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SPEECH

OPENING ADDRESS BY THE MINISTER OF HEALTH, HON. DR. BRIAN CHITUWO MP. DURING THE REGIONAL WORKSHOP ON HIV/AIDS IN SOUTHERN AFRICA (20TH TO 21ST MARCH 2002.)

- MR. CHAIRMAN
- HIS EXCELLENCY, THE JAPANESE AMBASSADOR TO ZAMBIA - MR. SAOTOME
- THE JICA SPECIAL ADVISER - MR. ABE
- THE PERMANENT SECRETARY IN MY MINISTRY - DR. SILWAMBA
- THE ACTING DIRECTOR GENERAL OF CENTRAL BOARD OF HEALTH- DR. MITI
- DIRECTOR GENERAL NATIONAL AIDS COUNCIL - DR. BOLLA
- INVITED DELEGATES FROM THE SADC REGION
- DISTINGUISHED GUESTS
- LADIES AND GENTLEMEN

IT GIVES ME THE GREATEST PLEASURE TO JOIN YOU ALL THIS MORNING, FOR THIS OFFICIAL OPENING OF YOUR VERY IMPORTANT WORKSHOP ON 'COMBATING HIV/AIDS IN SOUTHERN AFRICA'

I WANT TO START WITH A VERY WARM WELCOME TO YOU ALL TO THIS WORKSHOP AND A SPECIAL WORD OF WELCOME TO THE VISITORS TO THE REPUBLIC OF ZAMBIA. WE CAN SEE CLEARLY, FROM THE LARGE NUMBER OF DELEGATES FROM SADC AND BEYOND INCLUDING REPRESENTATIVES OF NGO'S, THAT THIS ISSUE IS BEING TAKEN WITH THE SERIOUSNESS THAT IT DESERVES.

WE ARE HONOURED TO BE HOSTING THIS WORKSHOP AND WE HOPE THAT YOUR TIME HERE WITH US WILL BE ENJOYABLE AND PRODUCTIVE.

LET ME ALSO EXPRESS MY GOVERNMENT'S GRATITUDE FOR THE WARM HOSPITALITY THAT ZAMBIA'S DELEGATION RECEIVED AT THE OKINAWA G-8 SUMMIT WHICH OUR FORMER PRESIDENT DR. CHILUBA ATTENDED. I AM SURE THAT TODAY'S REGIONAL WORKSHOP HAS COME ABOUT AS A FRUIT OF THAT SUMMIT.

THE SUBJECT MATTER FOR THIS WORKSHOP ALSO FEATURED PROMINENTLY WHEN JAPAN'S HIGH LEVEL POLICY MISSION VISITED ZAMBIA IN 2000. THE COMBATING OF HIV/AIDS HAS GRADUATED FROM BEING A BILATERAL TO A REGIONAL ISSUE UNDER ZAMBIA/JAPAN COOPERATION ACTIVITIES.

I AM GLAD TO INFORM YOU THAT ZAMBIA HAS DECIDED TO TAKE AN AFFIRMATIVE ACTION BY ENSURING THE CREATION OF A MULTI SECTORAL HIV/AIDS/STD AND TB COUNCIL WHOSE DIRECTOR DR. BOLLA WILL BE BRIEFING YOU THIS MORNING.

WE HAVE WATCHED WITH PLEASURE HOW JICA'S COOPERATION HAS SPREAD THROUGHOUT THE COUNTRY, BOTH IN URBAN AND RURAL COMMUNITIES AND NOW PLAYS A VITAL ROLE IN THE DEVELOPMENT OF OUR COUNTRY.

AT THE BILATERAL LEVEL, MY GOVERNMENT IS GRATEFUL THAT THE JAPANESE GOVERNMENT THROUGH JICA CONDUCTED RESEARCH ACTIVITIES IN SUPPORT FOR BUILDING LABORATORY CAPACITY IN HIV/AIDS AND TB CONTROL IN ZAMBIA. TO THIS EFFECT, UTH HAS BEEN IDENTIFIED AS A CENTRE FOR SOUTH TO SOUTH COOPERATION ON INFECTIOUS DISEASES CONTROL IN AFRICA.

MY GOVERNMENT IS ALSO GRATEFUL TO THE JAPANESE GOVERNMENT FOR SUPPORTING THE ZAMBIA HIV/AIDS BORDER INITIATIVE, WHICH IS BEING IMPLEMENTED IN CONJUNCTION WITH THE WORLD VISION INTERNATIONAL. THIS MR. CHAIRMAN, IS A VERY IMPORTANT INTERVENTION AS EVIDENCED BY STUDIES THAT SHOW THAT TRUCK DRIVERS AND OTHER CROSS BORDER TRADERS WERE AMONG THE HIV HIGH RISK GROUPS. ZAMBIA IS READY TO SHARE THE EXPERIENCES GAINED SO FAR AND I AM SURE THIS INITIATIVE COULD BE REPLICATED IN THE SUB-REGION.

LADIES AND GENTLEMEN I WISH TO REITERATE MY GOVERNMENT'S COMMITMENT TO WORK CLOSELY WITH NON-GOVERNMENTAL ORGANISATIONS, SOME OF WHICH HAVE DONE COMMENDABLE WORK IN ZAMBIA, SUCH AS IN THE DRIVE FOR BEHAVIORAL CHANGE AND HOME BASED CARE. HOWEVER, THERE IS NEED FOR CLOSE SUPERVISION FOR SOME OF THEM TO ENSURE THAT THE RESOURCES PROVIDED BY THE DONORS REACH THE VULNERABLE BENEFICIARIES IN THE RESPECTIVE COMMUNITIES.

THE NEED FOR INTERNATIONAL AND REGIONAL SUPPORT FOR HIV/AIDS PROGRAMMES CANNOT BE OVER EMPHASIED. THE ZAMBIAN GOVERNMENT THEREFORE, RECOGNIZES AND APPRECIATES THE ACTIVITIES UNDER THE ON-GOING GLOBAL INITIATIVE THROUGH THE USA AND UN AGENCIES. THESE ACTIVITIES MR. CHAIRMAN, HAVE RENDERED SUPPORT TO HIV CONTROL, REPRODUCTIVE HEALTH, CHILD HEALTH, AND IN THE GENERAL STRENGTHENING OF HEALTH SYSTEMS.

I KNOW THAT THIS MEETING WILL BE GETTING INTO DETAILS OF STRATEGIES AND MECHANISMS IN THE FIGHT AGAINST THE EPIDEMIC BUT I SINCERELY BELIEVE THAT THE SUCCESS OF OUR BATTLE WILL BE ACHIEVED IF WE CAN JUST ACCEPT THE PRINCIPLE THAT REGIONAL INITIATIVES IF COORDINATED WELL COULD MITIGATE THE IMPACT OF HIV/AIDS AMONG OUR PEOPLE.

FINALLY MR. CHAIRMAN, I CALL UPON THE INTERNATIONAL COMMUNITY TO SUPPORT THE IDEA OF UTILIZING THE EXCELLENT NETWORK AVAILABLE IN THE REGION TO SUPPORT NATIONAL HIV/AIDS STRATEGIES AND TO PROVIDE THEM WITH RESOURCES AND NECESSARY SKILLS TO MAKE A REAL CONTRIBUTION TOWARDS THE EPIDEMIC WHIH IS THE HIGHEST SOCIAL PRIORITY FOR ANY COUNTRY IN SOUTHERN AFRICA.

LET US THEREFORE WORK TOGETHER TO OVERCOME THIS THREAT TO ALL THE MILESTONES THAT WE HAVE GAINED AND TO HELP OUR PEOPLE FACE THE GREATEST CHALLENGE IN MODERN TIMES. LET ME END BY THANKING THOSE ORGANISATIONS WHO HAVE PLAYED KEY ROLES IN MAKING THIS MEETING A REALITY. I OWE A DEBT OF GRATITUDE TO THE JAPANESE GOVERNMENT AND ZAMBIAN GOVERNMENT AND INDEED OTHER COOPERATING PARTNERS.

IT IS NOW MY HONOUR LADIES AND GENTLEMEN TO DECLARE THIS WORKSHOP OFFICIALLY OPEN AND WISH YOU SUCCESSFUL DELIBERATIONS.

MAY THE ALMIGHTY GOD BLESS YOU.

REMARKS BY HIS EXCELLENCY MR. MITSUHIRO SAOTOME, AMBASSADOR OF JAPAN TO ZAMBIA ON THE OCCASION OF THE OFFICIAL OPENING OF THE REGIONAL WORKSHOP ON HIV/AIDS IN SOUTHERN AFRICA ON 20TH MARCH, 2002 IN LUSAKA, ZAMBIA

Honourable Dr. Brian Chituwo, M.P. Minister of Health,

Distinguished Workshop participants,

Ladies and gentlemen.

May I take this opportunity to congratulate you on your appointment as Minister of Health and to congratulate Honourable George Chulumanda, MP on his appointment as Deputy Minister of Health in the New Deal government of His Excellency the President Mr. Levy Patrick Mwanawasa, S.C. I eagerly look forward to enhanced and effective mutual cooperation in our development efforts particularly in the health sector.

On behalf of the Government of Japan, I have the honour and privilege to welcome you all to this Regional Workshop on HIV/AIDS in Southern Africa being jointly hosted by the Government of Japan and the Government of the Republic of Zambia.

I would like to express my sincere gratitude to all of you for kindly accepting our invitation to participate in the exchange of views on how best we can streamline and enhance cooperation in the various interventions being undertaken to reduce the spread and impact of HIV/AIDS in the SADC region.

Let me reiterate that this workshop is being held within the context of Japan's continued search for a world free from war, poverty, starvation and infectious diseases. In order to achieve these objectives, my government looks forward to

the continued strengthening of the warm and cordial relations that exist between Japan and the SADC member states.

The Government of Japan considers it an obligation to extend economic assistance to developing countries including the geographically distant countries of Southern Africa. This decision stems from the resolve to appreciate the role played by the international community in placing Japan where it is today. You will recall that after the Second World War, Japan was completely devastated but managed to rise to the position where it is today, because of the support it received from the international community. Therefore, although Southern Africa is geographically very far away from Japan, Japan feels duty-bound to extend development assistance to African countries to empower them into taking full control of their destiny. This firm determination by the people of Japan to deepen and broaden the relations between Japan and Africa was re-iterated by the former Prime Minister Yoshiro Mori when he visited some African countries.

In a policy speech delivered in Johannesburg, Mr. Mori stated that the Government of Japan wanted to build on the accomplishments of the first two phases of the Tokyo International Conference on African Development (TICAD).

Ladies and gentlemen, TICAD constitutes the framework within which Japan co-ordinates development aid to Africa. A regional TICAD meeting was held in Lusaka to map out specific concerns that need to be addressed in order to enhance development in Southern Africa.

The Government of Japan is glad to note the positive progress made since TICAD II and has since endorsed the New Partnership for African Development (NEPAD), an initiative conceived and launched by African governments. This is

an achievement that has been envisioned in the TICAD process as the framework of African endeavour based on African ownership and global partnership.

Regarding the theme of this workshop, you will recall that HIV/AIDS was one of the leading themes during the G8 Kyushu-Okinawa Summit meeting held in July, 2000. The Summit agreed to accelerate international efforts to fight infectious diseases especially HIV/AIDS, setting specific targes for reducing the number of the victims they claim.

On the basis of the agreement reached between the Government of Japan and the Government of the Republic of Zambia during the visit of the High Level Policy Mission to Zambia, the health sector, especially the issue of HIV/AIDS, was identified as one of the priority areas for cooperation.

The promotion of regional cooperation activities was also rated highly, hence the need for this workshop to come up with concrete and practical recommendations on how countries in the region can work together most efficiently and effectively in combatting HIV/AIDS across SADC borders.

Finally, I wish to re-iterate that the Government of Japan will continue to support efforts directed at combatting HIV/AIDS being undertaken by the governments and the people of the sub-region within the available resources and within both multilateral and bilateral frameworks.

I wish you successful and fruitful deliberations.

Than you.

Southern Africa HIV/AIDS Regional Workshop

The Honable, Dr. Chituwo, the Zambian Minister of Health

His Excellency, Mr. Misuhiro Saotome, Japanese Ambassador to Zambia

His Excellency, Dr. Silwamba, Permanent Secretary, The Zambian Ministry of Health

Distinguish Guests

Ladies and Gentlemen

On behalf of the Japan International Cooperation Agency (JICA), I would like to say our concept on HIV/AIDS before the start of the workshop.

As can be seen by examining JICA's technical cooperation, grant aid and the Japan Overseas Cooperation Volunteer (JOCV), HIV/AIDS is a high priority sector and it has been focusing its efforts on southern Africa in response to the region's urgent needs. Therefore, this workshop is a very important in which JICA expects the strong intension of participants will be shown through the presentation and discussions of the actual countermeasures. These will be reflected upon drafting the short and medium term of budgetary framework combating in HIV/AIDS of JICA.

As the Vice-President of JICA in charge of overseeing medical cooperation and the activities of JOCV until last year, I've been deeply involved in the planning of policies related to HIV/AIDS. I also participated as a member of the Japanese government delegation to the Special Session of the General Assembly on HIV/AIDS that was held in June in New York. It is because of these experiences that I feel great pleasure in being able to give this address at today's opening ceremony.

1. talk about two topics in the presentation. First, I would like to introduce two examples of JICA projects that have been implemented in the HIV/AIDS sector. And secondly, I would like to say JICA's basic concept and policy on HIV/AIDS.

2. JICA initially began its cooperation activities on HIV/AIDS a few years after the first case of AIDS was reported in 1981. JICA's first HIV/AIDS project was the Project at the Noguchi Memorial Institute for Medical Research in Ghana, which provided cooperation in serological diagnosis and seroepidemiologic research. It was in 1986.

3. Since then, JICA has implemented technical cooperation projects in Kenya, Zambia,

Thailand, the Philippines, and other countries in Africa and Asia. These involve 1) basic research in virology, epidemiology, immunology, bacteriology, parasitology, nutrition, and other fields, 2) development of diagnostic and blood testing capabilities, and 3) education, information and communication programs.

4. Here, I willingly mention to a JICA project that is presently being carried out at the University Teaching Hospital (or UTH) of the University of Zambia. The original purpose of this project, which started in 1980, was to provide assistance for the pediatric and neonate surgery departments at UTH. But due to critical socio-economic impediments brought on by the spread of AIDS, an urgent challenge became needed, and in 1989 the scope of the project initially began with establishing diagnostic methods in viral infectious diseases and pathological analysis, but with the expanded research in virology, bacteriology, and epidemiology, the objects of project was also extended to involve the establishment of a laboratory for bacterial testing and to strengthen the diagnostic system. This laboratory was approved as one of WHO referral laboratories for infectious disease tests, and that it has evolved into a high quality laboratory that gives testing services not only for Zambia but for neighboring countries as well. Following to these it was decided in negotiations between JICA and the Zambia Authorities concerned that UTH would be used in a new five-year project aimed at expediting activities against HIV/AIDS and tuberculosis. The goals of this new project extend to qualify improvement of regional voluntary counseling and testing (VCT) sites that will be set up nationwide by the Zambian HIV/AIDS council of Government. Efforts will not be restricted to government institutions, but will also provided for surveillance activities conducted by the Zambian Family Planning Association, one of the most respective NGOs in Zambia. As you may know most of JICA's cooperation has focused on dispatching Japanese experts and JOCV volunteers as well as setting up training programs in Japan for counterpart's experts and engineers of developing countries. In conjunction with providing cooperation to foster human resources, supply of equipment that are a part of the support activities of the Japanese experts and JOCV members are also being implemented.

5. Equipment supply program will be explained in the course of implementation of WHO Viral Laboratory network program, which has been composed by 16 laboratories of 15

countries such as Kenya, Uganda, Tanzania, Zambia, Zimbabwe, South Africa, and the Democratic Republic of Congo. Up to now, JICA has provided equipments for 7 laboratories of these 15 countries, and these have gained a high reputation among those African countries that do not have such facilities.

6. Another effective example of equipment supply program of JICA will come out on polio eradication. It is a well known fact declaration of eradicate wild polio in south and north America and the Caribbean, and the regions of East Asia and Oceania is exemplary of collaboration undertaken with the Japanese Government and JICA, WHO, UNICEF, NGOs, and the respective governments, in which Japanese side provided vaccine, cold chains, and vehicles for NID. I believe that working in collaboration with international institutions and NGOs enables limited human resources and budgets to be effectively utilized to counter infectious diseases, and especially HIV/AIDS, in African countries. This is the reason why I mention to special equipment supply program.

7. Next, I would like to introduce Japanese cooperation that has been undertaken in Thailand. The number of people infected with HIV/AIDS rose sharply in the latter half of the 1980s, and this strongly affected to Thai economy. Especially revenue generating tourism industry has been influenced by it. The Thai Government designated the spread to AIDS as one of the national grave issue. Using the functions of the National Institute of Health (NIH), which was built under the Japanese Government grant aid program, JICA started an infectious disease prevention project in 1993 to strengthen it's analytical and research capabilities in HIV/AIDS, to develop educational materials, and to conduct extension activities. Following to the project's success in the research works, a new goal to improve the basic research capabilities to develop vaccines was established in 1998. This was in conjunction with model project that focused on the care of HIV/AIDS affected people and infectious diseases prevention in the northern and rural communities of Thailand, which have a high number of infected people, as well as urban areas. The regional development of AIDS prevention and care in the rural area has served to consolidate the surveillance system by promoting the network of research centers and demonstrated that Thai government's strong determination have been pursued full-scale as a national level. As a result, the numbers of infections have remarkably decreased. This underscores the importance of pursuing AIDS countermeasures as a national

undertaking. In addition to these, there are many domestic and international NGOs that care HIV/AIDS affected people. JICA has secured a new budget, namely community empowerment budget and partnership budget to help cover development costs and has begun to assist the local activities of NGOs. These new development budgets will consolidate the collaboration with JICA and NGOs. These development promoted the shift of JICA's activities from the urban to rural communities due to the cumulative effect of past achievements, and the transition from cooperation focused strictly on government institutions to that targeting NGOs and civil society.

8. Secondly, I would like to tell JICA's overall concept on HIV/AIDS. As stated in the Okinawa Infectious Diseases Initiative, the problem of infectious diseases including HIV/AIDS does not only impede the economic development of developing countries, but also affect the advanced countries as well. W e must recognize the fact that this global problem must be resolved with cooperation and participation of the entire international community, international institutions, as well as each respective government and civil society.

9. JICA's principles are based on these fundamental concepts, and the following activities have been given priority. It is estimated that there are nearly 40 million people throughout the world who are infected with HIV. To stop infection from spreading further, priority must be given to coordination in prevention and its supporting activities, surveillance. And in countries where infection is already widespread, there is an urgent need to establish support systems for care and treatment.

10. First, I'd like to emphasize prevention activities. Among those activities for prevention, the first priority should be given to projects that strengthen voluntary counseling and testing (VCT) for all and education and knowledge programs not only for adults, but for the young as well. The idea of prioritizing strategy targeting your people has been established in projects implemented in Turkey and Tunisia. Simultaneously, to effectively utilize limited resources, cooperation that promotes HIV/AIDS information, education and communication activities (IEC), school education, pure education, VCT extension, and other ways must be borderless rather than confined to one country. Above these, projects in Kenya and Tanzania have proven that improving facilities of

screening of blood transfusions are very effective prevention measures despite fixed conditions.

11. Surveillance activities help us to monitor the spread of it and it is an important source of basic data for prevention. Hence cooperation for surveillance will be aimed at strengthening measures to develop human resources at research institutions and laboratories.

12. Secondly, we should put a priority on care. Health care services for the infected and their families as well as psychological, social economic, and other diverse forms of assistance are needed. There are many issued stemming from economic conditions that must be resolved in African countries, including the creation of a social security system and the establishment of health posts. In particular, we must have intense concern for children infected with AIDS. These include health care services, housing, food, and education, and if we consider the future of these issues are first and foremost on the list of items that we must tackle. It is difficult for one organization to assure the burden of providing all forms of assistance. Coordination and partnership will be expected to provide effective way for care. In addition, it is extremely important to improve the quality and access to basic health and medical care services when implementing projects against HIV/AIDS. Despite improvements in research and laboratory capabilities, if health administration has not been established or strengthened, many will be left deprived. Institution building and capacity building for administration are most needed for its operation of care services.

13. After the World War II, infectious diseases were widespread in Japan due to inferior health and sanitation conditions stemming from the loss of the country's socio-economic resources and infrastructures. Under the guidance of regional public health centers, local residents and organizations took the lead in securing safe drinking water, installing toilets and sewerage facilities, eradicating flies and mosquitoes, improving nutritional intake, improving knowledge of health sanitation, and others. This was followed by the development of social infrastructures by the national and regional governments and the provision of a health care system for vaccinations and examinations for pregnant women. As a result, Japan has achieved a history of overcoming and eradicating infectious disease

including malaria, schistosomiasis, filariasis, poliomyelitis and intestinal helminthiases within a surprisingly short period of time.

14. In conclusion, at the Kyushu-Okinawa Economic Summit meeting held in 2000, which Japan chaired, the Okinawa Infectious Initiative was announced in which it was promised that infectious disease control would be actively pursued using resources of official developing assistance (ODA) by donors. However, this has been used under some conditions. HIV/AIDS must not be viewed simply as a health care problem. Instead, it must become one of national policies for development program, which most of countries have already drafted. In this conduct, the government must be prepared to intensively invest needed capital and human resources with ownership. Since on the occasion of UNGASS, the UN is saying that "Noting with great concern that Africa, in particular, sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent action", ownership by each government is one of the most required conditions against HIV/AIDS.

15. In July 1999, the Council of Ministers of OAU in Algiers approved a resolution endorsing the International Partnership against AIDS in Africa (IPPA) and in April 2001 in Abuja, Heads of African States or Government pledged to set a target of allocating at lease 15 percent of their annual national budgets for the improvement of the health sector to help address the HIV/AIDS epidemic. This acknowledgement and strong commitment in combating HIV/AIDS will be discussed at the next World Economic Summit in July and the Environment Summit in August and these will be continued issue again at the next year's meeting of TICAD III if held. We do hope that this special workshop is the first step towards these occasions.

16. It is my hope that all of you will share with us your own experiences and perspectives at this workshop, and that fruitful discussions will result. And I thank you for your attention.

Japan's Initiatives for Infectious Diseases Control

YASUHIDE NAKAMURA

Research Center for Civil Society
Graduate School of Human Sciences
Osaka University

Japan's experience as a developing country

- High prevalence of infectious diseases
- High infant mortality rate
- Strengthening health care delivery system both in rural and urban areas
- People's efforts against infectious diseases through formal and informal collaboration

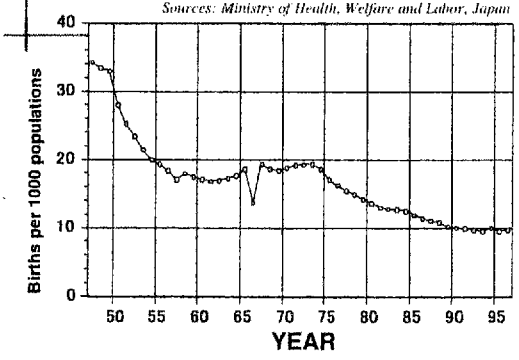
The Number of Patients with infectious diseases in Japan

YEAR	1950	1997
Tuberculosis	528,829	42,472
Trachoma	156,248	0
Whooping Cough	122,796	42
Dysentery	49,780	1,301
Diphtheria	12,621	1
Japanese Encephalitis	5,196	6
Typhoid fever	4,883	79
Polio	3,212	0
Malaria	1,016	69
Population	83,199,637	126,166,000

Sources: Ministry of Health, Welfare and Labor, Japan

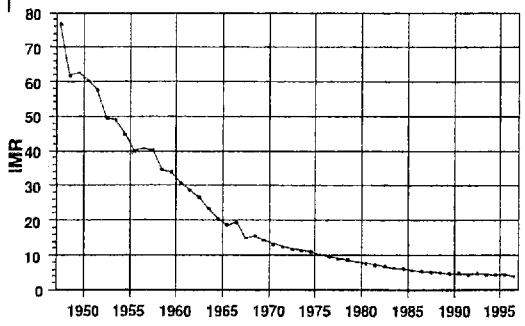
Birth Rate in Japan

Sources: Ministry of Health, Welfare and Labor, Japan

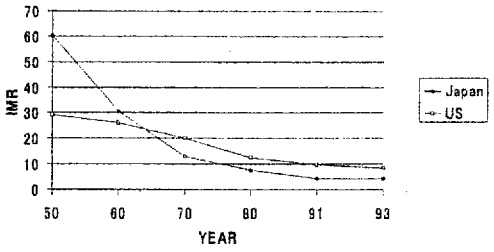


Infant Mortality Rates in Japan

Sources: Ministry of Health, Welfare and Labor, Japan



IMR in Japan and the United States



Sources: U.S. Department of Health and Human Services
Ministry of Health, Welfare and Labor, Japan

Possible Explanations for Japan's Low Infant Mortality Rate

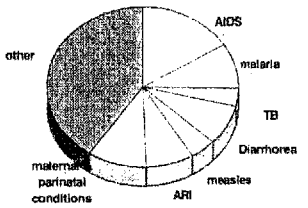
1 Narrow socio-economic distribution
2 National health insurance
3 Maternal and Child Health Handbook
4 Population-based screening and health check-ups
5 High value placed on childbearing

Source: Health and welfare for families in the 21st century, by Kiely M, Wallace HM, Nakamura Y et.al., Jones and Bartlett Pub., 1999

source: World Health Organization

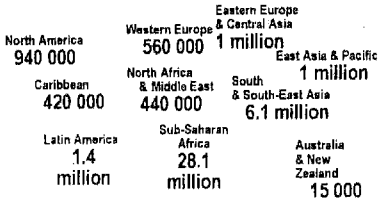
Most deaths among young people in developing countries are caused by just a few illnesses

Ages 0 - 4 in South-East Asia and Africa



World Health Organization

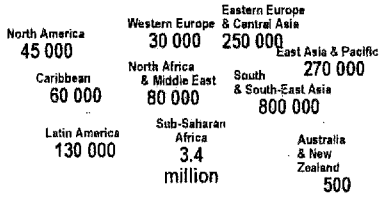
Adults and children estimated to be living with HIV/AIDS as of end 2001



Total: 40 million

Sources: WHO, UNAIDS

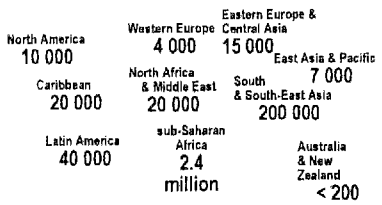
Estimated number of adults and children newly infected with HIV during 2001



Total: 5 million

Sources: WHO, UNAIDS

Children (<15 years) estimated to be living with HIV/AIDS as of end 2001



Total: 2.7 million

Sources: WHO, UNAIDS

Okinawa Infectious Diseases Initiative (Okinawa IDI: July 2000)

Basic Policy

1 Infectious diseases as a main developmental issue
2 Both global partnership and community-based action
3 Japan' s role and experience related to community health activities

Okinawa Infectious Diseases Initiative Basic Strategy

1 Ownership of developing countries
2 Human resources development
3 Partnership with civil society, international organizations and donor agencies
4 South-South Cooperation
5 Promotion of research activities
6 Strengthening of community health care

Okinawa Infectious Diseases Initiative HIV/AIDS

1 South-South cooperation
2 Commodity security
3 Youth and reproductive health
4 Children orphaned and made vulnerable by HIV/AIDS
5 Prevention of mother-to-child transmission
6 Safe blood supply
7 HIV/AIDS-TB co-infection

After Okinawa IDI

- Okinawa International Conference on Infectious Diseases (Dec. 2000)
- UNGASS(United Nations General Assembly Special Session) on HIV/AIDS in New York (June 2001)
- The Global Fund to fight AIDS, Tuberculosis and Malaria

The Characteristics of Japan's Role

- Various kinds of assistance schemes to support civil society
- International collaboration based on the concept of human security
- Stigma and discrimination
- Learn together, and work together for ensuring the quality of life of people

Japan s Initiatives for Infectious Diseases Control

Prof. Yasuhide Nakamura
Research Center for Civil Society
Graduate School of Human Sciences
Osaka University

His Excellency, ladies and gentlemen,

It is my great honor to have an opportunity for giving a keynote presentation at the Regional Workshop on HIV/AIDS in Southern Africa in Lusaka, Zambia.
I would like to give a short presentation of Japan s Initiatives for Infectious Diseases Control as a team leader of Japanese delegation to this important workshop.

(Slide)
I would like to start my presentation from Japan s experience as a developing country. Definitely, it is true that Japan was a developing country just after the Second World War. There were a high prevalence of many kinds of infectious diseases and many children died before their first birthdays. The Japanese central and local government made set up the system to fight infectious diseases and reduce infant mortality rate both in rural and urban areas. For examples, many public health nurses paid their attention only to tuberculosis and child health care in 1950 s. The individuals, families and the community also made efforts against infectious diseases through formal and informal collaboration. The community worked together with local government to clean the roads and neighboring environment under the movement of No Flies and No Mosquitoes

(Slide)
In 1950, the number of patients with infectious diseases was very high in Japan. As for tuberculosis, more than five hundred thousands patients suffered from tuberculosis. There were about 6 patients per 1000 population. It was remarkably higher prevalence rate in comparison to present African countries. There were many infectious diseases, such as trachoma, whooping cough, dysentery, diphtheria, polio. Japan is not a tropical country, but malaria was also prevalent after the Second World War.

(Slide)
Soon after the Second World War, the crude birth rate dropped sharply from 34.3 per 1,000 people in 1947 to19.4 in 1955. The year 1966 was a "Hinoeuma" year when many couples did not want babies because of the traditional belief that girls born in a "Hinoeuma" year will have a bad fortune. Off course, we can not find any scientific evidence about "Hinoeuma". Many people, however, did not have babies this year. I am sure that many health professionals and social workers combat against traditional belief in African continentals. I understand very well your difficulties. After 1973, the crude birth rate decreased constantly and reached 9.4 in 1999.

(Slide)

The infant mortality rate (IMR) has shown a drastic decrease from 76.7 in 1947 to 3.4 in 1999. The IMR decreased by about 50% for every decade; IMR was 60.1 in1950, 30.7 in 1960, 13.1 in 1970, 7.5 in 1980, 4.6 in 1990 and 3.4 in 1999. The decrease rate of IMR was constant. In 1950, pneumonia and diarrhea were the leading causes of infant deaths but the mortality rates specific to these diseases decreased drastically. Diarrhea caused 827.6 infant deaths per 100,000 newborns in 1950 but only 1.2 in 1990.
The life expectancy at birth as of 1999 was 83.99 years for females and 77.10 for males, both being the highest in the world.

(Slide)
I would like to show you the comparison between IMR in Japan and the United States. In 1950, IMR in Japan was about double than IMR in US. However, IMR in Japan became lower than that in US in 1964, when the first Olympic Game was held in Asia. At that time, Japan was still poor country and its GNP per capita was only 780 US dollars. I would like to place a special emphasis on this fact. The economy cannot explain everything. While the economical condition is not enough, people can enjoy their healthy and happy life.
(Coming June, the first World Cup will be held in Korea/Japan. I expect what kinds of things happen in Asian countries this year.)

(Slide)
Japanese and American researchers made one team to investigate the reasons why IMR in Japan was low. The team including me reached five possible explanations for Japan s low infant mortality rate; narrow socio-economic distribution, national health insurance covering the whole population, Maternal and Child Health Handbook which is now spread to many Asian countries, population-based screening and health check-ups, and high value placed on childbearing.
I think that many background of Japan is very different from that of Southern African countries. But I am sure that basic health care delivery system and community awareness is very important to fight infectious diseases and reduce mortality rate in many countries.

(Slide)
I would like to review the present situation of infectious diseases in the world. Most participants know very well about the fact.
Most deaths among young people in developing countries died due to AIDS, malaria, tuberculosis, diarrhea, measles and acute respiratory infections. These six infectious diseases occupied about a half of deaths of young generation.

(Slide)
Among 40 millions adults and children living with HIV/AIDS, about 70 % live in Sub-Saharan Africa following South and South-East Asia.

(Slide)
Among 5 millions adults and children newly infected with HIV, about 68 % live in Sub-Saharan Africa following South and South-East Asia.

(Slide)
Among 2.7 millions children under the age of 15 years living with HIV/AIDS, about 89 % live in Sub-Saharan Africa following South and South-East Asia. In Sub-Saharan Africa, HIV/AIDS of children is very big issue in comparison to other areas.

(Slide)
In Kyushu-Okinawa G8 Summit held in July 2000, Japanese Government stated Okinawa Infectious Diseases Initiatives to clear basic policy.
Infectious diseases control is not only a health problem but also a serious issue to the social and economic development, and should be a main issue of the development programs of developing countries, particularly in the efforts of poverty reduction.
Infectious diseases control is a global issue requiring global partnership among international organizations, donor agencies, private sectors and civil society. It also requires actions at community level based on the concept of primary health care.
As for Japan s experience, I already mentioned.

(Slide)
In Okinawa Infectious Diseases Initiatives, six basic strategy of Japanese Government was clarified; strengthening ownership and institutional building of health sector of developing countries, human resources development, global partnership among civil society, donor agencies, private sectors and international organizations, South-South cooperation to support the exchanges of knowledge and experience among developing countries, promotion of research activities, and strengthening community health care to ensure basic health care delivery.

(Slide)
As for HIV/AIDS, there are many targets focused by Japanese Government.

1 South-South cooperation
2 Commodity security
3 Youth and reproductive health
4 Children orphaned and made vulnerable by HIV/AIDS
5 Prevention of mother-to-child transmission
6 Safe blood supply
7 HIV/AIDS-TB co-infection

(Slide)
After Okinawa IDI, Japanese Government has continued to contribute infectious diseases control.
In December 2000, Okinawa International Conference on Infectious Diseases was held to strengthen countermeasures against HIV/AIDS, tuberculosis and malaria.
In UNGASS (United Nations General Assembly Special Session) on HIV/AIDS held in June 2001, Former Prime Minister Yoshiro Mori stated that the Japanese Government determined to implement specific support amounting to a total of approximately 700 million Us dollars.
The Global Fund to fight AIDS, Tuberculosis and Malaria, a new initiative to combat the epidemics that kill six million people, is very important to decide the appointment

of 17 international experts that will review all grant proposals and make recommendations for funding.

(Slide)
Finally, I would like to express my personal impressions about the characteristics of Japan s role to infectious diseases control.
There are various kinds of assistance schemes of Japanese ODA to support government activities and civil society. Frankly speaking, it is very difficult for me to understand the whole shape of the supporting system of JICA, even I worked with JICA for more than 16 years.
Secondly, international collaboration based on the concept of human security has been strengthened.
Thirdly, stigma and discrimination is the theme of the two-year World AIDS Campaign 2002-2003. Japan had a very long history of stigma and discrimination to the patients with tuberculosis and leprosy. Only in recent several years, patients with leprosy can live freely. This is a negative lesson of Japan. We understand in reality that stigma and discrimination are the major obstacle to effective prevention and care for infectious diseases.
Finally, there are very few experts on HIV/AIDS in Japan, because fortunately there is still low prevalence rate of HIV in Japan. Unfortunately, the prevalence rate of HIV/AIDS in Japan are increasing year by year, so we need many specialists on HIV/AIDS. Now there are many young Japanese professionals are very keen to HIV/AIDS. Even the authorities on HIV/AIDS have experience for only twenty year. I want to encourage young generation both in developing and developed countries to invite fight against HIV/AIDS. I would like to place emphasis on learning together, and working together for ensuring the quality of life of people with and without HIV/AIDS

Today I am very glad to participate in the discussions and presentations today and tomorrow, and I wish to learn from all the participants.
Thank you very much!

HIV/AIDS

in ZAMBIA

Background
Evolution of
Interventions
Networks
At what cost
Some results
Challenges

NATIONAL HIV/AIDS/STD/TB COUNCIL

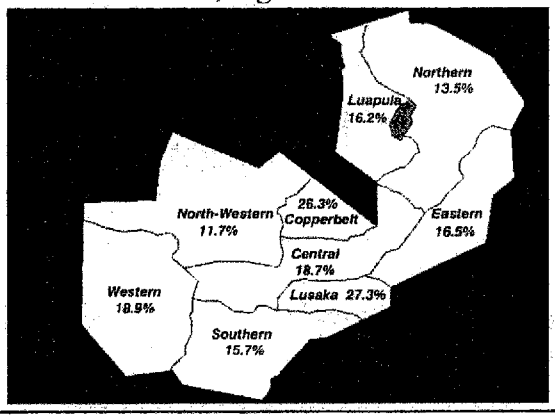
Background

- Area size-752,612 &Pop –10,3 million
- Population density-13.7
- Poverty levels- 80%
- Mortality
  - Infant per 1000 live births 114
  - Under 5 per 1000 live births 187
  - Maternal per 100.000 live births 650

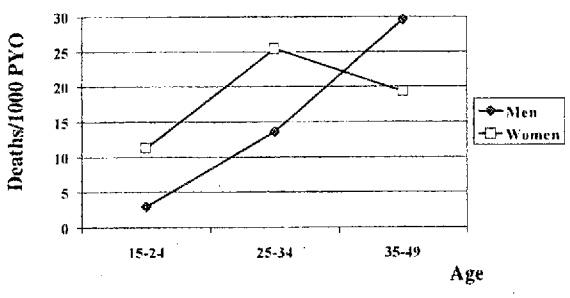
Background

- **Prevalence rate (15 – 45 yr age grp) - 20%**
- **Mother to child transmission - 40%**
- **Living with HIV/AIDS 800,000**
- **Deaths 650,000**
- **Orphans 700,000**
- **Life expectancy - 37 years**
- **Percent tested for HIV and know results**
  - **Urban 7.3%**
  - **Rural 5.3%**

HIV Prevalence, Ages 15 to 49 - 1998



Differential mortality by sex; Zambian population: 3-year follow up:1996-99



The Epidemic Is Fueled By

- **Poverty & Overburdened health services**
- Prevalence of other STDs
- Low use of condoms
- **Gender inequality** & Cultural practices
- Multiple sexual relationships
- **Denial, stigma and discrimination**

Evolution of response-approaches

- **Medical**

-Treated first case 1984

- **Public health-**

-National AIDS Prevention and Control Programme-1986

-Short Term Plan (safe blood and blood products)-1987

-First and Second medium Term Plan 1988-1998

- **Developmental and multisectoral**

-National Strategic Framework 2001-2003

Goals Of The National AIDS Plan

To adopt a multi-sectoral approach
With a range of interventions

SO AS TO

- Reduce the rate of new HIV infection
- Mitigate the social-economic impact of HIV/AIDS

Preventive and care interventions:

National strategies/plans

↓

Prevention

↕

Support/Care/mitigation

↕

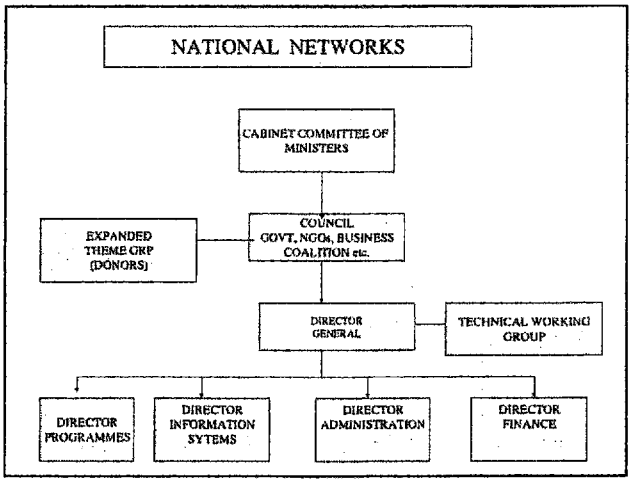
Strengthening health care systems

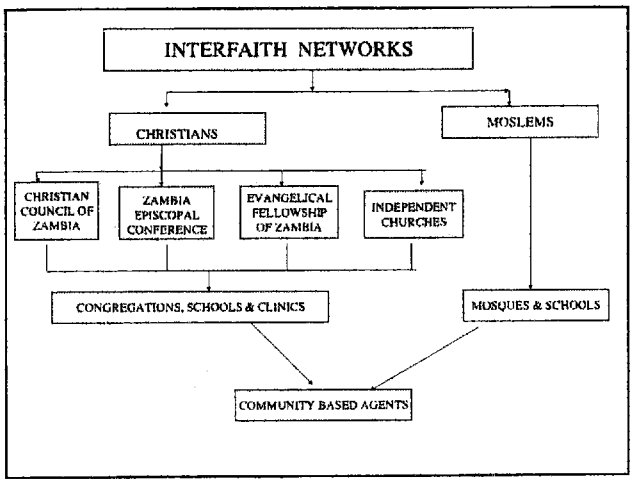
Interventions

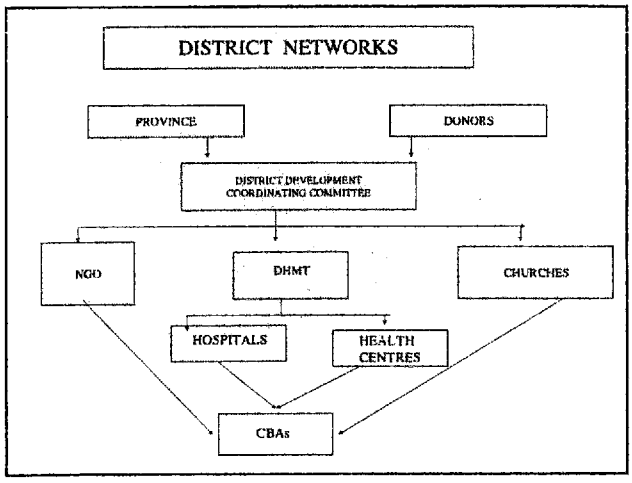
- **Multisectoral BCC campaign**
- **Condom promotion and distribution**
- **STI Management**
- Blood transfusion services
- **Voluntary Counselling and Testing**
- **Prevention of Mother to Child Transmission**
- **Community Home based Care**
- **Strengthening existing Projects** for OVC/NZP+
- Opportunistic Infections (TB etc)

Partners in the fight

- **Government initiatives**
  - MoE has 3 year strategic plan
  - MOH, MOD and etc
  - Ministry of community development(social welfare)
- **Private sector initiatives**
  - ZBCA (workplace)
- **FBOs, NGOs and CBOs**
  - 400 organisations
- **Targetted programmes**
  - -Youth Forum (30 orgs and 3000 members)
  - Children in need (CHIN)
  - High risk groups (Crossborder, Defence Forces, Prisoners, Refugees)
- **Treatment, care and support**
  - Home-based care
  - Medical care (OIs and ARVs)







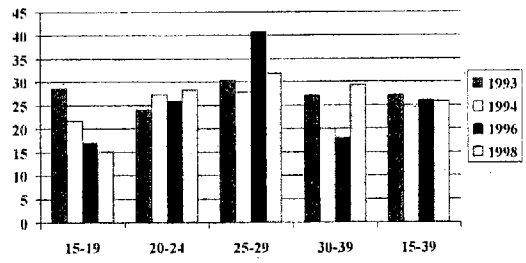
AT WHAT COST

- TOTAL REQUIREMENT FOR 3 YRS ($560M)
- GOVERNMENT ($150 MILLION)
  -BUDGET ALLOCATION
  -PRSP
- COOPERATING PARTNERS ($114 M)
  - DIRECTLY TO IMPLEMENTERS
  - THROUGH NAC
- GLOBAL FUND REQUEST (75M)
- SHORTFALL ($221 M)

Research, Monitoring and surveillance

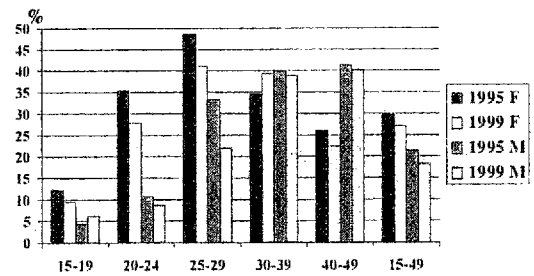
- Sentinel Surveillance
- Sexual behavioural surveys
- Strengthen existing information systems
- Program specific research

Trends in HIV prevalence (ANC): Urban Zambian site, 1993-1998



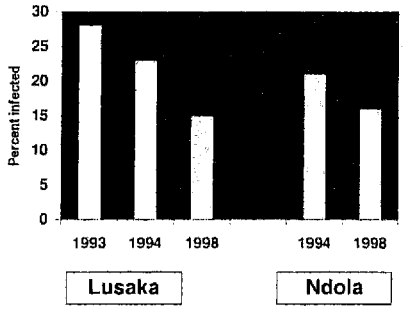
Sample size: 1993-98: 292, 443, 532, 776

PBS- trends in HIV prevalence: Urban Zambia 1995-98

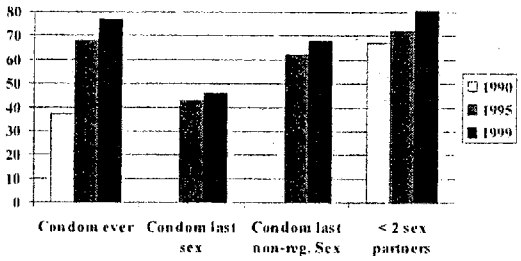


Sample size:1995/96: 2115; 1998/99: 2011; 15-49=Crude rate

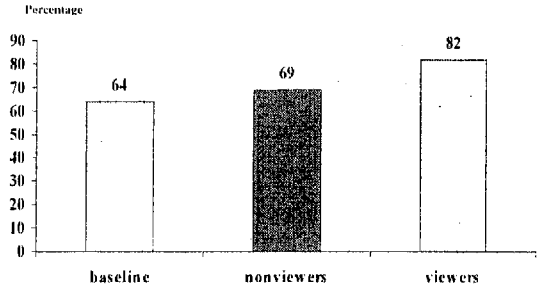
Estimated HIV Prevalence in Lusaka and Ndola, Ages 15 to 49



Sexual behaviour indicators: males 15-49 years, Urban site

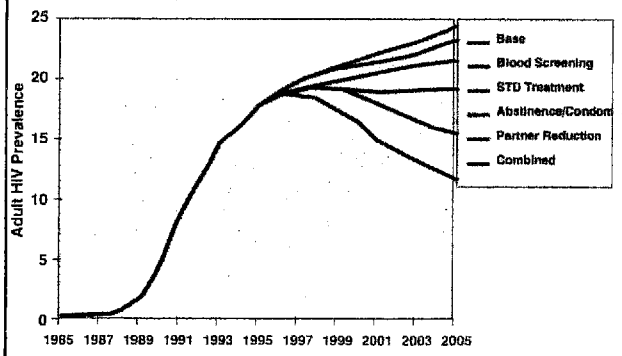


No to unwanted sex by youths



Source: Impact of HEART Campaign, Findings from the Youth Surveys in Zambia 1999 & 2000

Cumulative Effects of Interventions



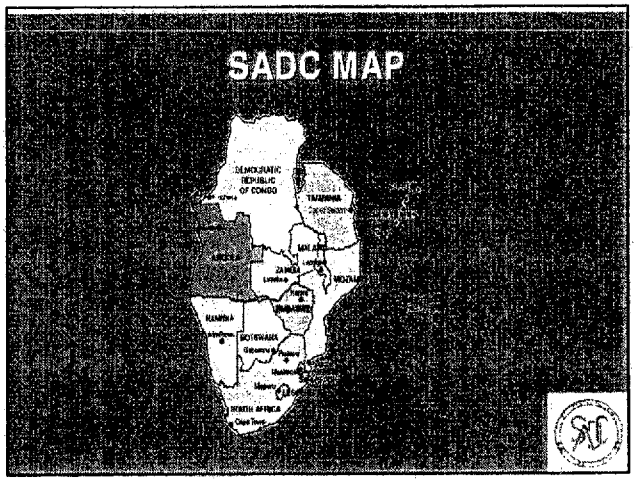
Challenges

- Interventions-limited coverage and quality
- Networks-loosely coordinated and just beginning
- Information-still scattered and not collated
- **Economy, poverty & debt stock**

REGIONAL WORKSHOP ON HIV/AIDS/AIDS FOR SOUTHERN AFRICA

- Masauso NZIMA
- SADC Health Coordinating Unit
- Pretoria, South Africa

Lusaka 20-21 March 2002



	Estimated number of people living with HIV/AIDS, end 1999						Estimated AIDS deaths	prelative 1999
Country	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Orphans (cumulative)	Adults and children 1999	
Global Total	34,300,000	33,600,000	1.07	15,700,000	1,200,000	13,200,000	2,800,000	
sub-Saharan Africa	24,500,000	23,100,000	8.57	12,900,000	1,000,000	12,100,000	2,200,000	
SADC level	11,950,000	11,430,000	17.05	6,364,000	431,500	4,720,000	992,100	
Angola	340,000	150,000	2.26	67,000	7,900	90,000	15,100	
Botswana	290,000	260,000	35.80	150,000	14,000	66,000	24,100	
Dem. Republic of Congo	1,100,000	1,100,000	3.67	600,000	53,000	460,000	90,000	
Lesotho	240,000	240,000	23.57	130,000	8,200	55,000	16,100	
Malawi	900,000	760,000	15.96	420,000	40,000	300,000	80,000	
Mozambique	1,200,000	1,100,000	13.22	630,000	52,000	510,000	98,000	
Namibia	160,000	150,000	19.54	85,000	10,000	67,000	15,000	
South Africa	4,200,000	4,100,000	19.94	2,300,000	95,000	820,000	250,000	
Swaziland	150,000	120,000	25.25	67,000	3,900	32,000	7,100	
United Rep of Tanzania	1,800,000	1,200,000	2.09	670,000	50,000	1,100,000	140,000	
Zambia	970,000	830,000	19.95	450,000	40,000	650,000	99,000	
Zimbabwe	1,500,000	1,400,000	25.06	800,000	50,000	800,000	160,000	
SADC level	11,950,000	11,430,000	17.05	6,364,000	431,500	4,720,000	992,100	

Source: UNAIDS, 2000

SADC HIV STRATEGIC FRAMEWORK AND PROGRAMME OF ACTION: 2000 -2004

- Approved by SADC Council of Ministers – August 2000
- Sectors involved:
  - Culture Information and Sport
  - Employment and Labour
  - Health
  - Human Resource Development
  - Mining
  - Tourism
  - Transport, Communication and Meteorology

SADC HIV STRATEGIC FRAMEWORK AND PROGRAMME OF ACTION: 2000 -2004

- In August 2000, Council also approved the inclusions of the SADC economic sectors
  - Finance and Investment
  - Industry and Trade
  - Food, Agriculture and Natural Resources

SADC HIV STRATEGIC FRAMEWORK AND PROGRAMME OF ACTION: 2000 -2004

Vision

SADC society with reduced HIV/AIDS

Overarching Goal

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

SADC HIV STRATEGIC FRAMEWORK AND PROGRAMME OF ACTION: 2000 -2004

Main Objectives

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

Three major categories of activities undertaken as follows:

- Policy/Advocacy;
- Mobilisation of Economic & other SADC Sectors:
- Initiation of the regional response

Policy/Advocacy

- ✓ Work on the harmonisation of HIV/AIDS policies completed awaiting comments from Member States on the FINAL draft document – before dissemination;
- ✓ SADC sectors met earlier and determined Human Resource Development (HRD) and Voluntary Counseling and Testing (VCT) as priority areas;

Policy/Advocacy ....

- ✓ SADC-HSCU recently held a workshop as first step in the development of regional guidelines on VCT (key organisations attended – SADC Member States; AIC, Uganda; BOTUSA-CDC, Botswana; Kenyan NACP; MACRO, Malawi);
- ✓ Initiated consultations with the Futures Group and the SADC HRD sector to jointly develop plan of action;

Mobilisation of Economic & other SADC Sectors

- ✓ To effectively mobilise the economic sectors (Directorate of Trade, Industry, Finance and Investment) for commitment to HIV/AIDS response;
- ✓ To include the civil/military alliances in SADC response to HIV/AIDS, via the Ministries of Defence and Safety and Security;

Initiation of the regional response

- ✓ A one-year work programme and cost estimate to be submitted to the EU for the release of programme funds *completed*;
- ✓ Implementation of activities is expected to start quarter Apr-June 2002 to proceed to end December 2002;

Initiation of the regional response

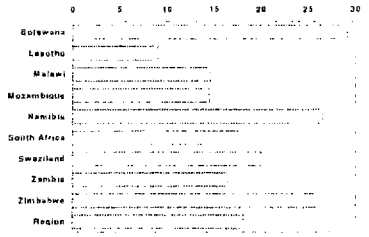
- To consult with the SADC on implementation of proposed activities on HIV/AIDS (TA provision, exploratory studies for foundation):
- To set up a project fund with support from the EU, a call for proposals to follow, proposals to be reviewed using criteria stipulated in the financing agreement:

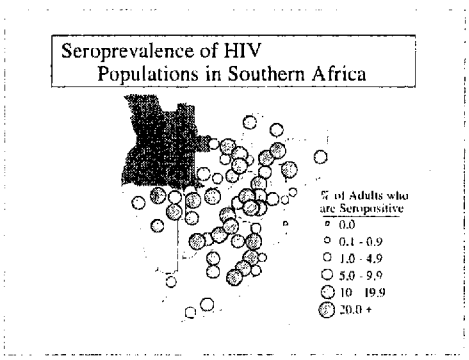
Country Level Performance

Session 1

HIV Prevalence

Among Adults ages 15-49), 1999





Functions of the HIV/AIDS national coordinating institutions

- Policy Guidance
- Secretariat for NAC
- Coordination of response
- Strategic Planning
- Advocacy
- Assist with Monitoring/Evaluation

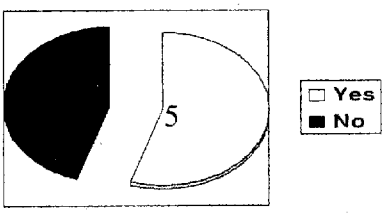
Functions of the HIV/AIDS national coordinating institutions

- Mobilization of resources
- Manage financial resources
- Supervision

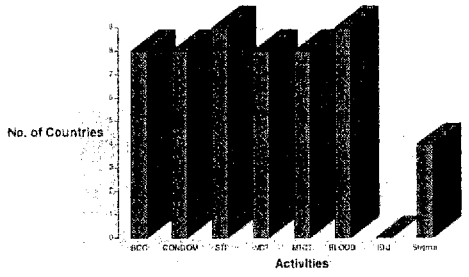
Priority Groups

> 80%	65-79%	<65%
PLWHA	**Orphans**	**Fishermen/ Fish mongers**
CSW	**Private sector**	**Women**
Military/ Uniformed	**Cross border traders**	**Families of PLWHA**
Truckers	**Public sector**	
Youth (in and out of school)		

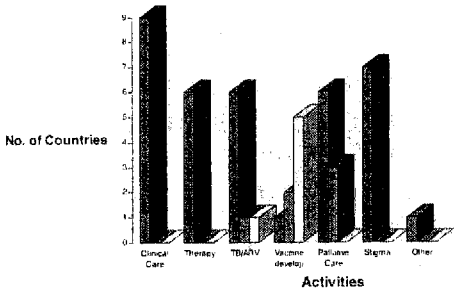
Priority Geographical Areas



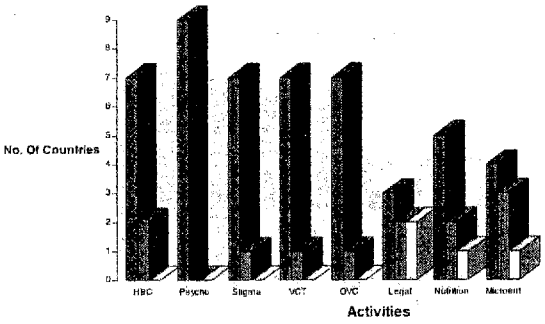
Prevention



Treatment and Care



Impact Mitigation



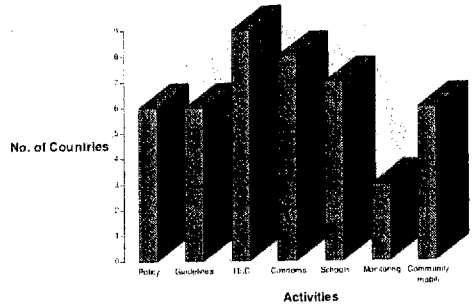
BLOOD SAFETY

Activity	No. of countries
National Blood Transfusion Policy	7
Guidelines for Transfusion	9
Constant availability of screening tests	7
Quality Control	8
Existence of Blood banks	8
Laboratory services	8
Training of lab technicians	5
Training of counselors	6
Counseling services	8
Screening of blood products than HIV	6

Constraints

- Not all district hospitals have blood packs
- Inadequate funding
- Physical infrastructure inadequate
- Inadequate technical capacity

Behavior Change Communication



Constraints

- Limited funding
- Limited sites
- Monitoring system inadequate
- No policy
- Inadequate personnel

Cross Border Initiatives

Activity	No. of Countries
Guidelines exist	2
CBI Manual exist	1
STI Drugs available	6
Syndromic Mx. Introduced	8
Personnel working with transit populations	2
Truck companies involved	5
I.EC Materials available	8
Community mobilization	3

Constraints

- Programme still in infancy
- Limited financial resources
- Inadequate supervisory support for medical personnel
- No monitoring system in place
- Inadequate supplies

Prevention of MTCT. I

Activity	No. of countries
MTCT policy exist/in process	6
National Guidelines exist/in process	6
MTCT center established	5
Availability of ARVs	5
HIV test kits available	7

Prevention of MTCT. II

Activity	No. of Countries
Laboratory set up	3
Counselors trained	7
National reporting systems in place	5
Training of medical staff in MTCT prevention and control	4
National campaign initiated	5
Alternative feeding options promoted	5

Constraints

- Inadequate quality control on HIV testing
- Inadequate equipment and resources
- Shortage of medical staff

STI Management

Activity	No. of countries
National policy exist	7
National guidelines	8
STD drugs are widely available	7
Medical staff trained in Syndromic management	9
STI test kits are widely available	4
STI Drug resistance Research	3
Youth Friendly clinics established	8

Constraints

- Erratic Drug supply
- Inadequate financial resources
- Inadequate trained personnel
- Inadequate follow-up
- Limited resources for research

TB Management and Prevention. I

Activity	No. of Countries
TB policy exists	9
National TB guidelines exist	9
TB drugs readily available	9
Laboratory set up	9
DOTS approach adopted	8

TB Management and Prevention. II

Activity	No. of Countries
Lab technicians trained	8
Medical personnel trained in diagnosis	8
TB research	5
Lab equipment available	6
TB prevention measures for HIV+ persons	6

Constraints

- Inadequate human resources
- Limited financial resources
- Inadequate supervision

Voluntary Counseling and Testing. I

Activity	No. of Countries
National VCT policy exists	3
National Guidelines exist	5
Quality control measures exist	4
VCT centers established	4
Lab. Facilities set up	2

VCT.II

Activity	No. of Countries
Lab. Technicians trained	4
Counselors trained	6
Reporting system exists	6
National campaign implemented	4

Constraints

- Inadequate trained counselors
- Inadequate HIV test kits
- Few VCT sites
- Limited financial resources

Reduction of risks to Intravenous Drug Users

Activity	No. of Countries
National policy on IDU	0
Guidelines on treatment and care	0
VCT centers for IDU	1
Counselors trained for the programme	3
National campaign initiated	1

Conclusion

- Based on this, majority of countries have adopted a comprehensive range of interventions to combat HIV /AIDS
- Interventions vary according to importance at country level

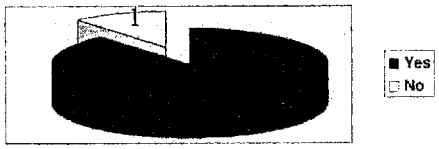
Gaps

- **Limited Financial resources**
- **Human Resources**
- **Physical Infrastructure**
- Advocacy
- Community mobilization
- Research

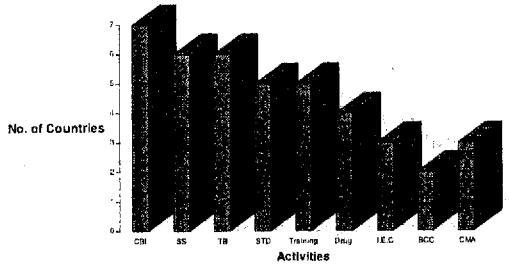
Regional HIV/AIDS and OVC Related Programmes

Session 2

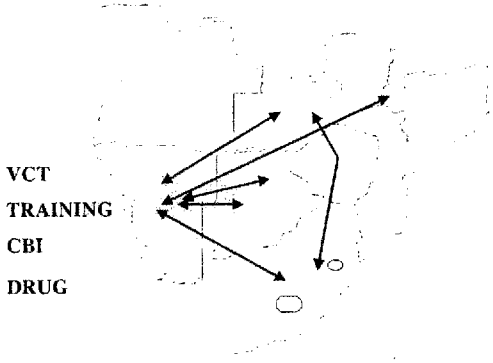
Participation in Regional Programmes



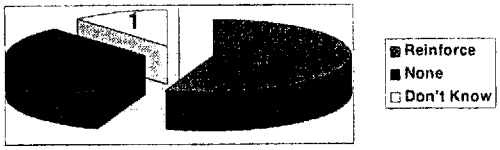
Regional Activities/Strategies



Country Collaboration



Relationship between National and Regional

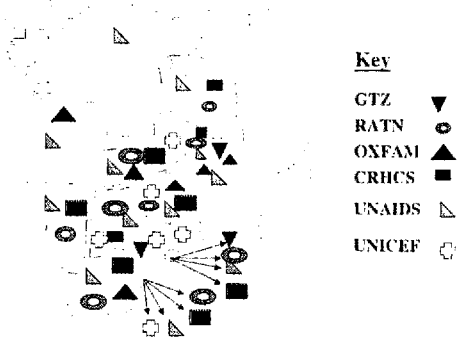


Key Areas for Regional Organisations

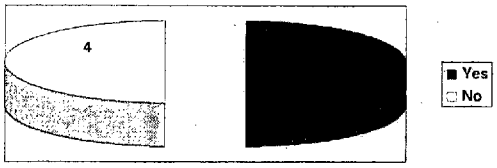
- **Technical Assistance**
- **Financial Support**
- **Advocacy/ Policy Development**
- I.E.C
- BCC
- Information/Database

Priority Target groups were quite diffuse and not well defined e.g countries, institutions, populations e.t.c.

HIV/AIDS Support



Cooperation with SADC Health Unit



Areas for Cooperation

- Networking
- Advocacy
- Capacity Building e.g. Training and management development.

Opportunities for closer collaboration with SADC

- Resource mobilisation
- Support capacity development in HIV/AIDS programmes
- Involvement of more partners to support SADC

Constraints for Collaboration

- Shortage of staff at SADC
- SADC lacks financial resources

Opportunities for closer collaboration with the SADC non-health unit

- Strengthening of the mutisectoral SADC strategy
- Political Advocacy
- Reaching the private sector for resource mobilisation
- Strengthening common interventions

Conclusion 1

- Variation in the conception of regional approach/activities
- Some regional organisation only have superficial knowledge of their operations
- Coordination among regional players is poor

Conclusion 2

- Only 50% of the responding organizations have any cooperation with SADC
- There are many coordinating bodies in the region with overlapping boundaries but with similar roles and responsibilities as SADC
- This raises the question of what mechanism should be put in place to facilitate coordination among regional organizations

JICA's Assistance to HIV / AIDS Control

Japan International Cooperation Agency
Regional Department, Africa Division

JICA's Objectives in Fight against HIV/AIDS

Japan's objective in Fighting against HIV/AIDS is to support African country's healthy development.

HIV /AIDS is a ploblem for public health as well as for social development.

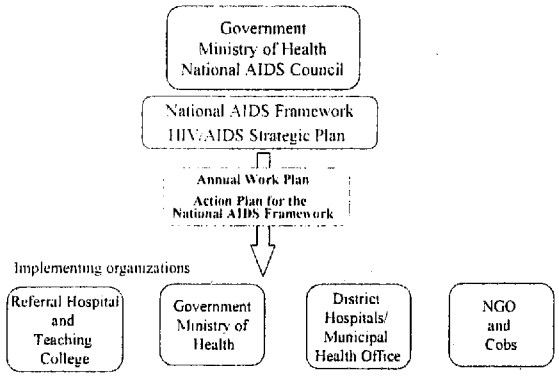
Japan considers HIV/AIDS as one of the ODA priorities. Through prevention, suppot and care for vulnerables, and surveillance, Japan supports Southern African development.

Japan/JICA's ODA

Improvement of Management skill	☆ Training Course in Japan ☆ Training Course in Third Country ☆ Dispatch of Experts (Japanese / Third Country) ☆ Collaboration Program with Japanese NPOs for Development
Improvement of Technical skill	☆ Training Course in Japan ☆ Third Country Training Course ☆ Dispatch of Expert (Japanese / Third Country) ☆ Project - Type Technical Cooperation ☆ Volunteers
Support for Logistics gap	☆ Equipment Supply Program for AIDS Control and Blood Test ☆ Project Type Grant Aid ☆ Program Type Grant Aid ☆ Grassroots Grant Aid
Support for adequate planning	☆ Development Study ☆ Project Formulation Activity
Support for NGO's activities	☆ Community Empowerment Programme ☆ Volunteers

How to use Japanese assistance scheme

Case study



Constraints of VCT from Questionnaires

1. Human resources
   - @ Inadequate management skill/supervision in all levels
   - @ Inadequate Training programmes
   - @ Inadequate Technical skills
2. Facility
   - @ Inadequate VCT sites
3. Lack of counseling guideline
4. Laboratory Function
   - @ Inadequate supply of lab kits
   - @ Inadequate supply of equipment
5. Financial resources
   - @ Inadequate financial resources

Example 1 **Human Resources**

1. Inadequate Management skill
   ? Training programmes in Japan/ in the third country
   ? Experts from Japan/ from the third country
2. Inadequate Training Programme
   ? Project-type Technical cooperation
   ? Training programmes in Japan/ in the third country
   ? Workshops
3. Inadequate Technical skill
   ? Experts from Japan/ from the third country
   ? Japan Overseas Cooperation Volunteers
4. Lack of Man power
   ? Japan Overseas Cooperation Volunteers

Example 2 **Facility and guidelines**

1. Inadequate VCT sites
   ? Grassroots grant aid
   ? Grant aid
2. Lack of Counseling guideline
   ? Experts from Japan
   ? Training programmes in Japan/ in the third country
   ? Workshops

Example 3 **Laboratory function**

1. Inadequate supply of HIV/AIDS test kits
   ? Grassroots grant aid
   ? Equipment supply programme for HIV/AIDS control and Blood tests
2. Inadequate supply of Equipment
   ? Grassroots grant aid
   ? Equipment supply programme for HIV/AIDS control and Blood tests

Example 4 **Financial resources**

1. Building
   ? Grassroots grant aid
   ? Grant aid
2. Human resources
   ? Japan Overseas Cooperation Volunteers
   ? Experts from Japan/ from the third countries
   ? Salary (X)
3. Commodity
   ? Equipment supply programme for HIV/AIDS control and Blood tests
   ? Grassroots grant aid
4. Running cost
   ? X

Japan/JICA's ODA

Improvement of Management skill	☆ Training Course in Japan ☆ Training Course in Third Country ☆ Dispatch of Experts (Japanese / Third Country) ☆ Collaboration Program with Japanese NPOs for Development
Improvement of Technical skill	☆ Training Course in Japan ☆ Third Country Training Course ☆ Dispatch of Expert (Japanese / Third Country) ☆ Project - Type Technical Cooperation ☆ Volunteers
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Support for adequate planning	☆ Development Study ☆ Project Formulation Activity
Support for NGO's activities	☆ Training Course in Japan ☆ Volunteers

Requirement s for applying JICA's assistance

Consistency with the National HIV/AIDS policy

Sustainability:
- **Counter part**
- **Responsible person**

Feasibility:
- **Available facility**
- **Management skill**
- **Accountability**

Ownership:
- **Continuation of the program after JICA's assistance ends**
- **Financial / Budget allocation**

Thank You

Japanese ODA Programme

JICA

Kyusyu

Okinawa

JICA ZAMBIA OFFICE

JICA

Dispatch of Expert

Improvement of Management Skill

Coordination of Japanese Programme

Expert → MOH (Zambia)

1) Promotion of existing requests to Japanese Govt.
2) Focal point of information related Global Fund for Japnese Govt.
3) Planning of Development Survey
(Survey on 1st referral hospital for further cooperation)
4) Promotion of South-South Cooperation(Focal point for Asian experience)

Expert → NAC(Malawi)

1) Conducting Survey on Lab. Abilities of 2nd referral hospital and VCT centers
2) Formulating training programme for Lab. technician for HIV tests
3) Formulating further cooperation for the training programme

Improvement of Technical Skill

Technical Transfer

Expert → UTH (Zambia)

1) Technology for research on Resistance of TB drug
2) Technology for research on Cultivation of HIV Virus

→ Project Type Tech. Cooperation
HIV/AIDS·TB Control Project in UTH

Training Programme

- Group Training in Japan
- Individual Training in Japan
- 3rd Country Training
- Region focused Training
- Country focused Training

Improvement of Technical Skill

Group Training in Japan for Zambia
- ★**Managing TB at Intermediate Level**
- ★**Seminar on Epidemiology &Control of AIDS/ATL Diseases**
- ★**TB Control Laboratory Management**

3rd Country Training
- ★**Blood Screening at KEMRI, Kenya**

(★Quality testing of HIV test kits at UTH, Zambia?)

Improvement of Management Skill

Region focused Training

(★Capacity Improvement of MIS for SADC countries)

For Zambia : 80personnel/year

Equipment Supply Programme

for AIDS Control and Blood tests ·····UNAIDS

(for Population and Family Planning)···UNFPA

(Maternal and Child Health)····· UNICEF

(for Infectious Disease Control)···· ···UNICEF/WHO

Support for Logistics Gap

HIV test kits
IEC Material
STD drug
Vaccine → MOH Zambia

Research Equipment → MOH Kenya

4years cooperation

Requirements for applying JICA's cooperation

Support for NGO's activities

Community Empowerment Programme

Resource gap of NGO

1) Logistic gap ← Community Empower Programme

Cross Boarder Initiative Project
1) Training costs for Peer Educator
2) Procurement of STD Drugs
3) Cost of local consultants for Technical support

2) Technical gap

3) Management gap

↑ **Grass roots Grant**

Grass Roots Grant

Direct Support for Community activities

From Embassy to Community

Logistic gap of Community activities
1) Lack of essential facilities
2) Lack of essential equipment
3) Lack of Facilities as initial resource

↔ **Grass Roots Grant**
Community Projects
1) Cost for construction of Clinic
2) Renovation for Orphanage
3) Procurement of Equipment and Material for Activities
4) Construction of Bore hole

Without Government Involvements

Japanese Embassy ⇄ Community Group(NGO)

Dispatch of Volunteers

Support for NGO's activities(Zambia)

Marketing researcher → International NGO
Collection of basic information for social marketing of condom

Social Worker → Mission Orphanage
Encouragement for self-support of AIDS orphans

Improvement of Technical Skill

- Intervention through schools(Zambia)
  School health Teacher → Basic School
  1) Strengthen school health activities
  2) Promotion of HIV/AIDS campaign through PTA
- Strengthening Polio Surveillance(Kenya)
  Surveillance assistant → MOH
  1) Implementation for Surveillance in rural areas
  2) Polio education in rural areas

Development Survey

Support for adequate planning

Preparation of Basic information for planning

Mapping of Health institutes
Mapping of Cold chain system

Preparation of Master plan for Strategies

Master plan for Rehabilitation of 2nd referral
Preparation for SIP

Cooperation with

Recipient country, JICA and Consultants

Project Type Technical Cooperation

NMIMR Ghana **KEMRI Kenya**

UTH Zambia

Dispatch of Expert
Acceptance of Trainee
Provision of Equipment

Large Scale
Technical Cooperation

5years Cooperation

Requirements for applying JICA's cooperation

Grant Aid

Support for Resource Gap

Facility
Construction of Pediatrics Ward and Isolation Ward

Commodity
Mosquito Nets for Social Marketing
(TB Drug for DOTS Operation)

Equipment
Basic Equipment for 2nd Referral Hospitals in Lusaka
Cold Chain System for Immunization, all area of Zambia

PA kit, TCTP & Cohort Studies

Dr. S. Mpoke, Prof. Amano,
Counterparts and JICA experts,
KEMRI/JICA Project,
Nairobi. KENYA.

1

Why PA kit in KEMRI?

- There is a demand for a cost-effective, reliable and sustainable test kit in Kenya
- Home made test kit will contribute to further development of technology in Kenya

2

KEMRI HIV-1 PA kit

KEMRI/JICA PROJECT

3

Production of PA kit

- Activation of gelatin particles
- Sensitization of particles with HIV antigen
- Lyophilization
- Quality control
- Current production capacity is about 5000 tests/batch

4

What is KEMRI HIV-1 PA kit?

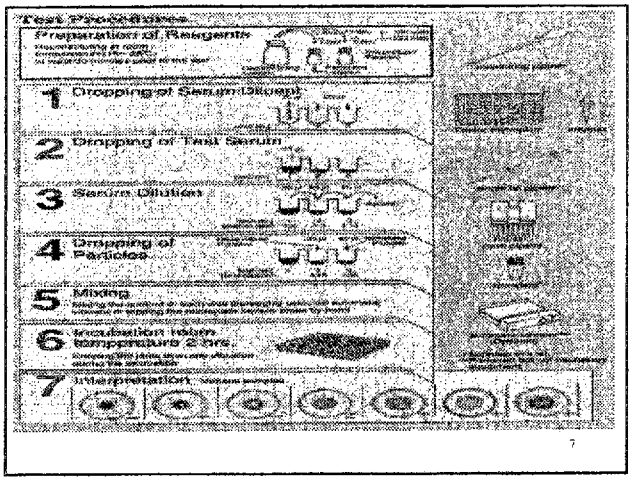
- P.A. is short for Particle Agglutination
- Gelatin particle technology-gelatin particles are used as HIV-1 antigen carriers
- The kit is used for the detection of HIV-1 antibodies
- The kit is simple, accurate and cost-effective

5

PA kit components

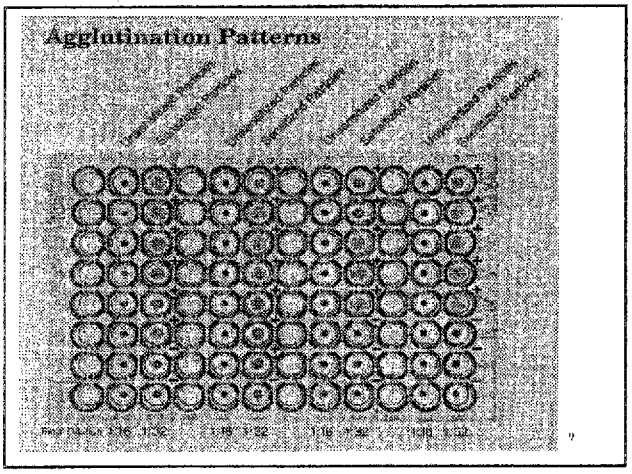
- Reconstitution buffer
- Serum diluent
- Sensitized particles
- Unsensitized particles
- Positive control
- Kit is sufficient for 220 tests

6



Distribution of PA kit

- 7 provincial hospitals
- National Public Health Laboratory Services
- Nairobi University, Dept. of Microbiology
- Matata Nursing home



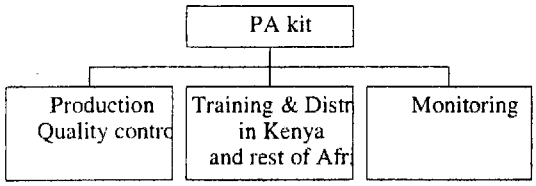
Evaluation of the PA kit

•Evaluated by 12 centers against 10 different commercial HIV test kits

•6498 tests performed

•Overall specificity - 99.4%
•Overall sensitivity - 98.6%

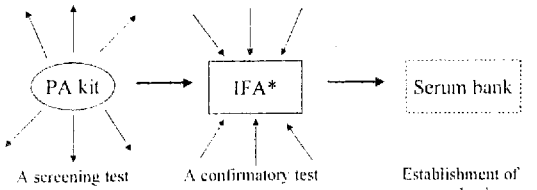
Strategies for the PA kit



Training of Laboratory staff

- In-country training
  - Training of lab. Staff from each of the 8 provincial hospitals in Kenya
  - Field training in 3 provinces (Nairobi. Central. Western)
  - In-house training
- Third country training program

A concept for HIV diagnosis in KEMRI



*Immunofluorescence Assay

13

COURSE PURPOSE

To train participants to update relevant knowledge on appropriate techniques in blood screening for **"Sustained Blood Safety".**

14

The KEMRI HIV-1 P.A. kit
was approved by the
National AIDS and STDs Control Council
on 8th June 2000

15

COURSE OBJECTIVES

Enable participants from African countries

- be competent in setting up blood safety screening capabilities in their own countries
- be able to run the tests, and interpret the results competently, make reports and keep good records
- be able to train other nationals

16

THIRD COUNTRY TRAINING PROGRAM

Blood Screening for Viral Hepatitis
and HIV/AIDS

17

COURSE CURRICULUM

- Lectures on Viral hepatitis and HIV/AIDS
- Practical sessions on appropriate use of KEMRI HIV-1 PA and KEMRI HEPCELL II kits
- Site visits to Blood transfusion centres. HIV/AIDS orphanages

18

TARGETED GROUP

- Laboratory technologists involved in Blood Safety activities
- Managers or Policy makers working or in-charge of Blood Screening programs

19

TRAINING UPDATE

- 3 training courses conducted so far (2000, 2001 & 2002)
- The duration of each course is 3 weeks
- A total of 17 countries have participated (Ghana, Swaziland, Malawi, Zambia, Zimbabwe, Botswana, Uganda, Tanzania, Eritrea, Ethiopia, Kenya, Mauritius, Seychelles, Lesotho, South Africa, Namibia and Nigeria).
- A total of 46 participants have been trained

20

COURSE ADMINISTRATION

- Course organizing committee
- Technical Implementation team

21

COURSE EVALUATION

- Internal Evaluation at end of each course (anomymous questionaires, analysed by course coordinators)
- External evaluation (by JICA)

22

COURSE SPONSORS

- The Government of Kenya, through KEMRI
- The Government of Japan, through JICA

23

EXPECTED COURSE OUTCOMES

- Enhanced and sustainable blood screening capacities in participating countries
- Establishment of blood safety network in Africa
- Greater south-south collaboration
- KEMRI/JICA's contribution to Global Initiatives (Okinawa, UNGASS Declaration, GII etc).

24

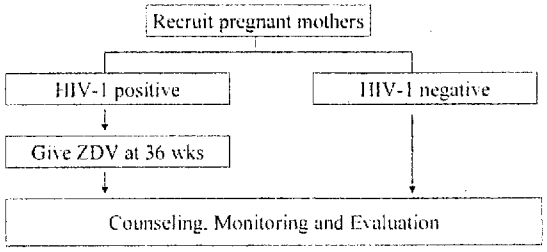
HIV/AIDS COHORT STUDIES

KEMRI/JICA PROJECT

Western Kenya

25

Study Methodology



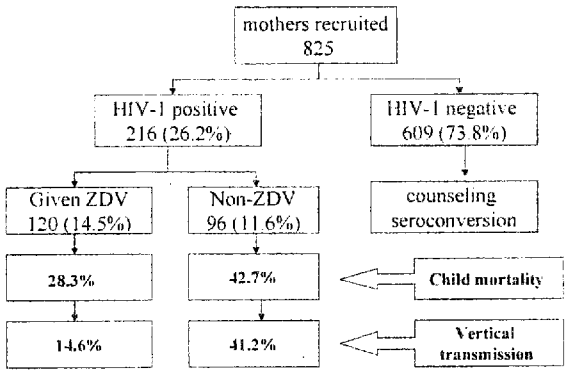
26

Effect of Prenatal Short Course Zidovudine on Vertical Transmission and Child Mortality in a Rural Community in Kenya

Counterparts and JICA Experts.
KEMRI/JICA

27

Study Results



28

Study Objective

Investigate the influence of prenatal short course Zidovudine on vertical transmission of HIV and child mortality in a rural population

29

CONCLUSION

- Short course ZDV significantly reduces rate of vertical transmission (by 65.6%).
- Short course ZDV significantly reduces risk of child mortality

30

ON-GOING & FUTURE STUDIES

- Long term effects of Zidovudine intervention (morbidity and mortality of mothers and children earlier exposed to zidovudine)
- Epidemiology and Evolution of HIV-1(host and viral factors influencing disease progression)
- Effect of HIV/AIDS counseling strategies

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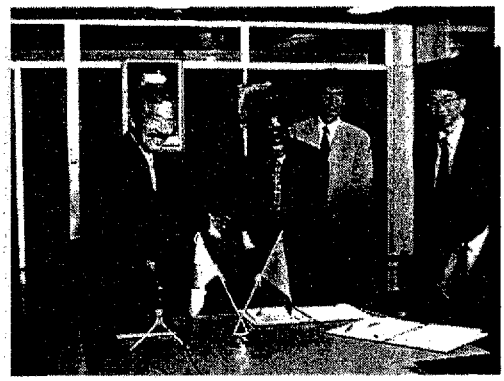
HIV / AIDS and TB Control Project University Teaching Hospital

F. C. Kasolo
MBChB. MSc. Ph.D. DTM&H

Regional Workshop on HIV/AIDS in Southern Africa, 20-21March 2002



Past & Present Japanese Assistance to Zambia in the Area of HIV/AIDS/TB control

- HIV/AIDS high risk group project (Cross border initiative)
- HIV education at a refugee camp
- Supply of HIV test kits for VCT (US$ 650,000 for 4 years: 2001-2004)
- Grant aid for laboratory equipment to TDRC#
- IDP & IDCP (1989 -2000)
- HIV/AIDS & TB Control project

OVERALL GOAL
↑ HIV/AIDS and TB Control in Zambia is improved.

PROJECT PURPOSE
↑ Laboratory Systems are strengthened and are effectively utilized for HIV/AIDS and TB control in Zambia.

OUTPUTS (1~5)
↑

ACTIVITIES (1~5)

The HIV/AIDS &TB control project

- Recognizing the importance of HIV& TB in Zambia a five year (March 30, 2001~March 29, 2006) project focusing on HIV & TB was developed.
- This project is based at the UTH Virology and TB Laboratories
- Certain activities such as VCT/MTCT are based at peripheral health centers

EXPECTED OUTPUTS

1. Performance of laboratory techniques, data management and overall laboratory management at the central laboratories are improved
2. Performance and quality of peripheral labs for HIV/AIDS and TB testing and surveillance is improved
3. Utilization of laboratory services by health workers (Private, public and NGO) is improved
4. Information on HIV/TB generated by the project is utilized widely by majority of stake holders in planning of future program (i.e., GRZ, other donors, health workers, NGOs, schools, youth and communities)
5. Collaboration with HIV/AIDS and TB working groups is institutionalized

Voluntary Counseling and Testing (VCT)

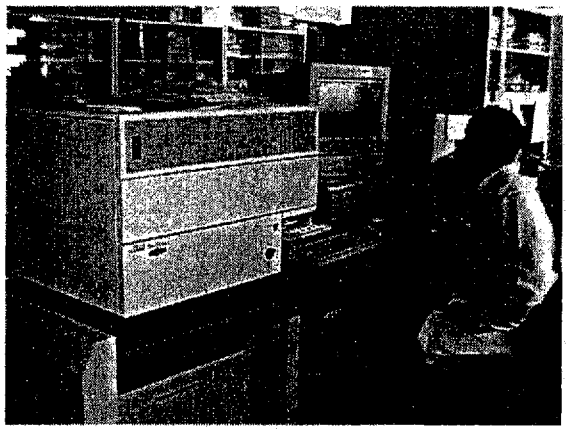
- Pre-test counseling → Sensitization for youth (4-4)
- HIV testing → Provide training to health workers in HIV testing (2-1,2-2)
  - Quality assurance (2-4a)
- Post-test counseling → Provision of Information on HIV to infected persons (4-1,4-2)

Care and Treatment

- Diagnosis of HIV → Training of lab staffs at central & peripheral in HIV diagnostics (1-1, 1-2, 2-1)
  - Quality assurance (2-4b)
- Treatment of HIV/AIDS → Monitoring of anti-HIV drug resistant HIV (1-3a)
  - Monitoring of response to treatment (1-1, 1-3a, 1-3c)

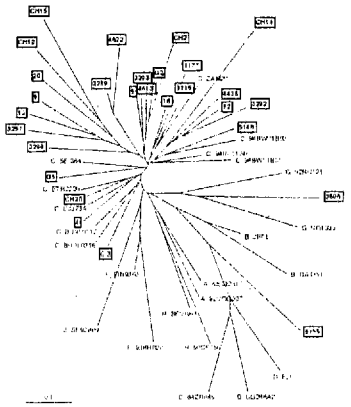
Prevention of Mother to Child Transmission (PMTCT)

- *VCT for pregnant women* → Provide training to health workers in HIV testing (2-1,2-2)
  - Quality assurance (2-4a)
- *HIV Transmission*
  -Intrauterine
  -During delivery
  -Breast milk
  - Monitoring of drug-resistant HIV (1-3a)
  - Evaluation of MTCT interventions through early diagnosis of HIV infection in children (1-3a)



HIV vaccine development for Zambia

- HIV-1 genotype analysis in Zambia → HIV genotype surveillance in Zambia (1-3b)
- Analysis of Immunological response to HIV-1 in Zambian → CTL assay for HIV-1 in Zambian (1-3c)
- Vaccine preparation based on the above information
- Trials (animal, human)



TB Prevention and Treatment (1)

- Diagnosis
  - Training of lab staffs at central & peripheral in TB diagnostics (1-1, 1-2, 2-1)
  - Development of training manuals (2-2)
  - Early diagnosis of TB (3-3)
- Treatment
  - Quality assurance (2-4b)
  - Surveillance of MDR-TB (1-3d)

TB Prevention and Treatment (2)

- Research
  - Concentration & Jik methods and PCR (1-3d)
  - Non-Tb detection (1-3d)
- Sensitisation
  - Provide information data base (4-1, 4-2)
  - Meeting with clinicians and stake holders (1-3e, 1-4, 1-5, 3-1, 4-1, 4-3)
  - Distribute handbooks to health workers (3-2, 4-4)
  - To actively participate in national TB programs (5, 4-3, 4-4)

NMIMR JICA Project GHANA

HIV/AIDS program

Previous HIV/AIDS activities

- Establishment of serological diagnosis for HIV –
- Provided HIV serology service for MOH
- Confirmatory service for HIV serology
- Isolation and characterization of HIV
- Evaluation of HIV test kits

Components of current program

- Genetic Characterization of HIV strains in Ghana
  - » subtype recombinants
  - » protease inhibitor resistance
- Quality Control /Assurance for HIV testing
- Evaluation of HIV test kits

Indirect support to current activities

- Prevalence of transfusion transmissible infections
- Assessment of OI treatment in HIV +ves in selected hospitals
- PMTCT pilot program and national scale-up plans
- Comprehensive Care pilot program for HIV/AIDS (Introduction of ART)

Other major activities

- Rural HIV/AIDS/STD education and VCT program with PPAG (Grassroots Grant)
- HIV/AIDS/STD Education (mobile) centers
- (FHI, USAID, GOJ)

- Workplace HIV/AIDS programs Military, Police, Bank of Ghana, Trad Rulers Assoc (World Bank, FHI-USAID)

Direct collaboration and support to National program

- National HIV testing
- VCT
- PMTCT – Guidelines, Pilot project
- MOH Guidelines for ART
- ART pilot program
- National ART program
- MOH Guidelines for STD
- National TB detection

NMIMR HIV project members

- Jim Brandful
- Kenzo Tokunaga
- Koichi Ishikawa
- Mubarak Osei-Kwasi
- Simeon Aidoo
- Victor Nuvor
- Regina Appiah-Oppong
- Lucy Brako-Hiapah
- David Ofori-Adjei
- Evelyn Yayra
- Nicholas Trebii
- Winifred Kumi
- Sena Tamakloe
- Aba Hayford
- Justice Kumi
- Peace Dzahini
- Adeline Assoku

SUMMARY

DAY ONE

Welcome Remarks

- Variations in policies, strategies and activities among SADC countries
- Need to utilise and harmonise existing networks
- Need to demonstrate results of our interventions
- Government commitment to work with NGOs
- Promote accountability

Hon. Minster of Health, Dr. B. Chituwo MP

Welcome Remarks

- Japan is committed to search for a World free from War, poverty, starvation and infectious disease

His Excellency Mr.M. Saotome, Japanese Ambassador to Zambia

Welcome Remarks

- "This is an important workshop because we need to discuss and share views on current responses to HIV/AIDS".

(Mr. K. Sasaki)

- *Mr.H. Abe* illustrated JICA's technical cooperation, grant aid and Japan Overseas cooperation on HIV/AIDS as a high priority sector in Southern Africa

Keynote Presentation

- *Prof. Y. Nakamura. Osaka University*

  Gave historical perspective of Japan's economic and health progress since 1950. He also talked about the Okinawa Infectious Diseases Initiative (IDI).
- *Dr. A.Simwanza , Director of Programmes National AIDS Council Zambia highlighted the Background, Projections, Impact and the Strategic Framework for combating HIV/AIDS in Zambia*

Objectives/Process

- In providing objectives of the workshop, harmonization of regional approaches was stressed

Dr. S.K Mitti
Director General,
CBOH

Country/Regional Response

- Most SADC countries have adhered to the recommended WHO interventions.
- There is poor coordination among regional organisations
- There is poor collaboration with the SADC Health Unit.

Dr. S. Mphuka/Ms. R. Siamwiza

SADC Response to HIV/AIDS

- Overview of the current situation of HIV/AIDS in Southern Africa
- SADC strategic HIV/AIDS framework
- SADC is undergoing restructuring to make it more responsive to member needs

Mr. N. Nzima
HIV/AIDS Programme Manager, SADC

GROUP WORK

- Definition of regional approach
- Identification of opportunities and constraints to regional approach
- Factors driving the regional approach
- Pre-requisite to a regional approach
- Possible areas of regional cooperation
- Coordination of regional organization

Japanese ODA Scheme

- JICA's assistance to HIV/AIDS control
- Key objectives on how to use the Japanese Assistance Scheme.
- JICA's promotion of South-to-South cooperation

Mr. Kadowaki,
Country Programme Officer, Africa Division

Japan Support in Southern Africa

- Emphasized what JICA can and cannot do.
- Provided examples in areas of training, human resources, grants, equipment and supplies and community empowerment

Mr. K. Ota
Deputy Resident Representative, JICA, Zambia

JICA Project Types

- Case Studies illustrating JICA's cooperation in East, Southern and West Africa.

Dr. S.Mpoke, Kenya/Dr.W.Ampofo, Ghana/ Dr. F. Kasolo, Zambia

ZAMBIA VOLUNTARY COUNSELLING AND TESTING SERVICES : LESSONS LEARNT

F. KASOLO, MBChB, MSc, Ph.D, DTM&H,
DIRECTOR ZAMBIA VCT SERVICES

REGIONAL WORKSHOP ON HIV/AIDS IN SOUTHERN AFRICA 20-21 MARCH 2002

HISTORY OF ZVCT SERVICES

- ✓ ZVCTS was established in March 1999 as part of the Zambian governments response to HIV.
- ✓ 22 centres were initially set up as part of a one year pilot project aimed at accessing acceptability of VCT among Zambians.
- ✓ Recognising the role of VCT in various HIV interventions a decision to expand VCT services was made by the Zambian

OBJECTIVES OF THE ZVCTS

- ✓To establish a free same day Client friendly VCT service accessible to majority of Zambians.
- ✓To integrate VCT into local health services
- ✓To establish VCT as an entry point into other HIV intervention programmes in
- ✓To provide technical and logistic support to local NGO's involved in the delivery of VCT
- ✓Zambia i.e T.B, STI, PMTCT, Future Vaccine trials and HAART administration.

SITE REQUIREMENTS FOR SETTING UP VCT SERVICE

(pilot phase).

- ✓Availability of laboratory facilities, or other HIV programmes i.e. PMTCT
- ✓Availability of at least 3 counselors per site at any given time
- ✓Easily accessible by road
- ✓High potential for replication
- ✓High potential for community mobilization
- ✓Willingness by the local population to have a VCT site

MODELS OF VCT INTRODUCED

- ➧ INTEGRATED MODEL OF VCT
- ✓ MCH SERVICES
- ✓ TB SERVICES
- ✓ STI SERVICES

- ➧ FREE STANDING MODEL OF VCT
- ✓ NGO VCT SERVICES

ZVCTS QUALITY ASSURANCE PROGRAMME.

- ✓ Quarterly supervision visits and meetings.
- ✓ Counseling session reflections and get together
- ✓ In service training workshops [bi- annually].
- ✓ Laboratory Quality Control:
  - ↗ At least three types of test kits per site (Abbott, genie II & bioner
  - ↗ Minimum use of two tests before releasing result
  - ↗ Re-testing of 2% of randomly selected samples from the site at the reference lab
  - ↗ inclusion of standard test panels in local testing.

LESSONS LEARNT (Pilot phase)

➔LOCAL ISSUES

- ✓Demand for extra duties pay by local VCT staff
- ✓Inadequate and inappropriate space to conduct Counseling
- ✓Inadequate personal to conduct community mobilization activities within the local communities
- ✓Few practicing counselors in comparison to the number of trained counselors
- ✓Lack of focus and involvement of the local stakeholders in the initial introduction of VCT services.

LESSONS LEARNED (Pilot phase)

➔Technical Issues

- ✓During the one year pilot phase lack of third test in the testing centres had an overwhelming effect on number of samples sent to the reference laboratory of re-testing
- ✓Lack of coordination and integration of the private sector and local NGOs driven VCT services into ZVCTS meant that VCT services were not standardized
- ✓During the pilot phase VCT was introduced in the 22 initial sites over a period of three months. This resulted in initial mis-understanding of what the services was all about.

LESSONS LEARNED (Pilot phase)

- ✓Delayed funding affected the overall performance of the service.
- ✓Disagreement between stakeholders on the type of VCT model to establish i.e. integrated versus free standing model.
- ✓High cost of HIV testing kits

CONSOLIDATION & EXPANSION PHASE OF ZVCTS

➔ **These phases was designed in order to address problems highlighted in pilot phase.**

◈ **Modalities.**

- ✓Formation of National AIDS Council to coordinate all HIV/AIDS related activities
- ✓ZVCTS activities were integrated as part of the VCT and Care technical working group.
- ✓Increased involvement and participation of the , CBOH through the directorate of public health and research, local community & local District Health Management Boards.

CONSOLIDATION & EXPANSION PHASE OF ZVCTS PHASE

- ✓Increased funding for VCT related sensitization, community mobilisation and outreach activities.
- ✓Implementation of decentralized quality control and addition of a third test at VCT testing centres.
- ✓Expansion of VCT services to all the 72 districts of Zambia (ongoing).

ACHIEVEMENTS OF ZVCTS

ATTENDANCE (1999 -2001)

↗ Total number of clients attending VCT:	185,892
↗ Total number of clients tested:	166,170
↗ Health persons seeking VCT	147,241
↗ Health Blood donors	6,027
↗ Clinical Referrals	3,115
↗ MTCT Referrals	9,787

ACHIEVEMENTS OF ZVCTS (cont)

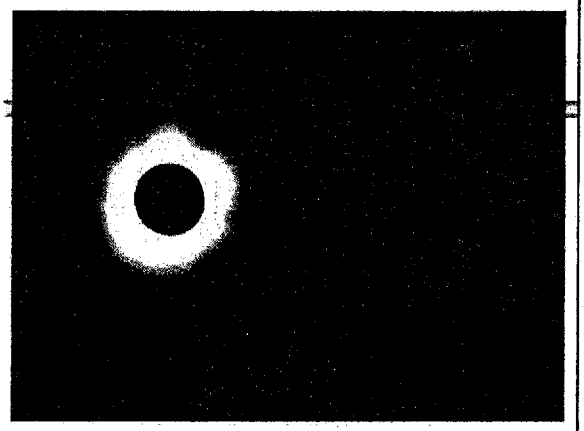
- 2. LOW DROPOUT RATE = 11%.
- REASONS FOR DROPOUT
  - ✓ Delay in releasing results due to low number of counselors
  - ✓ Long distances to the VCT testing sites.
  - ✓ Fear of knowing the results.
  - ✓ Negative influence from friends/ spouses.
  - ✓ Fear that general community will know ones status.

FUTURE DIRECTION OF ZAMBIA VCT SERVICE

- ✓By year 2004 ZVCTS aims to increase VCT centres from the present 56 to 100 sites country-wide.
- ✓By 2004, at least 25% of adult Zambians will have known their HIV sero status.

COOPERATING PARTNERS
(Acknowledgement)

- ➔NORAD, JICA, USAID.
- ➔Local NGOs i.e
- ✓Kara Counseling Trust
- ✓Hope Humana (DAPP)
- ✓Planned Parenthood Association of Zambia (PPAZ)
- ✓BOYS AND GIRL SCOUTS ASSOCIATION



BE READY FOR THE PARTIAL ECLIPSE THIS YEAR.

Thank you

Information/Database in HIV/AIDS
The Malawi Experience

JICA Regional Workshop for HIV/AIDS in Southern Africa.

Boniface Kalanda
National AIDS Commission
Malawi

Malawi

- 1. Background to the Programme in Malawi
- 2. Some statistics
- 3. Strategies to gather and disseminate information on HIV/AIDS
- 4. Tools to support regular collection of data
- 5. Human resource development needs to set up at national level
- 6. Constraints to operating and efficient HIV/AIDS database system
- 7. Lessons Learnt

1.Background to the Programme

- Implementation of a blood screening policy
- Implementation of a strategy for public education on HIV/AIDS
- Instituting multi-sectoral approaches incorporating social, psychological and economic dimensions in tackling the consequences of the epidemic
- The establishment of the National AIDS Control Programme

Background Cont....

- The establishment of the Cabinet Committee on HIV/AIDS
- The establishment of a multisectoral National AIDS Committee
- The establishment of programmes for orphans and patient home-based care and others
- The establishment of National HIV sero-prevalence surveillance system
- Development of a 5 year National Strategic Framework 2000-2004 (www.aidsmalawi.org)

SUCCESSES AND OPPORTUNITIES

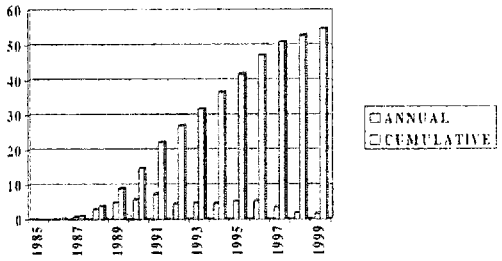
- Almost universal awareness
- Universal screening of blood
- Multisectoral involvement
- PLWA involvement in prevention and control efforts
- Window of hope - about 90% HIV negative
- Political will and commitment
- A participatory Strategic Framework

CHALLENGES

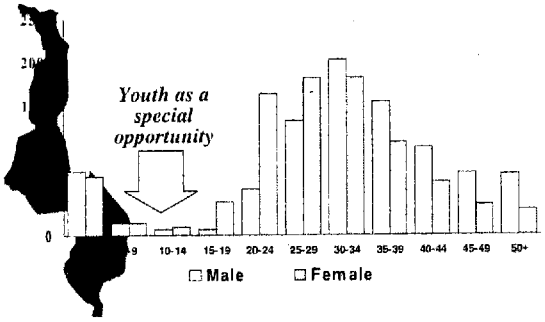
- Translating knowledge into positive behavior
- Lack of essential supplies
- Inadequate support for PLWAs
- Minimal acceptance of the condom
- Difficulties in implementing an effective IEC strategy

2. Some statistics

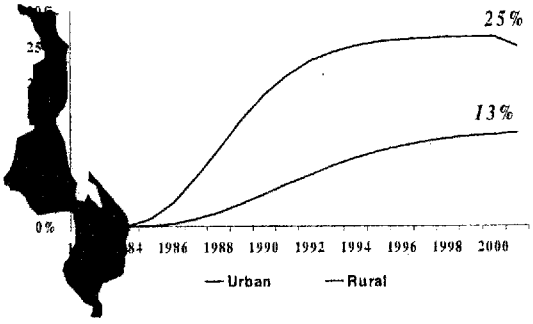
REPORTED AIDS CASES BY YEAR (*1,000)



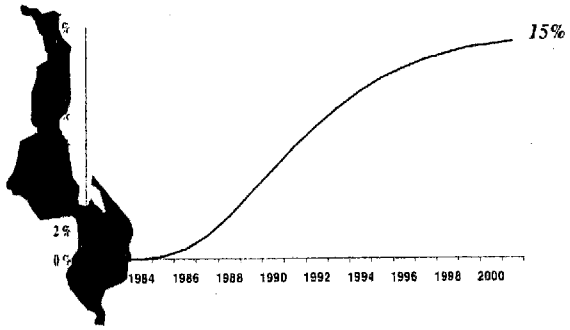
Reported AIDS Cases by Age and Sex (1995 - 1999)



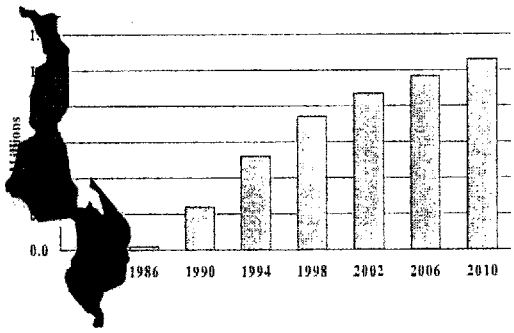
Urban/Rural Adult HIV Prevalence (1982 - 2001)



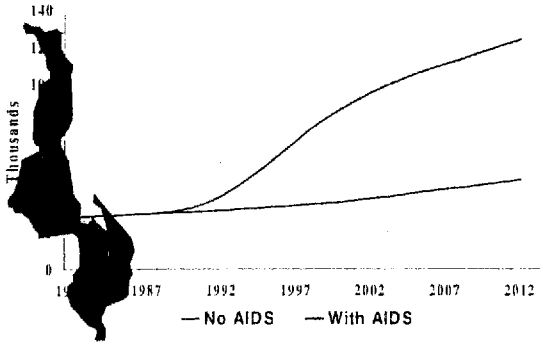
National Adult HIV Prevalence (1982 -2001)



Number Living with HIV/AIDS (all ages)



Annual Adult Deaths(Age 15-49)



3. Strategies to gather and disseminate information

- Monitoring and Evaluation Unit within the National AIDS Commission
- National Core M&E Group (proposed and budgeted for)
- Quarterly meetings of M&E experts from partner organisations (proposed and budgeted for)
- Technical Working Group of CRIS (Country Response Information System)

National M&E Core Group

- The group will be advising on:
  - aspects of sentinel surveillance
  - behavioural surveillance (yet to start)
  - appropriate indicators at different levels (national, district, NGO, community etc)
  - Dissemination strategy
- Quarterly meetings for:
  - M&E experts from partner organisations share their M&E experiences
  - Agree on what should be contained in a National M&E report
  - Training on common problems

TWG on CRIS

- Promote and develop the use of CRIS as Malawi's mechanism for the gathering and processing of information on HIV/AIDS
- Ensure data compatibility with neighbouring countries and the global response
- Evaluating CRIS periodically
- Provide and facilitate ongoing support and training for user agencies

4. Tools to Collect Data

- HIV/AIDS information System website
- M&E Strategy
- Collection forms agreed on by partners

HIV/AIDS information website collects:.....

- All organisations involved in HIV/AIDS activities in Malawi - both donor and implementing agencies
- Details of projects and activities they are involved in.
- Amount of money involved for each activity and/or projects
- Location of projects and/or activities
- Funding Sources and target of donations.

M&E Strategy

- Specifies indicators to be collected
- Indicators collected at national, district, NGO and community levels
- Indicators are collected on VCT, PMTCT, STI treatment and prevention, BCC, Policy development, Care and support (in health services, Community mitigation, Orphans and Widows, Surveillance and blood safety.

Data collection forms (Current)

- Sentinel surveillance (HIV) data annually
- Sentinel surveillance (STIs)
- AIDS case data (passive surveillance)
- STI case data (passive surveillance)
- Blood donor data
- Data on organisations working in HIV/AIDS and their donors.(International NGO's, local NGO's and CBO's)

5. Human Resource Needs

- Well qualified and experienced personnel
- Periodic training
- National AIDS Commission's M&E Unit has:
  - Planning, Monitoring and Evaluation Specialist (Head of Unit)
  - Monitoring and Evaluation Officer
  - Research Officer
  - Planning Officer
  - Data Processing Officer
  - Data Entry Clerks (2)
- District Co-ordinators trained in basic skills

6. Constraints

- Will at Management level
- Competencies/Skills of M&E staff
- Staff shortage
- Poor follow up by partners
- Finances to procure necessary resources
  - Computers
  - Softwares
  - Printing forms
  - Reagents (for passive surveillance)
  - Transport to aid data collection

7. Lessons Learnt

- Adequate manpower needs at all level are an absolute necessity
- At National level, there is need to decide on a minimum set of indicators to be reported on. Two many is a recipe for failure.
- M&E should be a participatory activity
- Data collection forms should be as simple as is possible (without compromising data collected)
- At district level, a Pentium III and fancy software is NOT VERY necessary

THANK YOU!

www.aidsmalawi.org

RHAP SOUTHERN AFRICA

REGIONAL HIV/AIDS PROGRAMME SOUTHERN AFRICA

USAID
Michele Russell

RHAP SOUTHERN AFRICA

HISTORY

<BUDGET 750K FY99, 1.5 MILLION FY00, 3.85 MILLION FY01>

- Initiated by a technical team of HPN Officers in Zimbabwe, Zambia, South Africa and Malawi and supported by Ambassadors
- Countries participating include: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe
- Managed by a coordinator with support from technical team of Health Officers from four countries.

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RHAP SOUTHERN AFRICA

ASSESSMENTS

- Assessments were conducted in Swaziland, South Africa, Mozambique, Lesotho, Zambia and Zimbabwe, Namibia to identify target populations and needs.
- After assessment, meetings were held with key stakeholders to determine whether or not to implement a program and types of interventions community would find most useful.
- Key findings from assessments included: high prevalence of STIs, multiple sex partners, lack of- access to and use of condoms.

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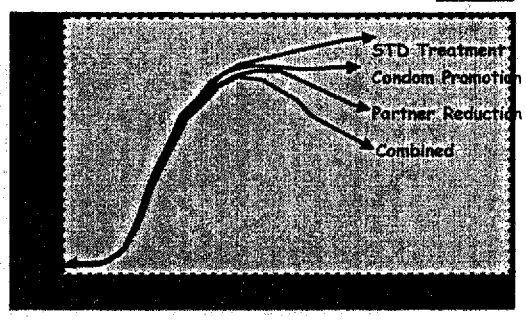
EFFECTS OF INTERVENTION



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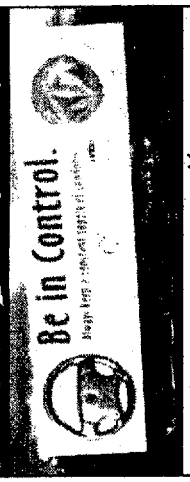
RHAP SOUTHERN AFRICA



Cross Border Sites

- Programs have been implemented in:
  - Messina, South Africa
  - Beitbridge, Zimbabwe
  - Chirundu, Zimbabwe
  - Chirundu, Zambia
  - Maseru and Maputsoe, Lesotho
  - Mulanje, Malawi.

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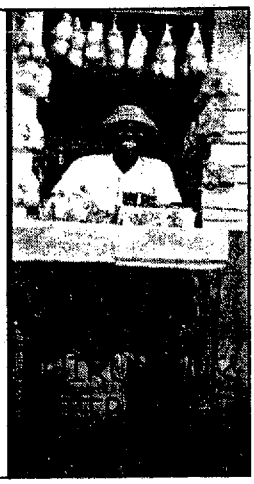
RHAP SOUTHERN AFRICA

MESSINA, SOUTH AFRICA

- Peer education & outreach activities for behavior change targeting men: truckers, traders, youth and uniformed services.
- Activities include: Edu-theatre, social marketing and dispensing of free condoms, referral to and support of STD clinics including training of clinic staff.
- Activities based in shebeens, bars, clinics, schools, at truck stops, border posts and in village centers

PHAP SOUTHERN AFRICA

» Condom social marketing, care and support activities targeting women, youth, truckers and the uniformed services.
» Activities include: edu-tainment emphasizing increased knowledge and use of condoms.
» In Beitbridge a HOPE Humana center is being implemented offering services to PWLH/As and the community including education, information and care for STIs as well as income generating activities and support.



PHAP SOUTHERN AFRICA

CHIRUNDU, ZAMBIA

» The existing cross border activity is being expanded to include: focused targeting of truckers, youth (ages 10-24), uniformed services, and health care workers (formal and non traditional) providing STI treatment.
» Activities include condom social marketing, encouragement of STI care seeking behavior, increased skills and sensitivity of care providers, and community mobilization promoting community wide dialogues, developing alternative activities for youth, lobbying and activism around the needs and issues of truckers.

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Cross Border Activities: LESOTHO

» Maseru and Maputsoe are characterized by informal traders and laborers moving between SA and Lesotho with very little trucking issues.
» Activities include community mobilization, peer support, home based care,
» Syndromic management of STIs and condom social marketing.

PHAP SOUTHERN AFRICA

Cross Border Activities: MALAWI

» Mulange, Malawi: Traders and others move between Malawi and Mocambique on bicycle, truck, and foot. Bikes transport sacks of rice, corn, meal, people (sick and healthy) w/chickens and fish hanging off handle bars.
» Peer education and outreach activities target CSW's, youth in and out-of-school, and traders promoting risk reduction, access to treatment for STIs, and behavior change for STIs and HIV/AIDS.

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Malawi Activities continued...

» Interactive drama facilitating self-assessment of risk
» Video shows for edu-tainment
» Competition at school open days
» Posters in local languages
» Condom promotion
» Training of health care workers

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PHAP SOUTHERN AFRICA

To increase mobility of peer educators to reach more target groups

Aim of Afribike Partnership

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Activities

- Programs in SA, Lesotho
- Procurement and distribution of 240 bicycles.
- Training of peer educators on safe use and maintenance.
- Training of two community members to run a bike repair shop.

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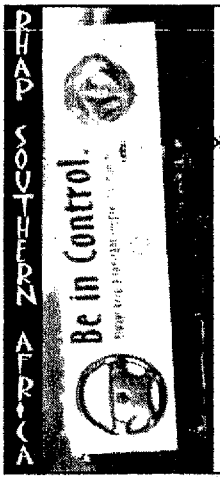

Accomplishments: Cross Border Sites

- New programs in:
  - Groblersberg Gate, Ficksburg and Ladybrand SA
  - Victoria Falls, Wenge, and Mutare, Zimbabwe
  - Kazangula, Nakonde, Livingstone, & Chipata, Zambia
  - Katima Mulilo, Namibia
  - Ngwenya, Lavumisa, Mbabane, and Manzini, Swaziland

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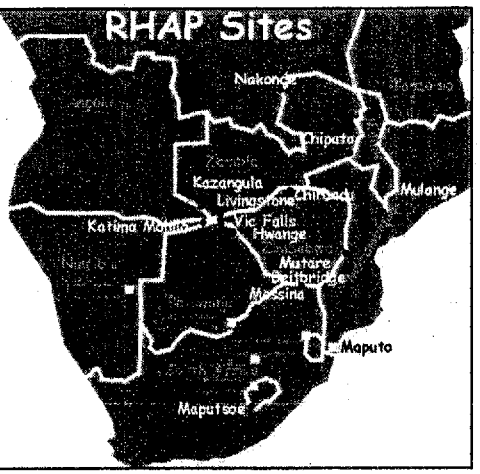
RHAP SOUTHERN AFRICA

RHAP Sites



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Accomplishments--Cross Border Sites

- Messina, South Africa:
  - 93 peer educators trained-- CSWs, Youth, LDDs and farmworkers
  - Monthly STD, HIV/AIDS radio talk slot
  - Providing 50,000 condoms monthly free
- Chirundu, Zambia
  - 31 peer educators-- youth, police and immigration
  - Blue House
  - Treated 200 CSWs and 34 LDDs for STIs
  - has sold 81K since 9/00 with AT of 70K

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Accomplishments--Cross Border Sites

- Beitbridge/Chirundu, Zimbabwe:
  - 60 CSW peer educators trained
  - This quarter 92,700 condoms sold out of AT 312K : 10,530 Chirundu and 82,170 Beitbridge
  - This quarter 940 Care condoms out of AT 2,400 : 880 Beitbridge and 60 Chirundu
- Maseru and Maputsoe, Lesotho:
  - 78 peer educators-- 38 LIWs, 40 CSWs
  - Engaged and mobilized Village HIV/AIDS Committees which are run by Village Chiefs
  - Beginning collaboration with SFH for training on Marketing and Sales of Condoms

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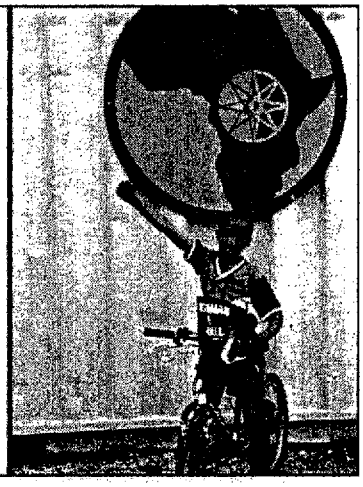
Accomplishments Afribike

- Afribike programs launched in SA and Lesotho. Kick-off bike races with prizes.
- Two Community members trained to run bike shops.
- Bike shops set up in SA and Lesotho
- Peer educators from Lesotho and SA participated in AIDS ride in SA.



WAY FORWARD

- We have been meeting in Zambia from March 20 to 21, 2002 in the Regional Workshop on HIV/AIDS and acknowledge the following.
- Southern African countries, NGOs and cooperating partners should take maximum efforts to fight against HIV/AIDS.
- It is crucial to devote attention to a regional approach against HIV/AIDS in Southern Africa.
- The role of SADC as a regional body in Southern Africa is essential because HIV/AIDS is cross-cutting and regional issue. SADC has the mandate of member states to lead the fight against infectious diseases in the region.
- In order to enhance SADC's leadership as a regional coordinating body, information sharing among governments, multi-, and bi-donors, and NGOs is essential.

Coordination

- Harmonizing policies, interventions and activities in common areas across countries in the region
- Strengthening linkages between regional and country-level interventions
- Developing a mechanism for facilitating cooperation between regional organisations
- Strengthen National AIDS Councils in the coordination of all HIV/AIDS programs within their respective borders
- Support the SADC HIV/AIDS Strategic Framework.

Interventions

- Standardize interventions where relevant, e.g. cross border activities, VCT for mobile populations, and regional information level database.
- Facilitate the sharing of best practices between member institutions
- Develop Research centre/Laboratory to validate traditional plants used for HIV/AIDS treatment.
- Provide ARVs, HIV test kits/other reagents and Laboratory equipment

Monitoring and Evaluation

- Develop appropriate indicators at regional level to capture social, economic and demographic dynamics of HIV/AIDS

Human Resource Development

- Recognizing mobility and mobidity, death and natural attrition of personnel in the region, there is need to develop a human resource development strategy at country and regional levels especially for technical personnel.

Partnerships

- Collaboration among partners is critical to avoid programmes collapsing due to dependence on one donor.
- The relationship between national and regional programmes/activities should reinforce each other
- Expand partnerships to include more NGOs, traditional healers, Faith Based Organisations and the youth.
- Regional HV/AIDS thematic group be established to coordinate with SADC and other regional organisations. Membership should consist of representatives of regional organisations, multi-laterals and bilateral that support regional activities

Information/Database

- Develop a regional task force with specific terms of reference to standardise information database in all countries in Southern Africa

Cross-border Initiatives

- Develop joint cross border activities between countries so that there are similar activities of both sides

Voluntary Counselling and Testing

- Constitute a task force to develop regional VCT Programme and submit it to SADC

Limited Financial Resources

- The resource gap in the region for HIV/AIDS activities is big. There is need for countries in the region and cooperating partners to increase financial allocation to HIV/AIDS.

JAPAN's Next Step

- JAPAN will consider supporting the strategic plan of SADC in fight against HIV/AIDS.
- JAPAN will consider supporting SADC countries based on their individual needs.
- JAPAN will further enhance its effort in priority areas, such as Voluntary Counseling and Testing, information/database and Cross-Border Initiatives.
- The detailed suggestions in the workshop will be acknowledged and due consideration provided.