's chairman, told an Irish audience last month. He was addressing an audience at the Development Studies Centre in Dublin – he said it was an "opportune" occasion because Ireland is now president of the European Union and is shaping EU policy on poverty reduction in the developing world.

There are three core elements to CHGA, he said:

- Exploring how HIV/AIDS devastates and reshapes families, households and communities;
- Advancing treatment programmes and examining their funding, their policy challenges and decentralized access to treatment;
- Examining funding issues from donor ceilings to disbursement problems.

Leadership call

But CHGA had to go beyond a technical exercise in research and analysis to engage with policymakers. Amoako said leadership at the personal, community and international levels was "absolutely necessary".

But to secure this leadership a better understanding was needed of how HIV/AIDS is undermining state-society structures in Africa.

For instance, the ramifications of mortality among senior government officials and its implications for the delivery of public services, economic development and

national security needed to be understood.

Governments need to rethink their growth and development strategies taking HIV/AIDS into account, he said. African policymakers needed to be provided with the tools to understand and respond to the governance and development implications.

HIV/AIDS now looms larger than all the other development challenges said Amoako and Africa was struggling to maintain its limited capacity.

The worst of the pandemic's impact on societies and economies still lies ahead because HIV/AIDS brings together many factors in a particularly devastating combination.

- It kills people in the prime of their working lives;
- It has a tremendous impact on agricultural activity;
- It has generated a rising population of orphans –

"Providing care, basic social services and security for this group is one of the core challenges for Africa" said Amoako.

- It is hitting an increasing proportion of women.
- It is increasingly hitting the private sector, raising labour costs.

But, said Amoako, "if our leaders continue to make strong and genuine efforts in this direction the socio-economic devastation that the pandemic causes can be averted".

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:

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

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PEOPLE

South Africa:

Tutu stirs condom controversy

South Africa's Anglican church has been seeking to reassure its Catholic brethren in the wake of Archbishop **Desmond Tutu's** criticism of the Catholic stand on condoms. Tutu used an international AIDS conference in Dublin last month to speak out against Catholic disapproval of condoms as a way of preventing the spread of AIDS. He said the idea that promoting condoms caused promiscuity was totally untrue.

The Southern African Catholic Bishops' Conference's AIDS office said it was "dismayed" at his criticism, and that by focusing on promiscuity, Tutu had failed to note the "wider positive and negative ramifications around the use of condoms". Archbishop **Njongonkulu Ndungane**, head of the Anglican Church in Southern Africa, commented: "We, as Anglicans, believe that the morality of condom use is for the preservation of life. However we must remember that different churches and organisations lay emphasis on different areas in responding to this pandemic."

In 2001 the Catholic Bishop of Rustenburg in South Africa, **Kevin Dowling**, urged that condoms should be promoted as a tool in the fight against AIDS. He was slapped down by the SACBC, who declared condoms were "an immoral and misguided weapon in our battle against HIV/AIDS".

South Africa:

Mandela and others slam stigma

Former South African President **Nelson Mandela** has again hit out at the stigma surrounding AIDS. On a recent visit to Limpopo Province in the north of the country he asked to visit a group of orphans. "At the time community members were singing revolutionary songs and they accompanied me to the hut.

"I went inside the house and stayed with the children for about 30 minutes. When I got out, all the people who accompanied me did not walk beside me anymore. They walked fast. I also walked fast to reach them and I could see they were running away from me because I went to speak to this children. They also stopped singing the revolutionary songs." Mandela concluded: "We must fight the stigma."

Meanwhile in Malawi President **Bakili Muluzi** has disclosed that his brother Dickson died of AIDS, also striking a blow against the secrecy and stigma attached to the disease. Muluzi emphasised the need for Malawians to go for voluntary HIV/AIDS testing. Only about three percent of the population of 11 million has so far been tested.

And in Lesotho Prime Minister **Pakalitha Mosisili** had a public HIV test and called on other African leaders to do the same to reduce AIDS stigma.



Muluzi: Call for HIV testing

Ethiopia:

First feature film on AIDS

Ethiopia's fledgling film industry is turning its attention to fighting the HIV/AIDS virus. The documentary film-maker **Kidane Yilak** said he felt compelled to make the country's first-ever film addressing the stigma and discrimination prompted by the virus, and the threat posed by HIV/AIDS, which has infected an estimated 2.2 million people in Ethiopia.

Zimbabwe:

Pressing hard for treatment

Scheduled for PATAM's third annual conference in Harare, Zimbabwe, this month were **Zackie Achmat** of the Treatment Action Campaign (TAC) of South Africa, and CHGA commissioner **Milly Katana**, lobbying and advocacy officer of the Health Rights Action Group in Uganda, both among PATAM'S founders. PATAM - the Pan-African Treatment Access Movement - was set up in August 2002 to mobilise communities, political leaders and all sectors of society for access to anti-retroviral therapy, as a fundamental part of comprehensive care for all people living with HIV and AIDS in Africa.

"We know ARV treatment is feasible in our countries and are launching a movement that won't take no for an answer", said Katana.



Katana: ARV action

MONITOR

International:

Global Fund seeks 'ambitious' proposals

The Geneva-based Global Fund to Fight AIDS, Tuberculosis and Malaria has called on governments and NGOs to put forward bold project proposals that stress HIV treatment for its new funding round.

The previous three funding rounds revealed what the Global Fund's Technical Review Panel called "shyness" in requesting funding to scale up treatment. The Global Fund has US\$900 million in this round and is likely to grow to around \$1 billion.

"We particularly want ambitious proposals for programmes that involve antiretroviral treatment," said Christoph Benn, the Fund's director of external affairs at the Pan-African Treatment Access Movement (PATAM) conference in Harare, Zimbabwe, this month.

The US-based Health GAP (Global Access Project) said it was critical that the Country Coordinating Mechanisms (CCMs) submitted proposals for Round 4 that were ambitious, technically sound and prioritised the scaling-up of access to treatment if the World Health Organisation's goal of three million people on ARVs by 2005 was to be realised.

PATAM brought AIDS activists from across Africa to Harare to discuss how to scale up access to ARVs in Southern Africa.

CCMs - which coordinate proposals sent to the Fund - came under fire at the three-day meeting, where delegates accused some CCMs of suggesting proposals be "less aggressive" and "more modest in terms of funding requests", as well as paying lip-service to the participation of people living with HIV/AIDS.

Region:

Direct funding of NGOs threatened

UNAIDS this month endorsed a proposal that would prevent funding from going directly to non-governmental agencies in some African countries.

Officials from Zambia and Zimbabwe - backed by Lesotho, Swaziland, Botswana and Namibia - said that funding no longer should be channelled through NGOs because the organizations lack accountability. The funding will instead be channelled through each government's central AIDS authority.

NGOs responded that the move would hurt the fight against HIV/AIDS, saying there was too much bureaucracy in government institutions.

Koichiro Matsuura, director general of the UN Educational, Scientific and Cultural Organization (Unesco), which is the current chair of UNAIDS, endorsed the move after a two-day conference on accelerating the fight against AIDS in Africa.

Nigeria:

Compendium of stakeholders

A compendium of all stakeholders working on HIV/AIDS/STIs in Nigeria is being compiled by the Nigerian Institute of Medical Research, Yaba.

Since the first case of AIDS was diagnosed in Nigeria in 1986 programmes have been initiated all over the country by a wide array of stakeholders, from government through developmental and funding partners/agencies, local and international NGOs, private sector establishments, to faith-based organisations.

But there has been neither documentation nor coordination of the activities at state or national level. Similar and parallel programmes are in operation across the country and there is a lack of collaboration amongst the stakeholders. There has also been inequity in the use of the scarce resources, say the organisers.

A questionnaire has been sent to as many stakeholders as can be reached in the country. The contact email address is: infor_nimr@yahoo.com

Zambia:

Drug-resistant strains appear

Zambian health officials are warning of the presence of drug-resistant strains of the HIV virus in their country because of loopholes in the state's ARV treatment programme.

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.

With an HIV prevalence rate estimated at 21.6% in 2001, the demand for treatment in Zambia is great. In 2003, Zambia initiated a programme to supply ARVs for up to 10,000 people living with HIV/AIDS through the public health service. However, 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.

Few receive adequate follow-up and counseling, and this adds to the risk of poor adherence and development of resistance.

International:

Key protein found in monkeys

Researchers have identified a protein able to block the replication of the HIV virus in monkeys, a key discovery that sheds light on mechanism that could halt the spread of AIDS among humans.

Humans have a similar protein, but it is not as effective at stopping HIV, according to the researchers, whose work is published in the journal *Nature*.

Nevertheless the identification "of this HIV-blocking factor opens new avenues for intervening in the early stage of HIV infection, before the virus can gain a foothold," said National Institute of Allergy and Infectious Disease Director Anthony Fauci.

The research was carried out at the Dana-Farber Cancer Institute by a team headed by Joseph Sodroski and supported by the US National Institute of Health's NIAID.

Djibouti:

First free ARVs

Some 40 HIV-positive people this month began to receive free anti-retrovirals (ARVs) after Health Minister Muhammad Ali Kamil launched Djibouti's first distribution of ARV medication at Peltier Hospital, the country's main medical centre.

At least 8,000 people have been found to be HIV-positive, while an estimated 10,000 others are HIV-positive and do not know it, he said at the launch. National health authorities estimate that the HIV prevalence rate country-wide is about three percent of a total population of some 600,000.

Several factors have contributed to the spread of the virus, including the high population concentration in the capital, and an illiteracy rate of 49 percent.

Djibouti also hosts a significant number of military bases, which has encouraged the proliferation of bars and nightclubs, the authorities say. There are also thousands of refugees fleeing conflict throughout the Horn of Africa.

The large-scale arrival of transporters from Ethiopia since May 1998, when Addis Ababa switched seaport because of its conflict with Eritrea, has also contributed to the spread of HIV.

Rwanda:

Vaccine trials to begin

Some 45 Rwandan volunteers are to take part in 10-month long trials for a new HIV/AIDS vaccine. The trials, conducted by a US-based San Francisco project in conjunction with the International AIDS Vaccine Initiative, are due to begin before the end of March in the Rwandan capital, Kigali.

Rwanda's HIV infection rate is high, estimated at 13 percent in urban areas and 5 percent in rural areas. Between 10 percent and 13 percent of Rwanda's 8.1 million people are HIV positive.

The trials are intended to explore the volunteers' immunity, monitor the adverse effects of the vaccine and analyse the kind of antibodies that are produced, government officials said.

Since the introduction of anti-retrovirals (ARVs) in Rwanda four years ago, the prices for the drugs have dropped from US \$727 to \$27 per dose. However, only a small portion of HIV/AIDS patients has access to ARVs.

Rwanda is still waiting for money from the HIV/AIDS Global Fund in order to further reduce ARV prices to at least less than a dollar a day for a patient, reports the UN news agency IRIN.