4．ワークショップ事前調査票

JICA REGIONAL ACTIVITES IN SOUTHERN AFRICA

QUESTIONNAIRE

PART I:
COUNTRY PROFILE

ID Number_____
(Do not write in the space above.)

Name of Country: _____

Name of Respondent: _____

Job Title: _____

1. Do you have an overall coordinating institution for HIV/AIDS at national level?
   ☐ Yes ☐No

2. What are some of the functions of the HIV/AIDS national coordinating institution
   A. _____
   B. _____
   C. _____
   D. _____
   E. _____
   F. _____
   G. _____
   H. _____
   I. _____
   K. _____

PART II
COUNTRY-LEVEL HIV/AIDS PROGRAMMES

1. Please rank in order of priority the areas listed below relating to prevention, care and support strategies as they appear in your National Strategic Framework/Plan.

Rank 1 for High Priority
Rank 2 for Low Priority
Rank 3 for not a Priority

Prevention	Rank	A.1Treatment and Care	Rank	A.2 Impact Mitigation	Rank
A. Behaviour Change Communication (BCC)		A.1.1 Clinical Care Clinical management of opportunistic infections and HIV-related illnesses		Home-based care	
		A.1.2 Prevention therapies			
		A.1.3 TB prevention and control Antiretroviral Therapies (ARV)			
B. Condom promotion and availability		B.1 Vaccine Development		B.2 Psychosocial support	
C. Sexually transmitted infection (STI) management		C.1 Palliative care		C.2 Stigma reduction	
D. Voluntary counselling and testing (VCT)		D.1 Stigma		D.2 VCT	
E. Prevention of mother-to-child transmission (MTCT)		E.1 Other (specify)		E.2 Orphans and other vulnerable children (OVC)	
F. Blood safety				F.2 Legal support	
G. Harm reduction for intravenous drug users (IDUs)				G.2 Nutrition programs	
H. Stigma reduction				H.2 Micro-enterprise and income-generation programmes	
I. Other (specify)				I. Other (specify)	

2. Are there priority target populations for HIV/AIDS interventions?

☐ Yes ☐ No

3. If yes, tick (✓) the appropriate category below.

Categories of target populations	✓	Categories of target populations	✓
A. People living with HIV/AIDS (PLWHA)		J. Fishmongers	
B. Orphans		K. Fishermen	
C. Commercial sex workers (CSW)		L. Prisoners	
D.Military/uniformed forces		M. Public sector workers	
E. Youth in-school		N. Other (Specify)	
F. Out-of-school youth			
G. Private sector workers			
H. Truckers			
I. Cross border traders			

4. Are there priority geographical areas for HIV/AIDS interventions?

☐ Yes ☐ No

5. Below is a list of activities categorised by strategy. Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

A. Blood Safety				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A national blood transfusion policy exist			
2	National blood transfusion guidelines exist			
3	Screening test kits exist			
4	There are measures to monitor quality of blood products			
5	A blood bank has been established			
6	A laboratory has been set up			
7	Training programmes exist for lab technicians			
8	Training programmes exist for counsellors			
9	Pre and post-test counselling services are attached to the programme			
10	A quality check is done on all blood products			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

B. Behaviour Change Communication				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A national BCC policy exists or is in the process of formation			
2	National BCC guidelines exist or are in the process of formation			
3	IEC materials are being produced			
4	Condom promotion is a part of the BCC strategy			
5	Condoms are made available			
6	Social marketing of condoms is part of the strategy			
7	Free distribution of condoms			
8	A school health component exist			
9	Youth anti-AIDS clubs have been established			
10	Community members have been trained			
11	A reporting system has been institutionalised			
12	Stigma reduction is part of the strategy			
13	There is a national campaign			
14	Youth friendly services have been established			
15	A monitoring system exist			
16	Community mobilisation exist			
17	A national structure exists for BCC			
18	Life skills training for school students exist			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

C. Cross Border Initiative				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	CBI guidelines exist or are in the process of being created			
2	CBI manual exist or are in the process of being created.			
3	STI drugs are available			
4	A laboratory has been established			
5	Syndromic management has been introduced			
6	The programme has trained lab technicians			
7	Medical personnel have been trained in diagnosis of STIs using the syndromic approach			
8	BCC is part of the strategy			
9	Personnel working with transit populations have been trained in BCC			
10	STI research is taking place			
11	Truck companies are involved in programme			
12	IEC materials are available			
13	Income generation activities have been introduced in border areas			
14	Community mobilisation takes place			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

D. Reduction of risk to intravenous drug users (IDUs)				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A national policy on IDU exist or is being formed			
2	Guidelines on care & treatment of IDU exist or are being developed			
3	A needle/syringe exchange programme for IDUs exist			
4	Quality control measures for HIV test exist			
5	VCT centres have been established for IDUs			
6	A laboratory has been established as part of the programme			
7	Laboratory technicians have been trained			
8	Counsellors have been trained to work in programme			
9	Pre and post-test counselling is done			
10	Quality checks on HIV test kits ARE DONE			
11	A national reporting system has been institutionalised			
12	There is a stigma reduction component			
13	A national campaign has been initiated			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

E. Prevention of Mother to Child Transmission				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A MTCT policy exist or is being formed			
2	National guidelines exist or are being developed			
3	HIV test kits are available			
4	Quality control measures have been developed for HIV tests or are being done			
5	Short-term ARV is available			
6	A MTCT centre has been established			
7	A laboratory has been set up			
8	Lab technicians have been trained			
9	Counsellors have been trained			
10	Pre and post-test counselling is done			
11	Quality checks on HIV test kits take place			
12	A national reporting system exists			
13	Stigma reduction exist			
14	A national campaign has been initiated			
15	Training of medical staff in MTCT prevention and control occurs			
16	Alternative feeding options are promoted			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

F. STI Management				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A national STI control policy exist or is being developed			
2	National STI guidelines exist or are being created			
3	STI drugs are widely available			
4	A national laboratory has been established			
5	Syndromic management techniques have been introduced or are in the process of being introduced			
6	Laboratory technicians have been trained			
7	Medical personnel have been trained in syndromic management techniques			
8	Youth friendly clinics have been established			
9	STI test kits are widely available			
10	STI drug resistance research is taking place			
11	Equipment is available			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

G. TB Management & Prevention				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A national TB control policy exist or is in the process of formation			
2	National TB guidelines exist			
3	TB drugs are available			
4	A laboratory has been set up			
5	T he DOTS approach is being implemented			
6	Laboratory technicians have been trained			
7	Medical personnel have been trained in diagnostic techniques			
8	STI resistance research is taking place			
9	Laboratory equipment is available			
10	TB prevention measures are being implemented among HIV positive patients			

Under each strategy, please tick activities that are undertaken in your country in column 1.1, if there are problems associated with these activities tick in column 1.2. Briefly describe major constraints associated with each strategy. (Write constraints in the space provided.)

H. Voluntary Counselling and Testing Services				
No	**Activities**	**1.1 Tick**	**1.2 Problems**	**1.3 Constraints**
1	A national VCT policy exist or is in the process of being developed			
2	National VCT guidelines exist			
3	HIV test kits are available			
4	Quality control measures for HIV tests exist			
5	A VCT centre has been established			
6	A laboratory has been set up			
7	Laboratory technicians have been trained			
8	Counsellors have been trained			
9	Pre and post-test counselling takes place			
10	Quality checks on HIV test kits are done			
11	A reporting system exists			
12	Stigma reduction activities take place			
13	A national campaign has been implemented			

PART III
REGIONAL HIV/AIDS PROGRAMMES

1. Does your country participate in any regional HIV/AIDS and OVC related programs?

☐ Yes ☐ No

2. If yes, in which regional programs/activities/strategies do you participate? Tick the appropriate box in the table below:

Activity/Strategy	**Tick (✓)**
A. Civil-Military Alliance (CMA)	
B. Cross-Border Initiative (CBI)	
C. Research	
a. Sentinel surveys	
b. TB Control and Management	
c. STD Control and Management	
d. BC C	
e. Other (specify)	
D. Training	
E. Drug standardisation/procurement	
F. IEC	
G. Other (specify) a. b. c. d. e.	

3. Are you collaborating with any other country(ies) in the activities mentioned above?

☐ Yes ☐ No

4. If yes, with which country? Please tick the appropriate category below.

	CMA	CBI	Research				Training	Drug Standard/Procurement	IEC	Other (specify)
			Sentinel Survey	BCC	Drugs	Other				
A. Angola										
B. Botswana										
C. Congo DR										
D. Lesotho										
E. Malawi										
F. Mauritius										
G. Mozambique										
H. Namibia										
I. Seychelles										
J.South Africa.										
K. Swaziland										
L. Tanzania										
M. Zambia										
N. Zimbabwe										
O. Kenya										
P. Uganda										

5. What is the relationship between national and regional programs/activities and strategies? Tick the statement that best describes the relationship.

☐They reinforce each other.

☐ There is no relationship, regional and national activities are carried out independently of each other.

☐ Other (specify):

JICA REGIONAL ACTIVITES IN SOUTHERN AFRICA

QUESTIONNAIRE FOR REGIONAL ORGANISATIONS WORKING IN HIV/AIDS IN SOUTHERN AFRICA

ID _____
(Do not write in the space above.)

Name of organisation: _____

Address _____

_____

Name of respondent _____

Job title _____

Please tick or write in the most appropriate response for the questions below:

1. What are your key areas of HIV/AIDS and OVC activity?

HIV/AIDS and OVC Activities	**Tick**
1.Information, communication, education	
2. Behaviour change communication	
3. Services	
4. Research	
5. Training	
6. Advocacy/policy development	
7. Information systems/database	
8. Technical assistance	
9. Financial support	
10. Information, communication, education	
11. Behaviour change communication	
12. Services	
13. Other (Specify	

2. Who are the target groups?

Target Population	Activities/Strategies														
	BCC	Vaccine	ARV Treatment	VCT	Drugs		Nutrition/ Food	Services	Blood Safety	Legal Support	Condom Promotion	HBC	MTCT	Research/ Surveillance	Other (specify)
					TB	STI									
1. Youth															
2. PLWHA															
3. CSW															
4. Military/ uniformed services															
5. Prisoners															
6. Cross border traders															
7. Truckers															
8. Public sector workers															
9. Private sector workers															
10. Orphans & vulnerable children															
11. Fishing camps															
12. women															
13. Institutions (specify)															
14. Others (specify)															

3. Is your assistance to individual countries, regional programmes and/or a combination of both? Please tick the appropriate box below.

- ô Individual countries
- ô Regional programmes
- ô A combination of both

4. Do you have any regional programmes involving several countries?

Yes No

5. If you are using a regional approach, please tick below the countries and HIV/AIDS activities you are supporting.

	Civil-Military Alliance	CBI	Research				Training	Drug Standard/Procurement	IEC	Other (specify)	VCT
			SSS	BCC	Drugs	Other					
A. Angola											
B. Botswana											
C. Congo DR											
D. Lesotho											
E. Malawi											
F. Mauritius											
G. Mozambique											
H. Namibia											
I. Seychelles											
J.South Africa.											
K. Swaziland											
L. Tanzania											
M. Zambia											
N. Zimbabwe											

7. Do you have any cooperation with SADC Health Unit?

Yes No

8. If yes, in what areas? (Please be specific)

9. What are some of the opportunities for closer collaboration with the SADC Health Unit?

10. What are some of the constraints?

11. What are some of the opportunities for closer collaboration with SADC non-health units for implementing a multisectoral approach to HIV/AIDS prevention and control?

12. What are the constraints?

Thank you very much for completing the questionnaire

Regional Workshop on HIV/AIDS in Southern Africa

WORKSHOP REPORT

Lusaka, March 20-21, 2002

Ministry of Health, Zambia
&
Japan International Cooperation Agency

Acknowledgement

This reports the Regional Workshop held in Lusaka, Zambia on March 20-21, 2002, which deals with regional approaches to fight against HIV/AIDS in Southern Africa. The workshop was organized by JICA, the Ministry of Foreign Affairs of Japan and the Ministry of Health of Zambia. The organizers would like to acknowledge the following organizations and individuals for their contribution to the success of the workshop and production of the subsequent report:

National AIDS Council of Zambia
Southern African Development Community Health Desk
United Nations Fund for Population Agency
United Nations AIDS Programme
United States Agency for International Development (Southern African Regional Office)
Country Managers of National AIDS Programmes.
Regional Organizations
Dr.Simon Mphuka and Ms. Robbie Siamwiza (consultants).
Workshop participants

This report was produced as a contribution to discussions on regionalizing HIV/AIDS approaches. The purpose is to explore Japan's potential areas for future collaboration with partner countries and regional organizations in the SADC countries.

Preface

In spite of the considerable progress in containing HIV/AIDS in the last 20 years, the epidemic continues to grow in most southern African countries and is spreading faster than many country-level efforts to contain the epidemic. Regional responses to the AIDS epidemic are hindered by poor coordination among countries, inadequate collaboration among regional organizations, and weak mechanisms for synchronizing various country and regional HIV/AIDS interventions.

The Southern African Development Community (SADC) has developed the SADC HIV/AIDS Strategic Framework and Program of Action: 2000-2004. The strategic framework aims to strengthen SADC member countries' responses to the epidemic. Although the framework does not explicitly target improving coordination among regional organizations, it is assumed that this will occur as a result of harmonization of member state HIV/AIDS policies, programs and activities.

To address some of these problems, JICA and Japan's Ministry of Foreign Affairs decided to hold a regional workshop on HIV/AIDS control for SADC countries, co-sponsored by the Ministry of Health of Zambia from March 20-21, 2002, The main goal of the workshop was to strengthen and explore current national HIV/AIDS programs from the viewpoint of scaling up a regional approach in southern Africa. The workshop was attended by representatives of 9 countries in the region and some of the regional organizations.

Based on the G8 Kyushu-Okinawa Summit held in 2000, Japan committed to cooperate with southern African countries to develop a regional strategy for controlling infectious diseases, including HIV/AIDS. Japan will collaborate with government health institutions, NGOs, community-based groups and regional organizations in this endeavor. This report outlines issues for future discussion, and identifies some of the challenges and constraints in implementing effective regional responses to HIV/AIDS.

Seroprevalence of HIV Populations in Southern Africa

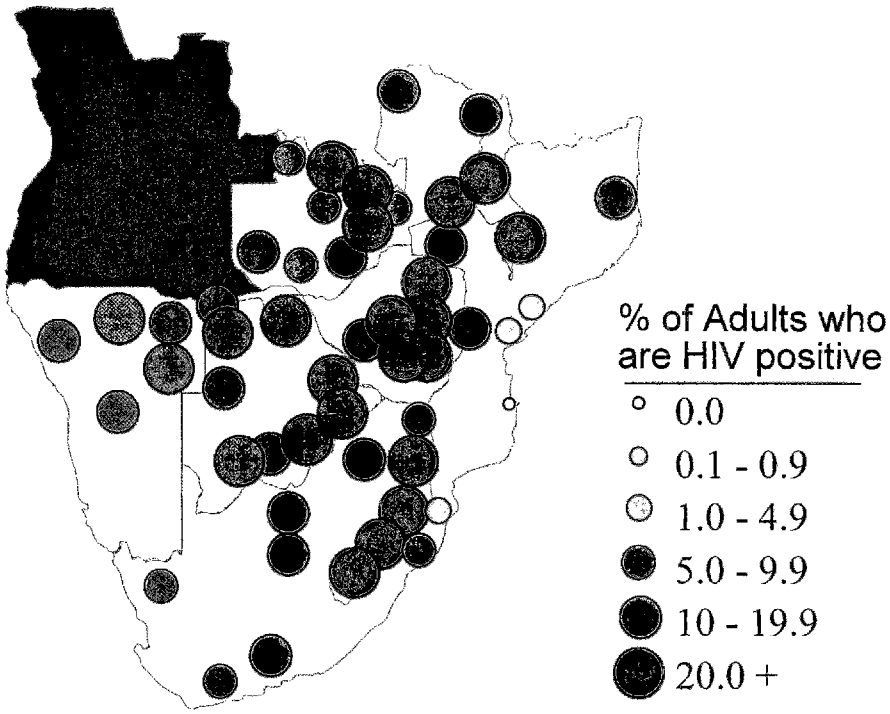


Table of Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
BCC	Behavior Change and Communication
CBI	Cross Border Initiatives
CBOH	Central Board of Health
CMI	Civil Military Alliance
CRCS	Commonwealth Regional Health Community Secretariat
CSW	Commercial Sex Workers
DFID	Department for International Development
DOTS	Directly Observed Treatment Therapy short course
EU	European Union
HIV	Human immunodeficiency virus
HRD	Human Resource Development
I.E.C	Information Education and Communication
IDU	Intravenous Drug Users
JICA	Japan International Cooperation Agency
MIS	Management Information System
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
NAC	National AIDS Council
NGO	Non-governmental organization
OVC	Orphans and Vulnerable children
PLWHA	People Living With HIV/AIDS
RATN	Regional AIDS Training Network
SADC	Southern African Development Community
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United National Fund for Population Agency
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VCT	Voluntary Counseling and Training
WB	World Bank
WHO	World Health Organization

Executive Summary

In 2000, Japan's government announced the Okinawa Infectious Disease Initiative, in which Japan committed to extending support for developing countries to control infectious diseases, especially HIV/AIDS. The Southern Africa Development Community (SADC) has developed a strategic framework[1] to strengthen the regional response for the HIV/AIDS pandemic. In order to strengthen and harmonize regional approaches, JICA and the Ministry of Health, Zambia, co-sponsored a regional workshop for southern African countries on March 20-21, 2002. The workshop objectives were:

1) To identify the current national strategies of HIV/AIDS control programmes and associated problems from the view point of a regional approach in southern Africa

2) To identify areas for potential Japanese cooperation in HIV/AIDS control programmes in southern Africa.

The workshop findings and deliberations were supplemented by an e-mail-administered survey prior to the workshop with 14 SADC member countries and some selected regional organizations.

The major findings and recommendations from the survey and the workshop are summarized as follows in the form of an appeal from the workshop participants.

[1] SADC HIV/AIDS Strategic Framework for the period 2000-2004.

Workshop Appeal

Workshop participants met in Lusaka, Zambia March 20-21, 2002 in the regional workshop for HIV/AIDS in southern Africa and acknowledged 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 a cross cutting and regional issue. SADC has the mandate of the 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-lateral, and bi-lateral donors and NGOs is essential.

The following recommendations were made in specific areas:

Recommendation 1: COORDINATION

For better coordination, following Conditions are to be met by member states:

- 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 among regional organizations,
- Strengthening National AIDS Councils in collaboration with all HIV/AIDS programs within their respective borders, and
- Supporting the SADC HIV/AIDS Strategic Framework.

Recommendation 2: INTERVENTIONS

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

Recommendation 3: MONITORING AND EVALUATION

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

Recommendation 4: HUMAN RESOURCE DEVELOPMENT

- Recognizing mobility, morbidity, 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

Recommendation 5: PARTNERSHIPS

- Collaboration among partners is critical to avoid programmes collapsing due to dependence on one donor,
- National and regional programmes/activities should reinforce each other,
- Expand partnerships to include more NGOs, traditional healers, Faith Based Organizations and the youth, and
- Regional HIV/AIDS thematic group should be established to coordinate with SADC and other regional organizations. Membership should consist of representatives of regional organizations, multi-laterals and bi-lateral agencies that support regional activities.

Recommendation 6: INFORMATION / DATABASE

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

Recommendation 7: CROSS-BORDER INITIATIVES

- Develop joint cross border activities among countries in order that there are similar activities of each side

Recommendation 8: VOLUNTARY COUNSELING AND TESTING

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

Recommendation 9: LIMITED FINANCIAL RESOURCES

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

Japan's Next Step

Based on the workshop appeal emanating from participants' deliberations and survey findings:

- 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.

1. Introduction

1.1 Background

Of the 40 million people living with HIV/AIDS worldwide, more than 70 percent live in sub-Saharan Africa. In 2001, the estimated number of new HIV infections was 3.4 million. During the same year, AIDS killed 2.3 million African people. Twelve of the world's 15 countries most affected by HIV/AIDS are in east, central and southern Africa and 10 of those countries are in southern Africa.

The whole southern African region has experienced exponential growth in the AIDS epidemic during the past decade. In 1999, the overall HIV prevalence among the adult population in the region was 20 %. However, recent antenatal clinic data show that several countries in southern Africa have joined Botswana with prevalence rates among pregnant women exceeding 30%. The ever expanding AIDS epidemic is projected to reach over 15 million adults by 2015 (POLICY Project, 2000). At this level of infection, AIDS will account for 4 of every 5 deaths in the adult age group 15-49 years.

The G8 Kyushu-Okinawa Summit meeting in July 2000 considered the issue of infectious diseases, including HIV/AIDS, as one of its leading themes. Participants in the Summit agreed to accelerate international efforts to fight infectious diseases, especially HIV/AIDS. This would be done by setting specific targets for reducing the number of people infected by the HIV virus. During the Summit, Japan announced the Okinawa Infectious Disease Initiative in which Japan committed to extend support to developing countries for measures against infectious diseases, especially HIV/AIDS.

The Japan International Cooperation Agency (JICA) is in the process of formulating a regional HIV/AIDS approach to be implemented in sub-Saharan Africa. SADC has been chosen to partner in this endeavor, which will use the SADC HIV/AIDS Strategic Framework and Programme of Action: 2000-2004 as the basis for cooperation in the Southern African region.

The approach will provide support to regional interventions but will also be cognizant of country-specific support provided by JICA missions in countries where they exist. Before implementing the approach, JICA supported two activities to provide information about HIV/AIDS interventions currently taking place in the Southern African region and potential areas for JICA support.

1.2 Workshop Objectives

The workshop was organized around two main themes (A workshop programme is attached as Annex I):

1) Identification of current national response to HIV/AIDS Control Programmes and associated problems from the viewpoint of Regional approach in Southern Africa.
2) Identification of areas for possible JICA cooperation on HIV/AIDS control programmes in Southern Africa.

1.3 Participants

The workshop was conducted with Directorial level staff from Ministry of Health or National HIV/AIDS Council (if established) of 11 SADC member countries, SADC Health Coordinating Unit, JICA Resident Offices in Southern Africa, JICA headquarters in Tokyo, the Embassy of Japan Zambia, and Ministry of Foreign Affairs, along with International Organizations, NGOs, Faith based organizations, and PLWAs. A total of 121 individuals participated in the conference. (A list of participants is attached as Annex 2)

1.4 Process

The workshop was organized by discussions on regional approaches in HIV/AIDS, introduction of Japan's ODA schemes, as well as requests and suggestions for Japan's assistance. At the Group discussion, participants were divided into six small groups in order to discuss better approaches for good regional cooperation in HIV/AIDS control, based on the presentation of pre-workshop survey data and based on three presentations on the focused area activities[2].

A pre-workshop survey was conducted by the consultants. Two types of questionnaires were designed to collect information on the current HIV/AIDS control activities from SADC member countries and selected regional organizations, which have HIV/AIDS related programs. The country-level questionnaire sought information on the national HIV/AIDS coordinating institution in each country, and dealt with the functions of a coordinating institution, prevention, treatment & care and impact mitigation strategies, priority populations and intervention, and amount of participation in regional programs. The questionnaire for regional organizations

[2] Voluntary Counseling and Testing: University Teaching Hospital in Zambia, Cross Border initiatives: USAID, and Information & Database: National AIDS council in Malawi.

sought to identify key activity areas, target groups, project-partners, and the current status of partnerships with the SADC health and non-health desks. (Annex II)

Questionnaires were sent to all 14 SADC member countries. Nine countries completed and returned the questionnaires. The responding countries were Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Eight regional organizations participated in the survey. These were the Regional AIDS Training Network, OXFAM, UNAIDS, UNICEF, the Commonwealth Regional Health Community Secretariat (CRCS), UNHCR, IPPF and GTZ.

Topics of the group discussions were follows:

1. Regional Approaches;
   - The constraints and opportunities of regional approaches
   - Definition of regional approaches
   - Factors driving regional approaches
   - Requirements for good regional practices
   - Possible areas of regional cooperation
   - Approaches and degree of coordination needs among institutions

2. Regional Approaches in the Voluntary Counseling and Testing (VCT), Information & Database and Cross Border Initiatives (CBI);
   - Method of developing regional approaches
   - Pre-requisites to regional approaches
   - Benefits and constraints of regional approaches
   - Requirements for improving current regional cooperation among key stakeholders

JICA and Japan's Ministry of Foreign Affairs introduced Japan's ODA schemes and current HIV/AIDS &TB related project-type technical cooperation projects in Zambia, Kenya and Ghana. Based on the Discussion and Japan's ODA scheme introduction, participants discussed possible JICA/Japan's assistance for HIV/AIDS control.

1.5 Constraints

The period of time available for disseminating the questionnaires and receiving responses was approximately

10 days. This was an insufficient amount of time for the respondents to provide the level of detailed and comprehensive information requested in the survey. Consequently, the response rate was relatively poor.

2. Summary of Keynote Speeches

2.1 Japan's Initiatives for Infectious Disease Control

Dr. Y Nakamura, Professor of Research Center for Civil Society, Osaka University (Annex 4-1)

Japan's experience in controlling infectious diseases after World War Two is a good example to control preventable diseases for the developing countries. Sharp decreases in the number of TB, malaria, Trachoma, Whooping cough, and Japanese Encephalitis were seen from 1950 to 1997. The decrease by approximately 50% in the Infant Mortality Rate from 1947 to 1960 was remarkable.

Dr. Nakamura studied key factors leading to this dramatic change without economical development. Dr Nakamura and his team concluded that the endeavors in central and local governments to create effective systems with a high participation of community, high value on childbearing and narrow socio-economic distribution worked together to decrease infectious disease rates and IMR. The government endeavor was represented by application of public health nurses, Maternal & Child health handbooks, population-based screening, and wide spread national health insurance coverage.

2.2 HIV/AIDS in Zambia

Dr. A. Simwanza, National AIDS/STD/TB Council, Zambia (Appendix 4-2)

Zambia currently has a 19.95% of HIV/AIDS prevalence among the adult population (aged 15 to 45 yrs-old), which has created approximately 7 million orphans. The prevalence rate is higher in the urban residents. Under this epidemic, the following factors are considered to fuel infections; poverty & overburdened health services, high STD prevalence, low condom utilization, gender inequity, stigma & discrimination toward HIV positive patients.

The Zambian government established a National AIDS prevention and control programme in 1986 and developed short and mid term plans in the following years. The plan applies multi-sectoral approaches, which are enhanced by the newly developed national, interfaith, and district networks seen in Annex 4-2.

Dr. Simwanza notes some success in the interventions including a decrease in the HIV/AIDS prevalence rate for the age group 15-29, and the HIV/AIDS prevalence rate in antenatal clinics. He also pointed out that Zambia and most of Southern Africa faces challenges such as poverty, debt, limited interventions and weak networks. Zambia requested further assistance from Japan to move forward in their effort.

2.3 Implementation of the regional response to HIV/AIDS/STD in the Southern Africa Development Community

Mr. M. Nzima, SADC HIV/AIDS Programme Manager, SADC Health Sector Coordinating Unit. (Annex 4-3)

In 1999, a Task Force on HIV/AIDS within SADC was set up under the leadership of the SADC Health Ministers (SADC 2000). The vision adopted by the SADC HIV/AIDS Task Force was "A SADC Society with reduced HIV/AIDS." This guided the work of the seven sectors participating in the development and implementation of a multi-sectoral SADC HIV/AIDS framework for the period 2000-2004.

Dr. Nzima introduced three major activities undertaken in the SADC Health Coordinating Unit. These are:

1. Policy and Adovocacy,
2. Mobilization of economic and other SADC sectors, and
3. Initiation of the Regional Response.

Under the Policy and Advocacy Programme SADC work to harmonize the HIV/AIDS policies has been completed but is awaiting comments from member states on the final draft document before dissemination. In addition, the SADC sectors have met and identified Human Resource Development (HRD) and Voluntary Counseling and Testing (VCT) as priority areas. SADC held a workshop to develop regional guidelines on VCT. Key organizations that participated included SADC member states, AIC, Uganda, BOTUSA-CDC, Botswana, the Kenya National AIDS Control Programme (NACP), MACRO, Malawi, and Uganda. As a way of strengthening regional networking, people from various institutions within the region and outside were a part of the process.

SADC has a Programme on Mobilization of Economic and other sectors, wchich encourages mobilize the economic sectors of SADC; Such as, the Directorate of Trade, Industry, and Finance and Investment, to commit themselves to HIV/AIDS programme support. This will entail the inclusion of the civil/military alliances in SADC through the ministries of Defense and Safety and Security.

Initiation of the Regional Response is another areas of SADC focus. This is one-year programme developed by the EU, aiming to implement HIV/AIDS programmes. In contributing to the regional response, project managers have also been employed to carry out consultations with the SADC on implementation of activities on HIV/AIDS in four areas, namely STD management, support for people living with HIV, support for national AIDS programmes, and support for behavioral change communication.

SADC HIV/AIDS Strategic Framework and Programme of Action

The HIV/AIDS strategic framework and programme of action was approved by SADC Council of Ministers in August 2000 and it covers the following areas:

- Cultural Information and Sport
- Employment and labor
- Health
- Human Resource Development (HRD)
- Mining
- Tourism
- Transport, communication and meteorology
- Finance and investment
- Industry and trade
- Food agriculture
- Natural resources

Overarching Goal:

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

Main Objectives

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

Outputs

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

3. Country Responses to HIV/AIDS Control

JICA consultants conducted a survey and literature review on the AIDS response in southern Africa. The study revealed that all countries in the region have produced a basic package of interventions (Annex 5) (UNAIDS, 2002; UNAIDS, 2001; and CRHCS, 2001). Generally, the responses include:

- Establishment through participatory processes of national HIV/AIDS strategies and action plans,
- Creation of administrative structures such as national HIV/AIDS councils and implementation secretariats with broad stakeholder participation,
- Adoption of multi-sectoral approaches involving every level from the community upwards, and
- Willingness of governments to channel public resources directly to communities and civil society organizations.

Results from the survey indicate that 9 of the 14 SADC countries have HIV/AIDS coordinating institutions, whose primary functions are:

- Policy guidance
- Provision of a secretariat for the National AIDS Council
- Coordination of the AIDS responses
- Strategic planning
- Undertaking and coordinating advocacy
- Assistance with monitoring and evaluation
- Mobilization of resources
- Management of financial resources
- Supervision

There is evidence that certain responses are effective in controlling the epidemic. HIV/AIDS technical specialists have tested and used 18 effective programmes and actions that prevent, mitigate and treat the epidemic (CRHCS). There are 10 key programmes for prevention, including youth interventions in school and for out-of-school youth, sex worker interventions, strengthening public sector condom distribution and condom marketing, strengthening STI treatments, workplace interventions, and mass media campaigns.

There are 5 generic care programmes that are an essential complement to efforts to prevent the initial appearance

and spread of AIDS. These include ①palliative care, ②clinical management of opportunistic infections, ③ home based care, ④clinical care for children, and ⑤prevention of opportunistic infections. Efforts to mitigate AIDS focus primarily on care for orphans and psychosocial support and counseling for persons living with HIV/AIDS.

Anti-retroviral drugs provide the most effective treatment for PLWHA.

Specific examples of successes in Africa are:

- A new study in Zambia shows urban men and women reporting less sexual activity, fewer multiple partners and more consistent use of condoms (UNAIDS 2001). This is in line with earlier indications that HIV prevalence is declining among urban residents, especially among young women aged 15-24.

- Botswana became the first country in the region to provide antiretroviral drugs through the public health system. The health budget was increased and drug price reduction was negotiated with pharmaceutical companies to provide this service.

- Large-scale information campaigns and condom distribution programmes appear to be having an impact in South Africa. Free male condom distribution rose from 6 million in 1994 to 198 million five years later (ibid).

These limited successes provide a rationale for scaling up those strategies that have generated documented results. Also, given the size and extent of the epidemic and its very rapid growth throughout sub-Saharan Africa, there is need for massive infusion of funding and technical support to control the epidemic.

In spite of these successes, a number of challenges remain. The vast majority of the people living in the region do not know their HIV status. Even when opportunities for testing are present, few people avail themselves of VCT. A study in Tanzania found that 50% of adult women knew where they could be tested for HIV but only 6% had been tested. In Zimbabwe, only 11% of adult women have tested for the virus.

3.1 Target Groups and Priority Areas

All countries in the southern African region have national priority target populations and action areas (UNAIDS, 2002). In the survey of SADC member countries, 9 out of 14 countries indicated the following priority target groups and action areas:

Table 1. Priority Groups

High Priority	Medium Priority	Low Priority
PLWHA	Orphans	Fishermen/Fishmongers
CSW	Private Sector	Women
Military/Uniformed Services	Cross Border Traders	Families of PLWHA
Truckers	Public Sector	
In and out-of-school youth		

Four of the nine countries have priority geographical areas, indicating a bias towards physical areas with high-risk activities and/or vulnerable populations. Only three of the countries indicating a bias to certain geographical areas also said they were engaged in cross-border interventions.

Table. 2 Priority Interventions[3]

Prevention	Treatment & Care	Impact Mitigation
BCC	Clinical Care	Psychosocial care
Condom promotion	Stigma	Home based care
STI	Prevention therapies	Stigma reduction
VCT	Palliative Care	VCT
MTCT	TB treatment	OVC
Blood safety	Provision of ARVs	

A more detailed analysis of the interventions by independent category reveals considerable similarity among countries in prevention strategies. All of the respondents made similar choices regarding their area of priority. However, there were major differences among countries in terms of the priorities given to treatment and care and impact mitigation strategies, as the following charts illustrate. All countries prioritize clinical care and the majority prioritized stigma reduction under treatment and care. There are major differences among countries regarding support to vaccine development and palliative care.

[3] 65-100% of the respondents ranked these interventions as priority areas.

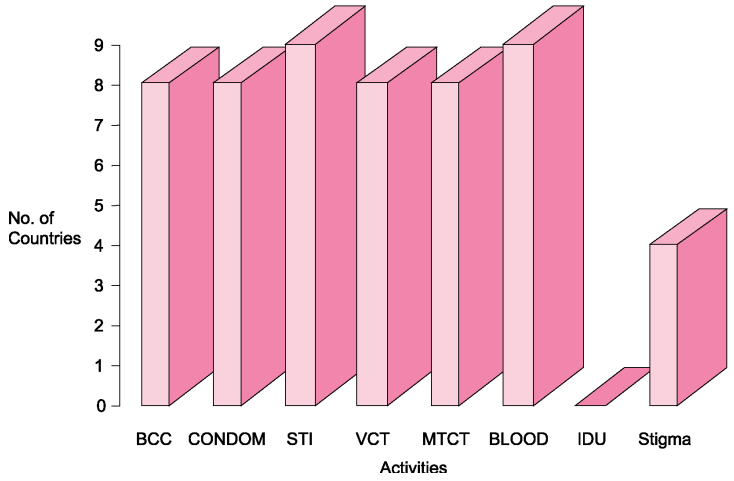


Fig. 1 Prioritized activities in the prevention areas

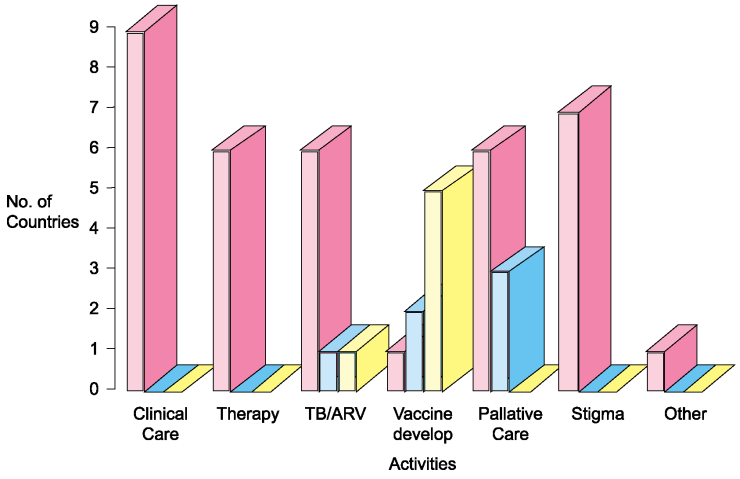


Fig. 2 Prioritized activities in Treatment and Care for HIV/AIDS patients

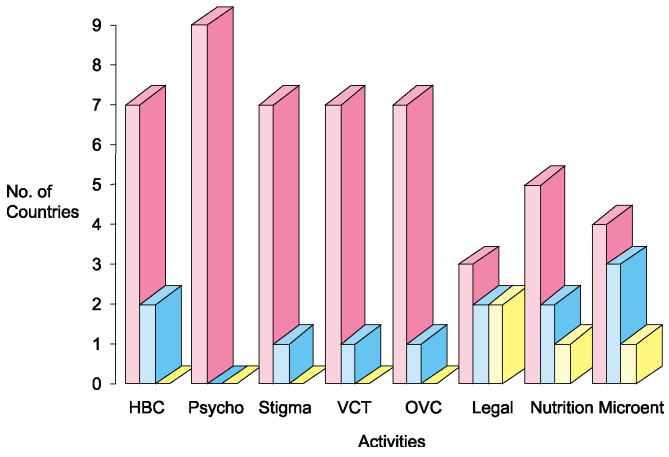


Fig. 3 Prioritized activities in the Impact Mitigation area

3.2 Priority Interventions

Specific areas of activities and associated problems in National AIDS programmes were asked by the pre-workshop survey. The intervention areas were selected from the basic standard interventions, which are as follows:

- Blood safety measures,
- Cross-border activities,
- Behavior change and communication,
- Harm reduction (prevention of intravenous drug abuse),
- Prevention of mother-to-child transmission (MTCT),
- Management of sexually transmitted infections,
- TB prevention and management,
- Voluntary counseling and testing, and
- Management of an in-country information/database on HIV/AIDS.

The following sections summarize interventions that countries have on-going, and in which they consider to be having constraints or problems.

3.2.1 Blood Safety

Blood transfusion is a potentially high-risk means of infection of HIV. WHO has been supporting safe blood schemes since the mid-1980s and achievements in setting high standards for blood safety appear to be widespread in the majority of SADC countries. All of the countries participating in the survey have national guidelines for transfusions, but only 7 of the 9 have a national blood transfusion policy. Eight of the countries have blood banks and quality control measures in place. Eight also have counseling services attached to the blood safety procedures. However, only 6 countries said they regularly screened blood products for other infections apart from HIV.

Some of the constraints associated with promoting blood safety are:

- Not all district hospitals have blood packs,
- Inadequate funding,
- Physical infrastructure is inadequate, and
- Inadequate technical capacity.

3.2.2 Behavior Change and Communication (BCC)

In the absence of a vaccine or cure for AIDS, BCC and IEC are important ways of controlling HIV transmission. BCC's primary objective is to promote safer sexual behavior, including abstinence. The survey shows that the pattern of interventions for promoting behavioral change was very similar among countries, as the illustration below shows. IEC and condom promotions are the dominant activities in all countries, followed by activities targeting youth and community mobilization.

Some of the constraints associated with behavior change and communication are:

- Limited funding,
- Limited outlets for condom sales,
- Inadequate monitoring systems,
- Lack of policy to guide some activities,
- Inadequate personnel to administer interventions.

3.2.3 Cross Border Initiatives (CBI)

Interpretation of what constitutes a cross border activity varied. Some countries have programmes that target border populations, but do not formally involve more than one country in the project. On the other hand, there are programmes that transcend borders in the region and target interventions at high risk and vulnerable populations in several countries simultaneously. Table 3 below indicates the number of countries who said they are involved in a cross border initiative and the interventions undertaken.

Table. 3 Cross Border Initiatives

Activity	No. of Countries
Guidelines exist	2
A cross border initiative manual exist	1
STI drugs are available	6
Syndromic management introduced	8
Personnel working with transit populations	2
Truck companies involved	5
IEC materials available	8
Community mobilization	3

Some of the constraints identified with cross border interventions are:

- Inexperience: the programme is still in its infancy,

- Limited financial resources,
- Inadequate supervisory support for medical personnel,
- No monitoring system in place,
- Inadequate supplies.

3.2.4 Prevention of Mother-to-Child Transmission (MTCT)

The risk of MTCT in the region is estimated to be 30 – 50% (POLICY, 2000). HIV can be transmitted from mother to child during pregnancy, delivery and through breast milk. Mother-to-child transmission appears to be a high priority issue among most countries in the region, as indicated in the Table 4 below. For example, basic procedures are in place to test and counsel pregnant women. However, other supportive services appear to be minimal.

Table 4. Prevention of Mother-to-Child Transmission

Activity	No. of Countries
MTCT policy exist or is in the process of formulation	6
National guidelines exist or are in the process of formulation	6
MTCT center has been established	5
ARVs are available	5
HIV test kits are available	5
A specialized laboratory has been established	3
Counselors have been trained	7
A national reporting system is in place	5
Training of medical staff in MTCT prevention and control exist	4
National campaign has been initiated	5
Alternative feeding options are promoted	5

Constraints associated with MTCT were:

- Inadequate quality control of HIV testing,
- Inadequate equipment and resources,
- Shortage of medical staff,
- The breastfeeding issue is contentious.

3.2.5 Sexually Transmitted Infection (STI) Management

STIs and HIV/AIDS are closely linked. STIs, particularly those associated with genital ulcers, increase vulnerability to HIV infection. Consequently, many countries have included STI prevention as part of their

AIDS control program.

The survey results show that most countries have well-developed STI programmes, as indicated in Table 5 below. However, research to monitor and assess drug resistance is only carried out in very few countries:

Table 5. Sexually Transmitted Infection

Activity	No. of Countries
National policy exist	7
STD drugs are widely available	7
Medical staff trained in Syndromic management	9
STI drug resistance research takes place	3
Youth friendly clinics have been established	8

The constraints associated with STI management are:

- Erratic drugs supplies,
- Inadequate financial resources,
- Inadequately trained personnel,
- Inadequate follow-up, and
- Limited resources for research.

3.2.6 Tuberculosis (TB) Management and Prevention

Throughout the region the number of TB cases has been rising rapidly during the past decade. HIV/AIDS is strongly correlated to TB as the HIV virus weakens the immune system of otherwise healthy adults. Because TB is endemic in Southern Africa, as many as half of the adults carry a latent TB infection (POLICY, 1999).

Most of the countries participating in the survey have comprehensive TB management and prevention programmes. All 9 countries participating in the survey have TB policy and guidelines to direct interventions. Drugs are readily available in all 9 countries to treat TB, and 8 countries reported having trained personnel to administer services. Although 9 countries have established TB laboratories, only 6 have sufficient equipment to satisfactorily run them. The DOTS approach has been adopted by 8 countries and TB prevention measures for persons living with HIV/AIDS are provided in 6 countries.

Constraints commonly experienced by the countries are:

- Inadequate human resources,

- Limited financial resources, and
- Inadequate supervision of personnel in the system

3.2.7 Voluntary Counseling and Testing (VCT)

VCT is strongly linked to HIV/AIDS prevention and care strategies. It has been demonstrated in a country such as Uganda that when people know their status they are less likely to adopt sexually risky behavior. Testing alone, however, is not effective. International guidelines on counseling and testing suggest that testing should be done on a voluntary basis, and that counseling precede testing and is also given when results are made available.

Table 6. VCT activities

Activity	No. of Countries
National VCT policy exists	3
National guidelines exist	5
Quality control measures exist	4
Lab Technicians trained	4
Counselors trained	6
Reporting system exists	6
National campaign implemented	4

Constraints associated with VCT are:

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

3.2.8 Reduction of Risks to Intravenous Drug Users (Harm Reduction)

In some regions, HIV is transmitted primarily through sharing un-sterilized needles during intravenous drug use and resultant vulnerability due to reduced personal responsibility. Substance abuse, particularly alcohol, is a problem in Africa, but the main modes of transmission are heterosexual intercourse and MTCT.

Most countries do not consider reduction in intravenous drug use as a priority or area for investing resources. As the Table 7 indicates, few countries have developed interventions in the area:

Table 7. Activities to control IDU

Activity	No. of Countries
National policy on IDU	0
VCT centers for IDU	1
Counselors trained for the program	2
National campaign initiated	1

4. Regional Response to HIV/AIDS Control

In response to the scourge of the HIV/AIDS epidemic, countries in east and Southern Africa have developed policies, strategies and programmes that are multi-sectoral in nature (CRHCS 2001). In addition, a number of regional organizations have been established in the region to combat HIV/AIDS. The kinds of regional organizations have included International NGOs, bilateral donors, UN agencies and religious organizations. The mission, source, level of funding and their capacity in the area of HIV/AIDS have determined their area of focus. Most of the regional organizations have their main offices in Nairobi, Kenya. In this section, "Regional Approaches for HIV/AIDS Programme" is analyzed with the data from the group discussions and pre-workshop survey. (Presentation by consultant is attached as Annex 5)

Defining a Regional Approach

'Regional Approach' is a buzzword with many meanings and interpretations. From the survey findings, some regional organizations interpreted regional approach as having offices or contacts at the country level to conduct country programmes. Some regional organization head offices did not have sufficient details on what kind of programmes were being conducted at the country level by their respective organizations.

Workshop participants defined a regional approach as

"*A consultative framework for the purpose of networking and sharing of information and resources that has been endorsed and owned by member countries on important cross cutting issues, duly recognizing inter country differentials, with a well defined coordinating and monitoring mechanism*."

4.1 Current Situation of Regional Approaches on HIV/AIDS in Southern Africa

Eight of the nine countries surveyed indicated that they were participating in Regional Programmes. Regional activities that countries participated in included cross border initiatives (CBI), sentinel surveillance (SS), tuberculosis control (TB), STD control, training, drug procurement, I.E.C, BCC and Civil Military Alliances (CMI). However there were apparent contradictions when countries were asked to indicate which countries they worked with and in what areas. Most respondents could not furnish details of the kinds of collaborations with other countries in the region.

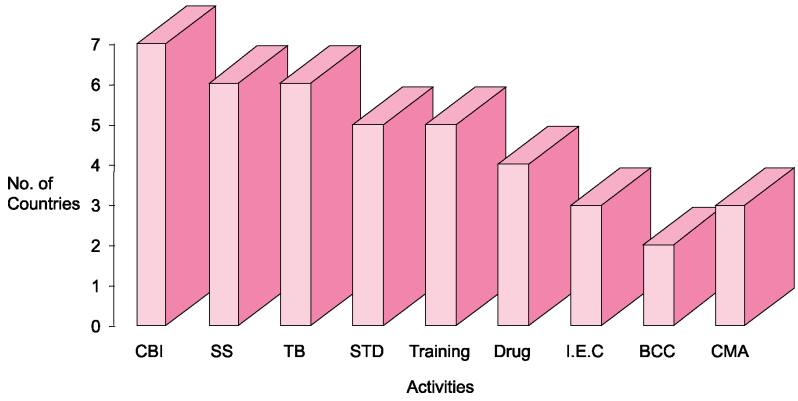


Fig. 4 Participation to regional Activities /Strategies

Activities and interventions undertaken by regional organizations according to survey results include technical assistance, direct financial support, advocacy, policy development, I.E.C (communication), B.C.C and information/databases.

The survey indicated that three of the nine countries felt there were no relationship at all between the regional programmes and the country programmes. Five respondents reported that the regional and country programmes reinforced each other, and the respondent in one country reported uncertainty about the relationship. This signifies general confusion among member countries about the benefits of regional HIV/AIDS activities.

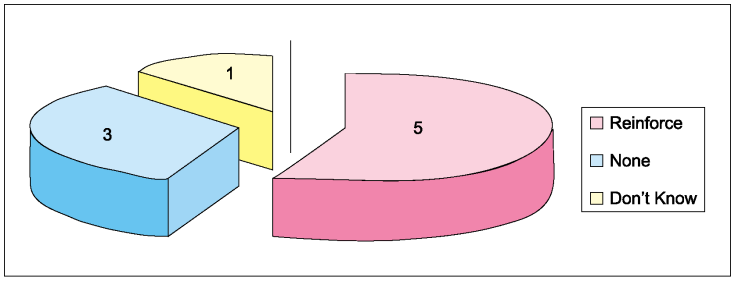


Fig. 5 Relationship between national and regional programme

The priority target groups for regional organizations in facilitating a regional approach varied and were quite diffuse and not well defined. They ranged from countries to various kinds of populations.

4.2 Rational for a Regional Approach

Opportunities, constraints and possible areas for the regional approaches were discussed during the group discussion in order to share the concept of good practices for regional approaches in the fight against HIV/AIDS in Southern Africa. This discussion was also held in order to identify required conditions for developing Regional approaches.

Opportunities

In the SADC region, several conditions were identified as opportunities by workshop participants. First, the existence of Regional coordinating organizations, local and international NGOs, and the UN system etc. (International NGO's with regional offices) are considered to be a trigger for developing regional approaches. The framework or strategy for HIV/AIDS control developed by those regional coordinating bodies will be able to guide neighboring countries to share their roles to use regional resources effectively, because in the course of developing frameworks common needs and resource availability are well examined. In addition, trading links have already been established in this region, including availability of regional media sources. The linkage is considered to be enhancing country to country coordination.

Funding sources such as DFID, EU, Global Fund, MAP, and World Bank, as well as cooperating partners such as donors also exist in the SADC region for encouraging and providing region-wide activities, such as cross-border initiatives and regional training networks.

Recent development of technology makes it possible for countries to share their information, such as experiences and current activities among countries having similar HIV/AIDS epidemics patterns and programming activities. Some participants also mentioned the availability of human resources in the region. In addition, people in the region use English as their common language, which makes it easier for countries to develop integrated programmes as well as to discuss effective coordination.

Constraints

Although the existence of regional coordinating institutions is identified as an opportunity, it is not sufficient to develop regional coordination. At the group discussion, participants identified regional coordinating organization's constraints as follows:

1. Poor coordination mechanisms,
2. Lack of funding,
3. Lack of effective monitoring systems,
4. Lack of clear mandates for regional entities.

Different levels of response from government, different levels in economic development, conflicts, wars, and natural disasters make it difficult to organize common activities and guidelines. Poor donor coordination was pointed out by participants, as it possibly creates further confusion to the regional approaches.

Possible areas for regional activities

Cross boarder initiatives, orphan care, information sharing, home based care, STI management, and MTCT are identified as suitable areas for regional cooperation, through the following interventions:

- Capacity building, especially in human resources development for regional training programmes,
- Mobilization of human, financial and technical resources, and
- Standardization of protocols.

4.3 Conditions for a good Regional Approach

There are activities that drive the HIV/AIDS epidemic at regional levels. Inter-regional trade spurred by the global economy, ease of travel, migration and historical cross border links fuel the spread of HIV infection internationally, and intensify vulnerability in particular country-specific settings. For instance, in countries like Malawi, Zambia and Zimbabwe, which are land-locked, have many borders, and are part of several international travel routes, STI and HIV infections are particularly high along major transportation corridors. These corridors of vulnerability extend to neighboring countries that also are part of the international road network.

Because the AIDS epidemic has become a regional problem as well as country- specific, increasing attention is focused on possible regional responses. A regional response can be implemented in several ways. It can encompass:

- Similar interventions targeting several countries in the region simultaneously, such as the USAID-funded "Cross Border Initiative" project,
- Interventions that operate at a regional level and in which individual countries participate. An example

is the regional training programme offered by the Regional AIDS Training Network (RATN),

- Policy level interventions that reflect a unified response, such as discussions by SADC countries on drug procurement through bulk buying, preference for generic brands, and setting up a distribution system that recognizes economies of scale.

4.3.1 Requirements for good regional practice

There was consensus in the workshop that for a good regional approach, the following needs to be in place:

- A focal point institution with backing and support from member countries and regional organizations,
- Development of an accepted common understanding and agenda on regional approaches,
- Access to resources such as human and financial capital, templates for policies, data collection and analysis, and access to other facilities, and
- Ability to implement programmes (political will and timely decision making).

The need for a regional approach was not disputed. It was stated that factors favoring or driving the regional approach included:

- The commonality of problems,
- Gravity of the HIV/AIDS epidemic, its complexity and economic impact,
- Inter-dependence of countries in the region,
- The cost effectiveness of programmes, i.e. training materials, procurement of drugs and complementary efforts,
- Sharing of information regarding best practices, new developments and experiences,
- Advocacy (power in numbers),
- Basic standardization of intervention packages and harmonization of policies, and
- Resource mobilization.

Coordination among neighboring countries

The issue of coordination was the most critical. Coordination should encompass overlapping themes, sectors engaged and coverage. There is a need to share protocols in areas such as training, information and networking.

It was strongly recommended that SADC should take up the role of coordinating programmes working in collaboration with the National AIDS Councils and the regional organizations. The net effect of this effort

would be to enhance capacity in human, financial and technical areas. They also suggested that JICA, in collaboration with SADC, could second personnel to the SADC health desk to help in spearheading this initiative.

Role of SADC in a Regional Approach

Article 10 of the SADC health protocol (SADC 1998) states that in order to deal effectively with the HIV/AIDS pandemic in the region, there is need to:

- Harmonize policies and identify mechanisms to reduce transmission of STDs and HIV infection,
- Develop approaches for the prevention and management of HIV/AIDS/STDs to be implemented in a coherent, comparable, harmonized and standardized manner,
- Develop regional policies and plans that recognize the intersectoral impact of HIV/AIDS and the need for intersectoral approaches to these diseases, and
- Cooperate in the standardization of sentinel surveillance systems, regional advocacy efforts and sharing of information.

Role of Countries in a Regional Approach

The SADC framework for HIV/AIDS seeks to complement current and on-going national responses to the HIV/AIDS epidemic as outlined in the respective National HIV/AIDS Plans and programmes. Consistent with the dynamics of HIV/AIDS in the region and lessons learnt there is now a greater need to develop multi-sectoral and regional approaches. Although the SADC framework provides for mechanisms to coordinate the use of resources and programmes, the institutional framework has lacked support from member countries.

Most member states are part of some regional organizations such as CRHCS, and COMESA. It appears there is poor coordination among regional organizations, leading to fragmentation and conflicting demands. There is a need therefore for member states to set up clear coordination mechanisms and clarify roles and responsibilities of regional organizations.

Role of Cooperating Partners in a Regional Approach

Based on the pre-workshop survey and group discussion, participants identified cooperating partners' needs in strengthening links with National AIDS Programmes and determination of priorities in the region.

Some regional organizations are not aware of what is taking place in countries. This has implications for lack of sustainability in some regional interventions. In order to build consistency in the country programmes and regional organizations' programmes, strengthening links with National AIDS Programmes is necessary.
In view of the multitude of regional players, some of whom have equal footing with SADC, the need for countries to set their own priorities cannot be under emphasized. Cooperating partners should ensure that regional programmes are in harmony with national priorities.

4.4 Cooperation between SADC Health Unit and Regional Organizations

Of the eight regional organizations surveyed, 4 reported that they had some cooperation with the SADC Health Unit. The areas of cooperation included networking, advocacy, capacity building (i.e. training and management development). Workshop participants identified following points as opportunities for closer collaboration to SADC Health Unit:

- Resource Mobilization,
- Support capacity development in HIV/AIDS programmes, and
- Involvement of more partners to support SADC.

The country level survey identified constraints in cooperating with SADC Health Unit as follows:

- Inadequate staff in the SADC Health Coordinating Unit, and
- Financial resources in the SADC Health Coordinating Unit.

In collaboration with the SADC Non-Health Unit, very few regional organizations had any form of collaboration. However, the following opportunities for future collaboration were highlighted:

- Strengthening of the multi-sectoral SADC strategy,
- Increasing Political Advocacy,
- Reaching the private sector for resource mobilization, and
- Strengthening common interventions.

5. Regional Approaches in the Focused Areas

— Voluntary Counselling and Testing, Cross Border Initiatives, and Information & Database —

In the course of the group discussion, participants discussed approaches for developing effective Regional Cooperation under the Voluntary Counselling and Testing area.

5.1 Regional Approaches: Voluntary Counselling and Testing

5.1.1 How can a Regional approach be developed?

- Use of existing SADC coordinating mechanism to spearhead the work of VCT,
- Establishment of a task force under the leadership and coordination of SADC to prepare and develop a regional VCT programme,
- Identify intermediary organs/institutions that are key in VCT,
- Identify existing documents and guidelines pertaining to VCT in the region, and
- Identify best practices in the region in VCT.

5.1.2 Prerequisites to a regional approach

- Conduct situational analysis of VCT needs in the region,
- Availability of an institutional mechanism to spearhead regional cooperation,
- Availability of financial, technical and human resources,
- Consideration of inter-country differences in the approach to VCT services,
- SADC health ministers commitment to VCT as a priority, and
- Implementation and monitoring of SADC ministers resolutions on health issues such as VCT.

5.1.3 Benefits of a regional approach

- It will be cheaper in the procure-ment of HIV test kits in bulk,
- Sharing of information and best practices will be better,
- Sharing of technical expertise to shape the VCT programme,
- It will be easier to harmonize policies, guidelines and protocols, and
- Development of common monitoring/evaluation indicators.

5.1.4 Constraints

- Each country has different procurement procedures,
- Countries have a different range of donors with different policies,
- Varying levels of national responses among SADC countries to HIV/AIDS, including VCT,
- Countries have different health care systems,
- Poor operationalization of national strategic plans in general by member countries,
- Varying levels of economies among member states,
- Different national policies and VCT models among member units, and
- Lack of coordinated funding mechanisms for response activities.

5.1.5 Requirements for improving current regional cooperation among key stakeholders

- Harmonization and coordination among member countries and partners (donors, NGOS private sector) in approaches to VCT,
- Improvement of the technical and management capacities in individual member states,
- To provide a forum for effective dissemination and networking among member states in VCT, and
- Development of effective and operational monitoring and evaluation systems in VCT.

Zambia Voluntary Counselling and Testing:Lesson Learned

Dr. F. Kasolo, Director Zambia VCT Service, University Teaching Hospital (Annex 9-1)

Zambia Voluntary Counseling and Testing Started in 1999 as a part of the Zambian government programme: Zambia Voluntary Counseling and Testing (ZVCT), which includes 22 testing centers. Currently the government programme expanded to 100 test centers. The objectives are to establish a rapid health care integrated ZVCT for integrating other HIV interventions. The VCT are used in MTCT, TB and STI services.

Several technical and management challenges are identified as follows:

Management issues:

- Lack of programme focus,
- Lack of involvement of local stakeholders,
- Fewer participants for counseling than testing, and
- Poor community mobilization.

Technical issues:

- Incomplete test kits and poor funding,
- Overwhelming number of samples, and
- Lack of standardization of VCT services.

Dr. Kasolo pointed out that the following are necessary to achieve good VCT services:

- The National AIDS Council should coordinate all HIV/AIDS relateed activities,
- ZVCT activities are integrated with the care technical working groups,
- CBOH is actively involved in the VCT programme,
- VCT sensitization and community mobilization activities are sufficiently funded, and
- A decentralized quality control system is established.

It is expected that by the year 2004, 25% of adult Zambians will take VCT and know their HIV sero status.

5.2 Regional Approaches: Cross Border Initiatives

5.2.1 How can a Regional approach be developed?

- SADC should coordinate the regional CBI programme.

5.2.2 Prerequisites to a regional approach

- Government and political commitment is essential,
- Development of common monitoring and evaluation systems in member states, and
- Involvement of all stakeholders- government, NGOs and donors during planning.

5.2.3 Benefits of a regional approach

- Access to a broad audience through a standardized approach in IEC,
- Expanded access to information and commodities (i.e. condoms, drugs etc) which complement national activities,
- Easier to reach migrant and high risk populations that travel frequently in the region, and
- Provides the opportunity for comparing information which is standardized (country to country) and also

allows easy monitoring and evaluation.

5.2.4 Constraints of a regional approach

- Inadequate financial and human resources,
- Poor government to government relationship (i.e. conflicts and wars), and
- Lack of an NGO's organisational structure to work with governments.

5.2.5 Requirements for improving current regional cooperation among key stakeholders

- Need for coordinating entity such as SADC to be recognized and strengthened, and
- Improvement of donor to donor communication in the design and implementation of programmes.

Regional HIV/AIDS Programme in Southern Africa

Ms. M. Russel, the Regional HIV/AIDS Programme Co-ordinator, USAID Regional Office, (Annex 9-3)

Ms. M. Russel, the Regional HIV/AIDS Programme Co-ordinator, USAID Regional Office gave a historical perspective of the cross-border initiatives involving Southern African countries, namely Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe to identify HIV/AIDS target populations and needs.

Assessments:

- Assessments were conducted in Swaziland, Mozambique, Lesotho, Zambia, Zimbabwe and Namibia to identify target population and needs,
- After assessments, meetings were held with key stakeholders to determine whether or not to implement a programme and type of intervention, and
- Key findings from assessments included: multiple sexual partners, and a lack of access and use of condoms.

Interventions:

Interventions were tailored to meet the needs of different target groups and health personnel. These included education and outreach activities for behavioral change, targeting men, truckers, traders, youth and uniformed services.

Cross border sites:

- Messina, South Africa
- Beitbridge, Zimbabwe
- Chirundu, Zambia
- Chirundu, Zimbabwe
- Maseru and Maputsoe, Lesotho
- Mulanje, Malawi

Achievements:

- New programmes in South Africa, Zimbabwe, Zambia, Namibia and Swaziland,
- Messina, South Africa – 93 peer educators trained, monthly STD/HIV/AIDS radio show and 50,000 condoms distributed,
- Chirundu, Zambia – 31 peer educators trained, treatment programme for CSW in place,
- Beitbridge/Chirundu, Zimbabwe – 60 CSW peer educators trained, 92,700 condoms distributed,
- Mareru, Lesotho – 78 peer educators trained, engagement and mobilization of village HIV/AIDS committees run by village chiefs,
- Afribike – programme launched in South Africa and Lesotho, bike shops set up in the two countries, and peer educators from both countries participated in the AIDS ride in South Africa, and
- In addition these people are engaged in mobilization of HIV/AIDS committees which are run by village chiefs. Interventions also included collaboration with SFH for training on marketing and sales of condoms.

5.3 Regional Approaches: Information and Database

5.3.1 How can a Regional approach be developed?

- Create a regional information database.

5.3.2 Prerequisites to a regional approach

- Development of country databases,
- Common tools and indicators for monitoring and evaluation, and
- Increase in technical, financial and material resources.

5.3.3 Benefits of a regional approach

- Increased ownership and responsibility of the information generated rather than deperdency on UNAIDS data all the time,
- Information generated will be used for regional priority setting and planning, and
- Facilitation of information sharing and networking among member states.

5.3.4 Constraints of a regional approach

- Differences in resources (financial and technical) amongst members.

5.3.5 Requirements for improving current regional cooperation among key stakeholders

- Increased political commitment in setting up regional information/database to feed into planning,
- Periodic evaluation and monitoring of regional management information systems, and
- Provide a form for information sharing.

Information/Database in HIV/AIDS – Malawi experience

Mr. B. Kalanda, Head of Planning, Monitoring and Evaluation, National AIDS Council, Malawi (Annex 9-2)

Mr Boniface Kalanda, the Head of Planning, Monitoring and Evaluation, National AIDS Council, gave a historical perspective of the HIV/AIDS programme in Malawi. A National AIDS Council and a Cabinet committee on HIV/AIDS have been established to coordinate the multi-sectoral approach for HIV/AIDS, based on the strategic framework for 5 years covering 2000-2004.

The following successes and opportunities have been recorded in Malawi:

- Almost universal awareness creation,
- Screening of blood for transfusion,
- Community and inter sectoral collaboration,
- Giving HIV/AIDS a face for effective intervention by involving PLWA,
- The window of hope aged between 10-14 have been found to be about 90% HIV negative,
- Political will and commitment, and
- A workable strategic plan of action.

Strategies to gather and disseminate information include:

- Instituting 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 organizations, and
- Technical working group of CRIS (Country Response Information System).

The functions of M&E Core group:

The group will be advising on:

- Sentinel and behavioral surveillance,
- Appropriate indicators for the surveillance at different levels of the health care system, and
- Disseminating strategy for the findings of the Core Group

Quarterly meetings for:

- M&E experts from partner organisations to share their experiences,
- To agree on what should be contained in a national M&E report,
- Training on common problems, and
- To develop terms of reference for a technical working group of the CRIS.

Tools to collect data

- HIV/AIDS information system website,
- M&E Strategy,
- Collection forms agreed by partners.

Human Resource Needs:

The programme needs well qualified and experienced personnel in research, monitoring and evaluation and data processing, who will need periodic training and continued education and are already in the National AIDS Commission's M&E Unit, as well as district coordinators trained in basic skills.

Constraints Experienced:

- Lack of will at management level,
- Lack of documented competencies/skills of M&E staff,
- Inadequate finances to procure necessary resources to run the unit (i.e. computers, software reagents,

and transport),

- Staff shortage, and
- Poor follow up by partners.

Lessons learnt

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

6. Japan's ODA and experience in Project-type technical cooperation in Africa

Since its establishment in1974, the JICA has supported human resource and socioeconomic development in order to facilitate the autonomous, sustainable development of developing countries, as one of Japan's ODA implementing bodies.

Contributing to Human Resource Development

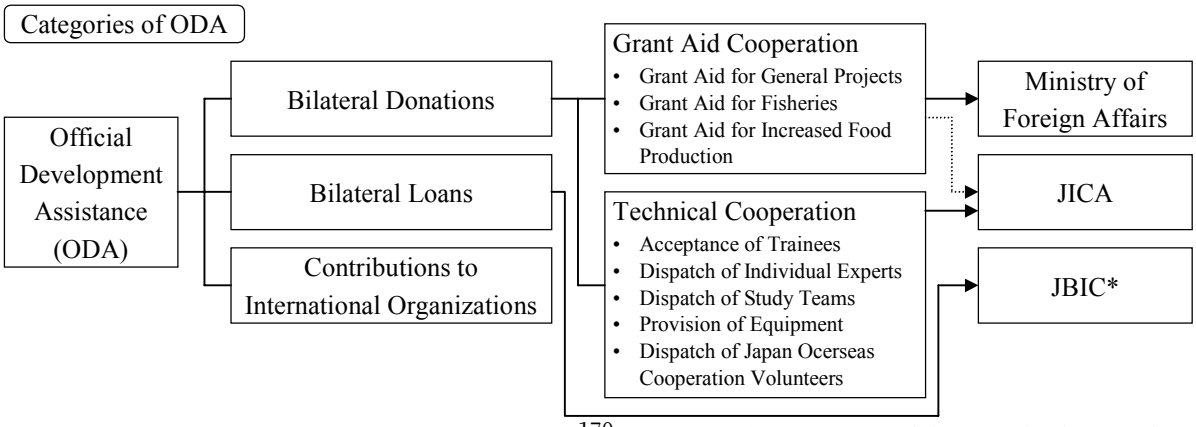
It is vital to develop a country's human resources in order to support its overall development. Technical cooperation involves interpersonal communication, for instance between Japanese experts and their counterparts in the partner country. This means technical cooperation activities have moved beyond the transfer of technology, to include the transfer of knowledge (such as development of organizations and systems), as well as fiscal policy.

Support for Self-help Effort

In order for developing countries to achieve sustainable development, they must play a leading role in their own development. In the case of support as well, it is vital to foment a sense of ownership on the part of developing countries. JICA encourages self-help efforts in developing countries in which it cooperates, for instance by assigning counterparts, providing facilities, and bearing a portion of operational costs commensurate with the country's ability to pay.

Grass-root Cooperation with Local Communities

JICA is enhancing its grass-roots cooperation with communities. The remarkable economic development of some developing countries has highlighted the experience of people living in poverty, who have not benefited from this economic prosperity. JICA is fully committed to answering the needs of local residents by satisfying Basic Human Needs (BHN), including rural and agricultural development, public health, and medical care.



*JBIC = Japan Bank for International Cooperation

6.1 Kenya Medical Research Institute-JICA Project

Dr. S. Mpoke, Counterparts of KEMRY/JICA project, Nairobi, Kenya (Annex 7-3)

The Kenya Medical Research Institute (KEMRI) has been playing a leading role in finding better ways to control and treat diseases, as well as ways of extending public health services in Kenya and other parts of Africa. The institute was established in 1979 with grant aid from Japan, and JICA has been cooperating for the last 21 years, covering various areas such as viral hepatitis, viral diarrhea, bacterial diarrhea, schistosomiasis, and filariasis during the course of cooperation.

Dr. Mpoke introduced three components of the JICA-KAMRI project: 1) Development and production of an HIV PA-test kit, 2) Third country training course in KEMRI and, 3) KEMRI-JICA HIV/AIDS cohort studies on the influence of prenatal short course Zidovudine on vertical transmission of HIV and child mortality in a rural population.

1) Production of KEMRI HIV-1 PA is one of the ongoing projects. The PA-kit is a Particle Agglutination type test for detection of HIV-1 antibodies. Dr. Mpoke explained that the demand for a cost-effective, reliable and sustainable test kit in Kenya and the idea of home made test kit will contribute to further development of technology in Kenya lead to this project. The quality of the test kit was approved by the National AIDS and STDs Control Council on 8th June 2000. He also explained that to maintain the quality of the test, training components are crucial.

2) Dr. Mpoke introduced the JICA sponsored training course: "Third country training programme: Blood Screening for Viral Hepatitis and HIV/AIDS". This course is conducted in order to train participants to update relevant knowledge on appropriate techniques in blood screening for "Sustained Blood Safety." The course is targeted for managers or policy makers working, or in-charge of, blood screening programmes, and laboratory technologists involved in blood safety activities.

3) The JICA-KEMRI project conducting HIV/AIDS cohort studies in Western Kenya, which studied the effects of prenatal short course Zidovudine on vertical transmission and child mortality in a rural community in Kenya. The study results were as follows:

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

6.2 Zambia University Teaching Hospital-JICA Project

Dr. F. Kasolo, Counterparts of UTH/JICA project, Lusaka, Zambia (Annex 7-1)

Dr. Kasolo introduced the 5-year JICA-UTH Project, "HIV/AIDS &TB project" at UTH. The primary purpose of this project is, "Laboratory Systems are strengthened and are effectively utilized for HIV/AIDS and TB control in Zambia." The Project has two main components: The HIV/AIDS control programme and The TB control programme.

Under HIV/AIDS Control Programme:

- Care & treatment
- VCT
- Prevention of Mother to Child transmission
- HIV Vaccine development

Under TB control Programme:

- Prevention & treatment

The expected outcomes of the project are follows;

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

6.3 Noguchi Memorial Institute for Medical Research (NMIMR)

JICA Project Ghana HIV/AIDS Programme

Dr. W. Ampofo, Counterpart of NMIMR-JICA Project (Annex 7-2)

Dr. Ampofo introduced activities of the JICA infectious disease project at NMIMR, which started in 1999 and will continue until 2003. The aim of the project is to improve the health of Ghanaian people through research activities and training on infectious diseases and control. The project includes research on the following infectious diseases:

- HIV/AIDS,
- STDs,
- Tuberculosis,
- Viral haemorrhagic fevers,
- Measles, and
- Schistosomiasis.

Under the HIV/AIDS Programme, the following activities are on-going: 1) Genetic characterization of HIV strains in Ghana, 2) quality control for HIV testing, and 3) Evaluation of HIV test kits. These activities are in collaboration with government National programmes such as National HIV testing, VCT, implementing guidelines, a pilot project of prevention of Mother-to-Child transmission, implementing Guidelines for ART, an ART pilot programme, the National ART program, implementing STD guidelines, and National TB detection.

7. Conclusions

7.1 Workshop Appeal

Workshop participants met in Lusaka, Zambia from March 20-21, 2002 in a regional workshop for HIV/AIDS in Southern Africa and acknowledged 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 a cross cutting and regional issue. SADC has the mandate of the member states to lead the fight against infectious diseases in the region, and
- In order to enhance SADC's leadership as a regional coordinating body, information sharing among governments, multi-lateral, and bi-lateral donors and NGOs is essential.

7.2 Suggested Way Forward

Based on the workshop deliberations, it appears that the majority of countries have adopted a comprehensive range of interventions to combat HIV/AIDS. The interventions vary according to importance at the country level. Based on survey findings and workshop discussions, it can be concluded that:

- There is variation in the conception of regional approach/activities,
- Some regional organizations only have a superficial knowledge of their operations at the country level,
- Coordination among regional players is poor, making it onerous for country-level partners to meet their obligations in the partnership,
- Only 50% of the responding regional organizations have any cooperation with the SADC health unit, indicating that prospects for closer collaboration are poor,
- There are many coordinating bodies in the region with overlapping boundaries but similar roles and responsibilities. This raises the question of what mechanism should be put in place to facilitate the coordination among regional organizations and member states of SADC,
- Countries stated that they are being held ransom by bilateral, multilateral and regional partners because of demands to attend meetings and participate in multiple uncoordinated activities,

- Country-to-country collaboration on HIV/AIDS interventions is currently ad hoc and information on the degree of coordination is not fully appreciated by key government and NGO stakeholders, and
- NAC is not always consulted and fully consulted on regional initiatives.

It can also be concluded that major gaps in programme design and implementation exist at the country level. Some of these gaps are:

- Limited financial resources,
- Inadequate Human resources,
- Inadequate physical infrastructure,
- Insufficient advocacy,
- Lack of adequate community mobilization, and
- Lack of appropriate research.

Bibliography

CRHCS *Regional HIV/AIDS Strategy for East, Central and Southern Africa*, Arusha, Tanzania, 2001.

JICA *Minutes of the Regional Workshop on HIV/AIDS in Southern Africa*, Lusaka, March 2002.

Loewenson, Rene and Alan Whiteside HIV*/AIDS Implications for Poverty Reduction*, UNDP 2001.

POLICY PROJECT *HIV/AIDS Policies in the Southern Africa Development Commission (SADC) Region: A Review,* Draft Report, September 2001.

POLICY Project *HIV/AIDS in Southern Africa: Background, Projections, Impacts and Interventions*, Washington, D. C. March 2000.

POLICY Project *HIV/AIDS in Zambia: Background, Projections, Impacts and Interventions,* Lusaka, Zambia 1999.

SADC *SADC HIV/AIDS Strategic Framework and Programme of Action 2000-2004*, August 2000.

SADC *Protocol of Health 1998.*

Shongwe, Steven *Strategic Planning for HIV/AIDS: A Summary of Regional Organizations Working in HIV/AIDS,* 2000.

UNAIDS *Sub-Saharan Africa National Responses to HIV/AIDS: Country Implementation Readiness Profile,* Geneva, Switzerland, January 2002.

UNAIDS/WHO AIDS *Epidemic Update*, Geneva, Switzerland, December 2000.

6．帰国報告会議事録

南部アフリカ域内ワークショップ（HIV/AIDS 対策）帰国報告会会議事録

1　日時　2002 年 4 月 23 日（火）10：00-12：00

2　場所　新宿マインズタワー１０Ｆ　JICA 地域部内会議室

3　参加者　外務省　経済協力局　調査計画課：矢加部裕之、開発協力課：溝上健、
技協課：山口典史、政策課：神谷望、無償課：犬島朋子

JICA　企画・評価部援助協調室：鈴木あゆみ、無償部計画課：古市剛久、
無償 2 課：戸塚真治、森本康裕、武村勝将、クリスティン・ビルカベッジ、
医協部計画課：新井明男、岡野香苗、医協 2 課：八重樫成寛、境勝一郎、
奥本恵世、協力隊海外 2 課：水谷恭二、洲崎毅浩、
アフリカ・中近東・欧州部　アフリカ課：鍋屋史朗、安藤直樹、宮城兼輔、
総務部付職員：北澤志郎、客員専門員：尾崎実旺、

オブザーバー　国際協力出版会：工藤美和
（財）ジョイセフ：初沢美香、船橋周、
（特活）HANDS：竹中伸一、
（財）エイズ予防財団：沢崎康、山崎敏之、
マリー・ストープス・インターナショナル：齋藤玲子、

調査団員　大阪大学大学院人間科学科：中村安秀
外務省経済協力局：調査計画課：國井修
JICA 特別嘱託：阿部英樹
JICA アフリカ中近東欧州部アフリカ課：門脇聡、河崎絵里子

4　議事概要

（1）団長、団員の所感、提言

1）広域企画調査員の派遣及び TOR について

- ワークショップのフォローとして、域内協力案件の形成に専念する TOR の広域企画調査員の派遣が必要である。
- 企画調査員は、各国 JICA 事務所が国別 HIV/AIDS 対策戦略を形成するための情報収集から具体的なプロポーザル作成までをサポートしていく必要がある。

2）日本の援助の方向性について

- 国毎または、地域の JICA 全スキームに共通する援助テーマ（分野）を設定し、統一性のある投入で日本のプレゼンスを見せることが必要。（ザンビアの HIV/AIDS 分野は、VCT に重点的に投入するなど）。

- JOCV の活用にあたり、各国受入対象機関へ、より具体的かつ積極的な宣伝が必要（エイズ/IT 隊員、エイズ/村落開発隊員等）。
- 留意点として、各国におけるリソース（人材、インフラ、予算）不足、動機の低さ等先方の実施能力に配慮する必要がある。

3）JICA 支援（広報）／スキーム説明

- JICA 用語（特にスキーム名）の国際基準化（英語）、外部者が理解しやすい共通パンフレット作成が必要。
- JICA 技術協力の宣伝を JICA 以外の人材が行うことも良い（例えば本ワークショップでプロ技3拠点のカウンターパートが発表した様に）。
- 戦後の復興期（被援助国時）の経験を踏まえた保健活動をアピールすることで日本援助の優位性創出。（例えば、民間レベルのＰＨＣ活動や差別・偏見の反面教師的な体験等）。

4）今後のワークショップ等の開催への提言

- ワークショップ開催にあたり、事前の重点項目や投入目標の設定等、開催ポリシーが必要。
- HIV/AIDS ワークショップは、詳細な分野（例：ＶＣＴ、Information 等）を絞れば実施意義ある（比較優位性出せる）。

5）その他

- 参加者、プレゼンテーションを含め、総合して本ワークショップの評価は高い。また、今後のワークショップ開催に向けてロジ・サブ面共に勉強になった。
- 会議準備段階において、現地事務所、JICA 本部、外務省、大使館間の連携が大切。次回、同様の会議等開催時には、例えサブが白紙の状態からでも準備段階からメール等で積極的に外部者関係者、専門家を巻き込んで欲しい。
- 国のキャパシティー不足のため自国の HIV/AIDS 対策対応で手一杯である（域内協力まで手が回らない）とのコメントが参加者の多くからあった。これに対し、日本はキャパシティービルディングの面でまだまだ支援の余地がある。

（3）質疑応答／協議内容

1）支援委員会/プログラムアプローチについて

＜新井 JICA 医協部計画課長＞アジア諸国では、JICA プロジェクト協力の評価は高い。JICA 本部は、HIV/AIDS 対策活動の戦略、体系化を必要と感じており、国総研と共同で「開発課題に対する効果的アプローチ」の中で地域的戦略を取り纏め中。

アフリカ地域における HIV/AIDS 対策アドバイザーグループ（支援委員会）設立を、医協部として前向きに検討してみたい。支援委員会の人材選定にあたり、細分化した分野の人材より、分野横断的に多方面の有識者に参加してもらえる体制を考えたい。

＜矢加部外務省調査計画課事務官＞今後のワークショップ開催にあたり、サブ・ロジを含め準備段階から外部委託（コンサルタントの傭上）を提案する。

また、JICA 医協部、国総研で纏められている「開発課題に対する効果的アプローチ」を外務省でも検討し、指針をオールジャパンとして推奨したい。

プログラム的アプローチは、今後派遣される企画調査員から比較的小規模な案件（チーム派遣的な案件）を多く発掘してもらえると良い。

＜國井調査団員＞現在の（大型）プロジェクト方式技術協力は、プロ技間または、関連個別案件との情報共有が臨機応変に行い難く、プロ技拠点構想やプロ技から地域への協力効果波及の期待は難しい。

2）協力隊について

＜JICA 協力隊事務局水谷海外 2 課長＞HIV/AIDS 分野協力隊派遣については、HIV/AIDS 教育等へ医療技術（協力隊カテゴリーでの）のない隊員も含めて検討してみたい。また、手続き的には、協力隊派遣は在外からの要請が必要であり、要請内容の具体化につき本部からも勧奨をする。

＜山口外務省技協課長補佐＞協力隊派遣にあたり、専門性に不安のある人材に対しバックアップできるよう、アドバイザー型のシニアボランティアを活用したチーム型の派遣の検討をしては。

＜中村調査団長＞技術は医療技術だけではなく、システムエンジニア等技術のある人材の活用をして欲しい。JOCV の効果的な活用のために積極的な要請開拓が必要である。

＜國井調査団員＞JOCV のポテンシャルは高い。専門家等のバックアップがあれば、技術的にも充分対応可能な業務もある。

3）日本の優位性を出せる HIV/AIDS 対策について

＜阿部調査団員＞アジアの拠点やガーナの野口研など日本の建設した研究センターを他国研究機関（ＣＤＣ等）が活発に活用している。技協の拠点を考える際、日本のプロ技、無償の施設がいつまでも日本の専有物ではない可能性に注意する必要がある。（日本としての施設への関わり方を常に検討する必要有。）

＜中村調査団長＞日本が自信を持って紹介できる協力として以下の２つが考えられる。

- 戦後の結核を含む、感染症対策（町内会・保健所を中心とした地域活動）の経験を踏

まえた地域主体の対策への協力。

- 差別と偏見の経験（結核、癩病等）について、負の実例として紹介。

4）今後のワークショップフォローについて

＜HANDS 竹中＞VCT のガイドライン等は各国で既に作成されており、今後は VCT 普及活動の実施面への支援が必要となるが、JICA では消耗品等の投入計画があるのか。（具体的にはテストキットやコンドームといった資機材投入）

＜**安藤 JICA アフリカ課長代理**＞具体的な資機材供与に関しては、未定。今後の案件形成のプロセスの中で検討していく。

＜**國井調査団員**＞JICA だけでなく、外務省のスキーム（感染症無償、子供の福祉無償）でもコンドーム、テストキットの供与例は既にある。米国は技術協力、日本は、資機材供与といった分担だけではあまり好ましくない。

DANIDA 等では、供与金額は低いが保健省に人材を派遣し、HIV/AIDS 対策の方向性決定などに関与しプレゼンスを出している。日本は、多数の人材を派遣し、HIV/AIDS 分野でも日本協力のプレゼンス向上に努めるべき。

＜**中村調査団長**＞資機材投与の多い在外事務所は、プログラムオフィサー的な人材による資機材活用についてのフォローアップ実施も必要では。

＜**矢加部外務省調査計画課事務官**＞当面のワークショップ後のフォローアップ計画は如何。

＜**鍋屋 JICA アフリカ課課長**＞現在、進められるのは HIV/AIDS 対策の方向性策定を含めた支援委員会（アドバイザリーグループ）の立ち上げとプログラムアプローチ策定についてである。

支援委員会については、アフリカ・中近東・欧州部のみならず医協部をはじめとする関係部署へ協力要請をする方向で検討。また、医協部でも多方面の有識者に協力依頼する方向で検討。プログラムアプローチおよび国別 HIV/AIDS 戦略については在外事務所主導としていく方向。日本としてプログラムアプローチを示せる様モデル事業の策定など在外事務所を巻き込んで考えていきたい。

7．調査団資料

調査団氏名	担当	役職
中村　安秀	総括/団長	大阪大学　大学院人間科学研究科教授
國井　修	ワークショップ運営/協力政策	外務省　調査計画課　課長補佐
阿部　英樹	技術協力（保健・医療）	JICA 非常勤嘱託
門脇　聡	協力企画	JICA　アフリカ中近東欧州部　アフリカ課職員
河崎　絵里子	HIV/AIDS 対策	JICA　アフリカ中近東欧州部　アフリカ課ジュニア専門員

調査日程

日程		河崎	門脇	國井	中村 阿部	宿泊
3/10	日	17:30　成田発（JL735） 21:35　香港着 23:40　香港発 （SA7801）				
3/11	月	06:30　ヨハネス着 10:00　ヨハネス発 （BA6251） 12:00　ルサカ着 14:00　JICA事務所と打ち合わせ				ルサカ　(1)
3/12	火	ワークショップ準備 事務所打ち合わせ				ルサカ　(1)
3/13	水	ワークショップ準備 事務所打ち合わせ				ルサカ　(1)
3/14	木	UTH訪問 ワークショップ準備 事務所打ち合わせ	17:30　成田発（JL735） 21:35　香港着 23:40　香港発 （SA7801）			ルサカ（2）
3/15	金	ワークショップ準備 保健省、エイズ事務局、ワークショップ事務局と打ち合わせ	06:30　ヨハネス着 10:00　ヨハネス発 （BA6251） 12:00　ルサカ着 14:00　JICA事務所と打ち合わせ			ルサカ（2）
3/16	土	ワークショップ準備 コンサルタント打ち合わせ	ワークショップ準備	17:30　成田発（JL735） 21:35　香港着 23:40　香港発 （SA7801）		ルサカ（2）
3/17	日	ワークショップ準備 事務所打ち合わせ	ワークショップ準備	06:30　ヨハネス着 10:00　ヨハネス発 （BA6251） 12:00　ルサカ着 14:00　JICA事務所と打ち合わせ	17:30　成田発（JL735） 21:35　香港着 23:40　香港発（SA7801）	ルサカ（3）

日程		河崎	門脇	國井	中村 阿部	宿泊
3/18	月	ワークショップ準備 事務所打ち合わせ	ワークショップ準備 事務所打ち合わせ	ワークショップ準備 事務所打ち合わせ エイズ事務局、保健省 打ち合わせ	06:30　ヨハネス着 10:00　ヨハネス発 （BA6251） 12:00　ルサカ着 14:00　JICA事務所と打ち合わせ	ルサカ（5）
3/19	火	ワークショップ準備 コンサルタント打ち合わせ ザンビア大使表敬訪問	ワークショップ準備 ザンビア大使表敬訪問	ワークショップ準備 ザンビア大使表敬訪問	ワークショップ準備 ザンビア大使表敬訪問	ルサカ（5）
3/20	水	8：30-18：00　域内ワークショップHIV/AIDS				ルサカ（5）
3/21	木	8：30-18：00　域内ワークショップHIV/AIDS				ルサカ（5）
3/22	金	8：30-18：00　日本人側関係者ワークショップ打ち合わせ	8：30-18：00　日本人側関係者ワークショップ打ち合わせ	8：30-18：00　日本人側関係者ワークショップ打ち合わせ	8：30-18：00　日本人側関係者ワークショップ打ち合わせ 17:20　ルサカ発（SA067） 19:25　ヨハネス着	ヨハネス(2) ルサカ（3）
3/23	土	ワークショップ報告諸準備、資料整理			12:55　ヨハネス発 （SA7800） 07:50　香港着 10:05　香港発(JL730) 14:50　成田着	ヨハネス(2) ルサカ（3）
3/24	日	ワークショップ報告書 準備、資料整理	12：10　ルサカ発 （SA067） 14：30ヨハネス着	12:10 ルサカ発(SA067) 14：30　ヨハネス着 17：20　ヨハネス発 （SA286）		ルサカ（1）
3/25	月	ワークショップ報告書 準備、資料整理 UTH訪問	12:55　ヨハネス発 （SA7800）	12：30　香港着 15：10　香港発(JL732) 19：55　成田着		ルサカ（1）
3/26	火	ワークショップ報告書 準備、資料整理 コンサルと打ち合わせ	07:50　香港着 10:05　香港発(JL730) 14:50　成田着			ルサカ（1）
3/27	水	ワークショップ報告書 準備、資料整理				ルサカ（1）
3/28	木	ワークショップ報告書 準備、資料整理				ルサカ（1）
3/29	金	12：05　ルサカ発 (SA063) 14：10　ヨハネス着 17：20　ヨハネス発 （SA286）				
3/30	土	12：30　香港着 15：10　香港発(JL732) 19：55　成田着				

2　JICA　HIV／AIDS 関連既存案件

Main Cooperation in HIV/AIDS areas over the Last Ten Years

Project-type Technical Cooperation

Philippines: Project for Prevention and Control of AIDS (July 1996-June 2001)

Thailand:	Project for Prevention and Control of AIDS in the Kingdom of Thailand (July 1993-June 1996)
Thailand:	Project for Model Development of Comprehensive HIV/AIDS Prevention and Care (February 1998-January 2003)
Thailand:	Project for Strengthening of National Institute of Health Capabilities for Research and Development on AIDS and Emerging Infectious Diseases (March 1999-February 2004)
Ghana:	The Noguchi Memorial Institute Project, Phase II in Ghana (October 1991-September 1997)
Ghana:	The Infectious Diseases Project at the Noguchi Memorial Institute for Medical Research (January 1999-December 2003)
Kenya:	The Research and Control of Infectious Diseases Project in Kenya: Phase II (May 1996-April 2001)
Kenya:	Research and Control of Infectious and Parasitic Diseases Project (May 2001-April 2006)
Zambia:	Infectious Diseases Control Project (April 1995-March 2000)
Zambia:	The Strengthening of Laboratory Systems for HIV/AIDS and TB Control Project (March 2001-March 2006)
Brazil:	The Clinical Research Project of State University of Campinas in Brazil (April 1999-March 2002)

Equipment Supply Program for AIDS Strategy and Blood Testing (1996-)

Provision of HIV testing equipment, testing kits, AIDS educational materials, and other items to Philippines, India, Pakistan, Brazil, Tanzania, Ghana, Kenya, Mexico and South Africa.

Training in Japan

Virological Diagnosis Techniques of HIV Infection (AIDS) (1993-)

HIV/AIDS Control Plan (1996)

Seminar on Epidemiology and Control of AIDS/ATL Diseases (1998-)

South Asia HIV/AIDS Control Plan (1998-)

Third-country Training

Philippines:	Laboratory Diagnosis of HIV and Opportunistic Infections in AIDS (1997-2000)
Kenya:	Blood Screening for Viral Hepatitis and HIV/AIDS (1999-)
	Community Empowerment Program
Thailand:	Northern Thailand AIDS Prevention Care Through Community Organization
South Africa:	Adolescent Sexual Health HIV/AIDS Project
Zambia:	Zambia HIV Prevention Borders Initiative
Zimbabwe:	Reproductive Health Care for Young People
Mexico:	Sexual Health Program for Street Children