Regional Workshop on HIV/AIDS in Southern Africa

WORKSHOP REPORT

Lusaka, March 20-21, 2002

Ministry of Health, Zambia
&
Japan International Cooperation Agency

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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

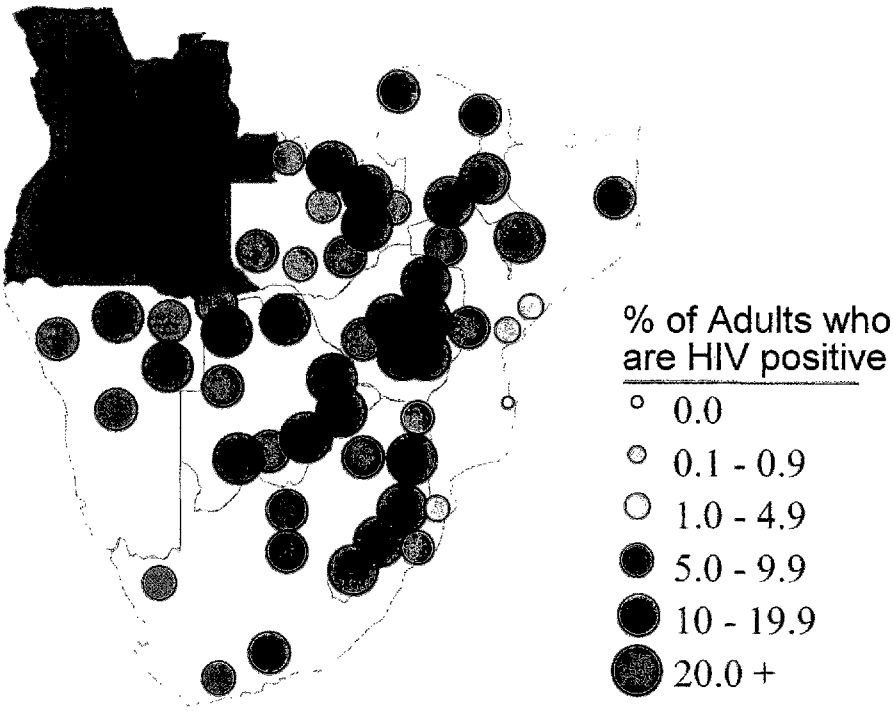
In spite of the considerable progress in containing HIV/AIDS in the last 20 years, the epidemic continues to grow in most southern African countries and is spreading faster than many country-level efforts to contain the epidemic. Regional responses to the AIDS epidemic are hindered by poor coordination 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



At the conference Chaired by
Dr. O. Kunii (Japan)
and by Dr. G. Bolla (Zambia)

Distinguished guests and host members in front of main entance.
Mulungshi International Conference Centre
Lusaka, Zambia

One of the 6 groups Discussion on
Cross Border Initiative

Voices from the activities on the ground

Prof. Y. Nakamura,
providing his key-note speech

Participants from variety of groups

Presentation by Dr. F. Kasolo.
University Teaching Hospital, Zambia

Presentation by Ms. M. Rusesell,
Regional HIV/AIDS Programme Coordinator,
USAID Southern Africa regional Office

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Annexes

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.

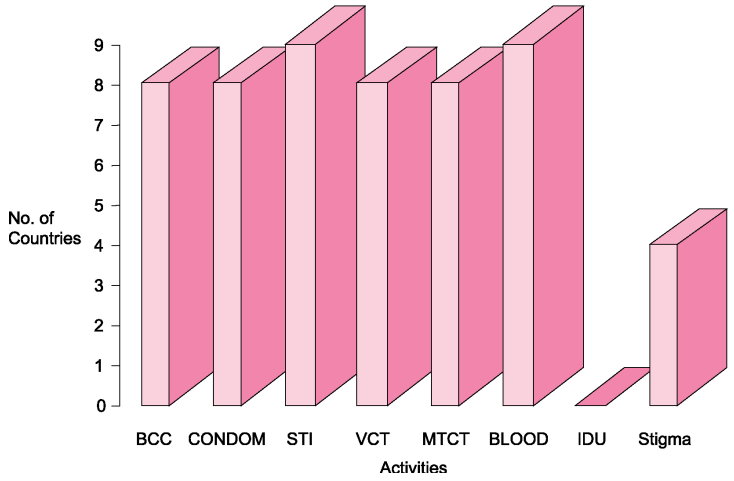


Fig. 1 Prioritized activities in the prevention areas

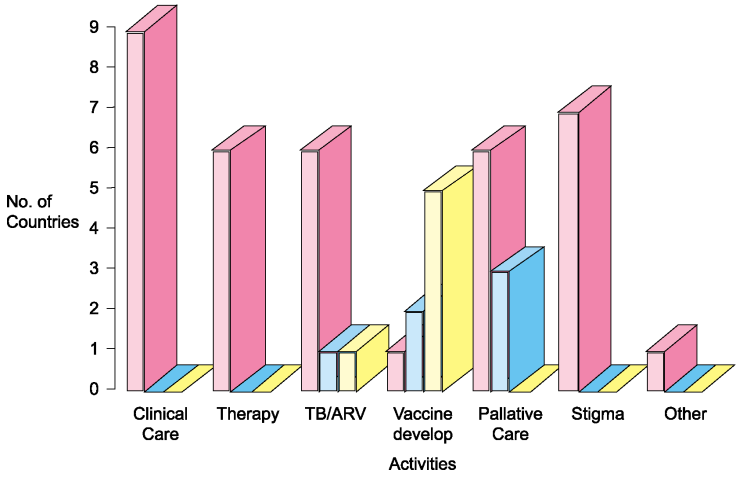


Fig. 2 Prioritized activities in Treatment and Care for HIV/AIDS patients

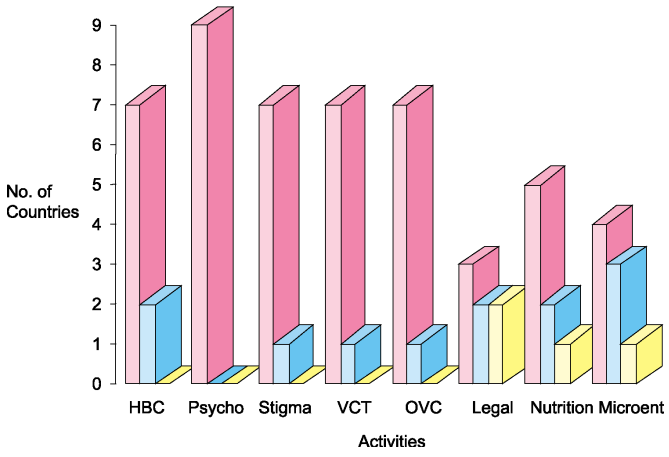


Fig. 3 Prioritized activities in the Impact Mitigation area

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.

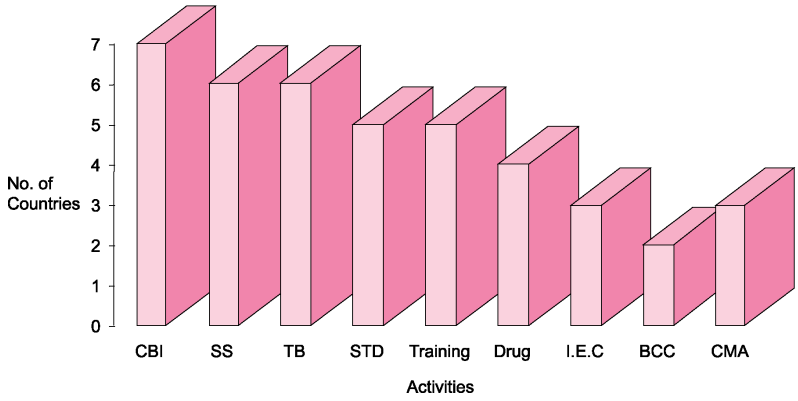


Fig. 4 Participation to regional Activities /Strategies

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.

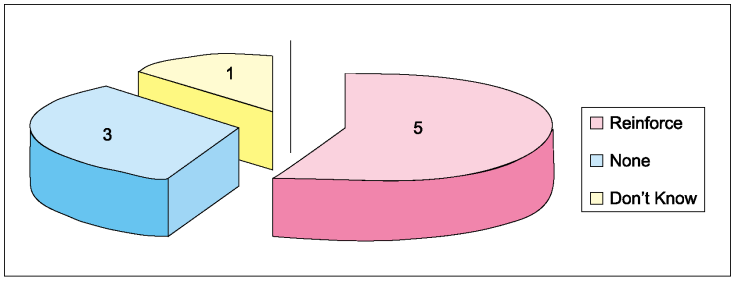


Fig. 5 Relationship between national and regional programme

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

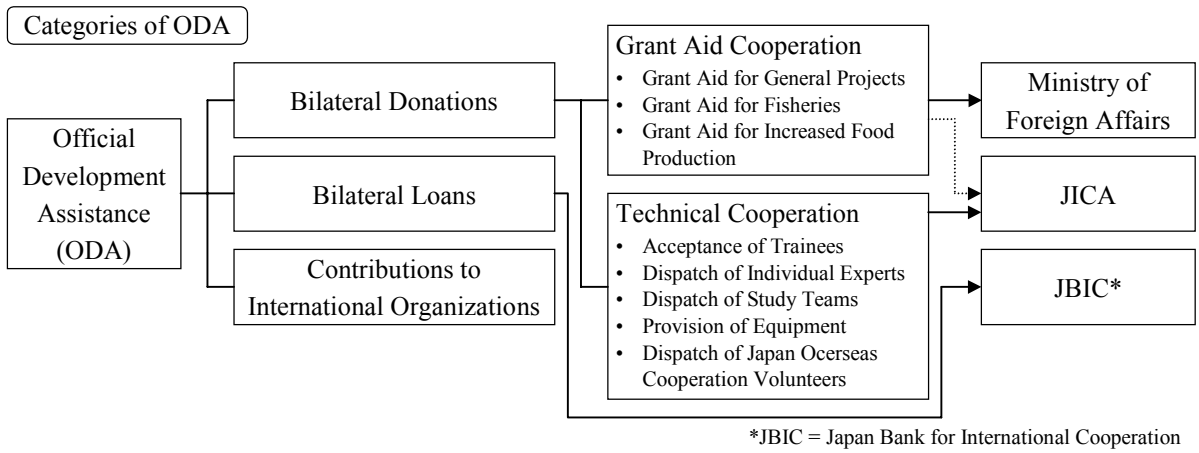
It is vital to develop a country's human resources in order to support its overall development. Technical cooperation involves interpersonal communication, for instance between Japanese experts and their counterparts in the partner country. This means technical cooperation activities have moved beyond 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.

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Annexes

1 Workshop Programme

Annex 1

Regional Workshop on HIV/AIDS in Southern Africa

Amendited

Date : 20-21/March/2002

Venue : Mulungshi International Conference Centre/ Lusaka ZAMBIA

DAY1

Time	Contents	Facilitator/Presentator
08:30-09:00	**Registration**	
09:00-09:10	**Welcome Address**	Mr.K Sasaki (Resident Representative, JICA Zambia)
09:10-09:45	**Opening Ceremony**	His excellency Mr.M.Saotome (Japanese Ambassador to Zambia) Mr.H. Abe (Former Vice-President, JICA) Dr.G. Silwamba (Permanent Secretary, Ministry of Health Zambia) Hon.Dr. B. Chituwo (MP) (Minister of Health Zambia)
09:45-10:00 10:00-10:15	**Key Note Presentation** "Japan's Support for Infectious Disease Control" "HIV/AIDS /TB/STI Programme in Zambia"	Prof. Y .Nakamura (Professor, Osaka University Japan) Dr. G.Bolla (Director, National AIDS Council Zambia)
10:15-10:45	**Tea Break**	
10:45-11:00	**Objectives /Process**	Dr. S.K. Miti (Director General, Central Board of Health Zambia)
11:00-11:30	**Presentation** Country response to HIV/AIDS Control Regional response to HIV/AIDS Control	 Dr.S. Mphuka (Consultant) Mrs. R.Siamwiza (Consultant)
11:30-13:00	**Discussion (Group)** Regional Approach	Dr.S. Mphuka (Consultant) Mrs. R.Siamwiza (Consultant)
13:00-14:00	**Lunch**	
14:00-15:15	**Presentation (by Group)** Discussion	Dr.S. Mphuka (Consultant) Mrs. R.Siamwiza (Consultant)
15:15-15:45	**Presentation** Strategic Response to HIV/AIDS in SADC	Mr.M. Nzima (SADC HIV/AIDS Manager, SADC Health Unit)
15:45-16:15	**Tea Break**	
16:15-16:45	**Presentation(2)** Japanese ODA scheme	Mr.S.Kadowaki (Country Programme Officer, Africa Division JICA HQ)
16:45-17:15	**Presentation(3)** Japan /JICA 's support in Southern Africa	Mr.K.Ota (Deputy Resident Representative, JICA Zambia)
17:15-18:00	**Presentation(4)** JICA Project type of Coorperation in Southern Africa	Dr. S. Mpoke (KEMRI/JICA Project Kenya) Dr. W. Ampofo (NMIMR/JICA Project Ghana) Dr. F.Kasolo (UTH·HIV/AIDS &TB control, JICA Project Zambia)
19:00-20:30	**Reception**	Hosted by JICA

DAY 2

08:30-08:45	Summary of Day1	SADC Member /Dr. O.Kunii (Policy Advisor, Ministry of Foreign Affairs Japan)
08:45-10:15	**Presentation (5)** 1) Voluntary Counselling and Testing 2) Management Information System 3) Cross Border Initiatives(BCC·STI treatment etc) Discussion	 Dr.F.Kasolo (Director, Zambia VCT Services) Mr B.Kalanda (Head of Planning Monitoring & Evaluation, NAC Malawi) Ms.M. Russell (Regional HIV/AIDS Programme Co-ordinator, USAID Regional Office)
10:15-10:30	**Preparation for Group work**	Dr.S.Mphuka (Consultant)
10:30-11:00	**Tea Break**	
11:00-12:30	**Discussion (3) (Group work)**	
12:30-14:00	**Lunch**	
14:00-15:30	**Presentation(6) (by Group)** Discussion	
15:30-16:00	**Tea Break**	
16:00 -17:00	**Discussion (4)** Role of Japan to SADC Countries	Dr. O.Kunii (Policy Advisor, Ministry of Foreign Affairs Japan)
17:00-17:30	**Conclusion**	Dr. G.Bolla / Dr.Kunii
17:30-18:00	**Closing Remarks**	Prof. Y .Nakamura (Professor, Osaka University Japan) Dr.G.Silwamba (Permanent Secretary, Ministry of Health Zambia)
18:00-19:00	**Closing Ceremony**	Hosted by Ministry of Health Zambia

2 List of Participants

Annex 2

Work Shop Participarts list

	COUNTRY	NAME	POSITION	ORGANISATION
Bidden Guest	SADC	Mr. Masauso Nzima	HIV/AIDS Programme Manager	SADC Health Sector Coordinator Unit
	South Africa	Dr. N.P. Simelela	Head of Secretariat Chief Director	South African National AIDS Council
	Botswana	Ms. K. Molosiwa	Deputy HeadAIDS/STD Unit	Ministry of Health
	Botswana	Mrs. M. Tselayakgosi	Programme Planning Manager	National AIDS Coordinating Agency
	Swaziland	Ms. Beatrice Dlamini	Director	Swaziland National AIDS Programme (SNAP)
	Swaziland	Mr. N. Simelane	Chairperson	National Emergency Response/Committee on HIV/AIDS
	Swaziland	Dr. S. Mahaliyana	HIV/AIDS/STI Doctor	MoH Social Welfare
	Namibia	Dr. H. Shipanga		Ministry of Health & Social Services
	Lesotho	Ms. N. Mabitle (P.M)	AIDS Manager	Ministry of Health
	Lesotho	Dr. M. Moteetee	Chief Executive	Lesotho AIDS Programme Coordinating Authority
	Lesotho	Dr. P. Ntsekhe	Director	Disease Control TB/MoH
	Zimbabwe	Dr. J. Chirenda	Medical Officer for Health Advocacy & Communication Officer	Ministry of Health & Child Welfare
	Zimbabwe	Ms. Zorodzai Machekanyanga		National AIDS Council
	Zimbabwe	Machekanyanga	Communication Officer	National AIDS Council
	Malawi	Ms. S. Tobias	HIV/AIDS Focal Person	Ministry of Health & Social Services
	Malawi	Mr. B. Kalanda	Head of Planning, Monitoring, Evaluation	National AIDS Commission
	Tanzania	Dr. Bennet Fimbo	Principal Medical Officer	National AIDS Control Programme, Ministry of Health
	Tanzania	Dr. Joseph M.V. Temba	National Response Coordinator	Tanzania Commission for AIDS
	Kenya	Dr. P.A. Orege	Deputy Director	National AIDS Control Council/Office of the President Council/Office of the President
	Zambia	Dr. G. Bolla	Director	National AIDS/STD/TB Council
	Zambia	Mr. C. Mwale	HIV/AIDS Focal Person	Central Board of Health
Government	Zambia	Dr. G. Silwamba	Permament Secretary	Ministry of Health
	Zambia	Dr.. S.K. Miti	Director General	Central Board of Health
	Zambia	Mr. C. Mwale	HIV/AIDS Programme Officer	Central Board of Health
	Zambia	Dr. M.R. Sunkutu	Director, Public Health and Research	Central Board of Health
	Zambia	Dr. B.U. Chirwa	Director, Health Services Planning	Central Board of Health
	Zambia	Dr. M. Maboche	Technical Support Services	Central Board of Health
	Zambia	Dr. Mtolo	Clinical Care & Diagnosis Services	Central Board of Health
	Zambia	Mr. B Sikateyo	Information and Research	Central Board of Health
	Zambia	Dr. A. Simwanza		National AIDS Council
	Zambia	Mrs. F.C. Chikamba	Coordinator	Zambia Business Coalition
	Zambia	Lt. Col. C. Makwala	HIV/AIDS Focal Point Person	Defence Force Medical Services
	Zambia	Dr. F. Kasolo	Director , Virology Laboratory	University Teaching Hospital
	Zambia	Dr. R.M. Musonda	Deputy Director	Tropical Diseases Research Centre
DHMT	Zambia	Mr. Derick Nyirenda	Chairman HIV/AIDS	DHMT North Western
	Zambia	Dr. C. Phiri	Acting District Director of Health	DHMT Southern
	Zambia	Mrs. N. Sitali	Acting District Director of Health	DHMT Western
	Zambia	Ms. Rhoda Buleze	Acting District Director of Health	DHMT Luapula
	Zambia	Dr. Felix Silwimba	District Director of Health	DHMT North
	Zambia	Mr. S. Mutibo	Clinical Officer Kapata Clinic	DHMT Eastern
	Zambia	Dr. Caroline Phiri	Acting DDH	DHMT Livingstone
UN THEME GROUP	Zimbabwe	Ms. H. Jackson	Southern African Regional Advisor	UNFPA
	Zambia	Ms. M. O'Callaghan	Resident Representative	UNFPA
	Zambia	Ms. B. Chikotola	HIV/AIDS Officer	UNFPA
	Zambia	Ms. H. Rakotomamonjy	HIV/AIDS Project Officer	UNICEF
	Zambia	Ms. C. Muntungwa	HIV/AIDS Officer	UNICEF
	Zambia	Dr. R. Kumwenda	Project Analyst HIV/AIDS	UNDP
	Zambia	Dr. E. Limbambala		WHO
	Zambia	Ms. Chaava		WHO
	Zambia	Ms. H. Mbao	Social Development Specialist	World Bank
	Zambia	Mr. Sakala	HIV/AIDS Officer	ILO
	Zambia	Mr. Jeff Wheeler	HIV/AIDS Officer	ILO

	COUNTRY	NAME	POSITION	ORGANISATION
COOPERATING PARTNERS	South Africa	Ms. M. Russell	Regional HIV/AIDS Programme Progamme Coordinator	USAID
	Zambia	Ms. B.W. Highes	Deputy Director	USAID
	Zambia	Mr. P. Kangwa	Population Health & Nutrition Office	
	Zambia	Dr. K. Shelly	Senior Technical Advisor on HIV/AIDS	
	Zambia	Ms. F. Phiri	HIV/AIDS Coordinator	
	Zambia	Ms. A.K. Kandimaa	Senior Programme Officer for Social Development	SIDA
	Zambia	Mrs. P. Likwasi	Health Consultant	CIDA
	Zambia	Dr. O. Lulembo	Health Adviser	IRELAND
	Zambia	Dr. A. Mwiinga	Chairperson TB Working Group	CDC (Centre for Diseases Control)
	Zambia	Mr. M. Shields		CDC (Centre for Diseases Control)
	Zambia	Dr. Wen-richter		German Agency for Technical Cooperation
NGOS	South Africa	Mr. K. Kgatshe	Programme Manager	National Progressive Primary Health Care Network (NPPHCN)
	Zimbabwe	Ms. Kate Mhambi	National Coordinator	Zimbabwe AIDS Network
	Malawi	Mrs. L. Tauzi	Health Service Manager	Banja La Mtsogolo
	Malawi	Mrs. L. Vinyo	Deputy Director	Banja La Mtsogolo
	Malawi	Mr. J. Katangwa	Deputy Director	Population Services International Malawi
	Tanzania	Mr. Z.G. Ssebuyoya	Executive Director	WAMATA
	Zambia	Dr. K. Nimo	Health Coordinator	World Vision International
	Zambia	Mrs. K. Manda	Country Director	Family Health International
	Zambia	Mr. Kayawe	Executive Director	Kara Counselling
	Zambia	Mr. A. Chella	Vice National Chairman	People Living with Aids
	Zambia	Dr. R. Vongo	President	Traditional Healers Association
	Zambia	Mr. G. Musonda	Executive Director	Planned Parenthood Association of Zambia
	Zambia	Mr. H. Kaimba	Senior Programme Officer	Planned Parenthood Association of Zambia
	Zambia	Mr. Nils Gade		Society for Family Health
	Zambia	Ms. Mwamba Chasaya		Youth Alive Zambia
	Zambia	Mr. M. Chonta		Youth Alive Zambia
	Zambia	Mr. K. Ngoma		Youth Alive Zambia
	Zambia	Ms. N. Mwanza		Youth Alive Zambia
	Zambia	Sister Rose		Youth Alive Zambia
	Zambia	Dr. C. Msumali		ZIHP
	Zambia	Rev. John C. Mubika		HIV/AIDS Task Force
	Zambia	Mr. George A. Mwelwa		Hope for Africa
	Zambia	Rev. Charles Mwape		Hope for Africa
	Zambia	Mr. J.N. Nkoma		Hope for Africa
	Zambia	Mr. Justin Kumwenda		THAPAZ
	Zambia	Ms. Margaret Daka		THAPAZ
	Zambia	Mr. Wisdom Himanteka		ZANA
	Zambia	Mr. Cuthbert Miti		ZNBC
	Zambia	Ms. J. Mwankontani		ZNBC
	Zambia	Ms. M. Matibini		ZNBC
	Zambia	Mr. Israel Banda		TCYR
	Zambia	Pastor K. Salukanga		Operation Whole AIDS Awareness
	Zambia	Mr. B. Phiri		Post Newspaper
	Zambia	Lwanga Mwilu		QFM Radio
	Zambia	Mukula Mukula		Daily Mail
	Zambia	T. Mumba		Africa Today Magazine
	Zambia	Mr. Emmanuel Kamwi		SADC Youth support Network
	Zambia	Dr. Leo Oks		SADC Youth support Network
	Zambia	I. Mutembo		CCZ
	Zambia	G. Mwanei		CCZ
	Zambia	D. Chanda		UNZA School of Medicine
	Zambia	A.S. Mweene		UNZA Rapporteur
	Zambia	Mr. Beck Banda		Youth Forum Zambia
	Zambia	Dr. S. Mphuka		Churches Medical Association of Zambia
JICA EXPERT	Kenya	Prof. Amano	JICA Expert	JICA/KEMRI Project
	Ghana	Dr. Tokunaga	JICA Expert	NMIMR/NIID
	Zambia	Dr. K. Oizumi	JICA Expert	AIDS/TB Control Project, JICA
	Zambia	Dr. Ichiyama	JICA Expert	UTH
	Zambia	Mr. Satoshi Sasaki	JICA Expert	PHC
	Zambia	Dr. Mami Hirota	JICA Expert	PHC
	Zambia	Mr. K. Yokoi	JICA Expert	HIV/AIDS & TB Control
JICA (C/P)	Kenya	Dr. Solomon Mpoke	Senior Research Officer	KEMRI Project

	COUNTRY	NAME	POSITION	ORGANISATION
	Ghana	Dr. William Ampofo	Senior Researcher	NMIMR
JICA STAFF (Japanese)	South Africa	Ms. Larhed	Project Formulation advisor	JICA South Africa
	Zimbabwe	Mr. T. Umetani	Project Formulation advisor	JICA Zimbabwe
	Malawi	Ms. T. Harada	Project Formulation advisor	JICA Malawi
	Tanzania	Mr. H. Takada	Ast. Res Representative	JICA Tanzxania
JICA (National Staff)	Malawi	Mr. E. Kachale	Aid Coordinator	JICA Malawi
	U.K.	Ms. A. Pearcey	Programme Officer	JICA U.K.
Japanese Participants (Tokyo Office)	Japan	Mr. Abe	Technical Advisor	JICA Tokyo
	Japan	Prof. Nakamura	Professor	Osaka University
	Japan	Dr. Kunii	Workshop Advisor	Ministry of Foreign Affairs
	Japan	Mr. Kadowaki	Country Officer	JICA Tokyo
	Japan	Ms. Kawasaki	Expert	JICA Tokyo

3 Opening Remarks

3-1 Dr. B. Chituwo, Minister of Health

SPEECH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MAY THE ALMIGHTY GOD BLESS YOU.

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

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

Distinguished Workshop participants,

Ladies and gentlemen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I wish you successful and fruitful deliberations.

Than you.

3-3 Mr. Abe, JICA former Vice President

Southern Africa HIV/AIDS Regional Workshop

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

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

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

Distinguish Guests

Ladies and Gentlemen

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

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

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

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

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

3. Since then, JICA has implemented technical cooperation projects in Kenya, Zambia, Thailand, the Philippines, and other countries in Africa and Asia. These involve 1) basic research in virology, epidemiology, immunology, bacteriology, parasitology, nutrition, and other fields, 2) development of diagnostic and blood testing capabilities, and 3) education, information and communication programs.

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

5. Equipment supply program will be explained in the course of implementation of WHO

Viral Laboratory network program, which has been composed by 16 laboratories of 15 countries such as Kenya, Uganda, Tanzania, Zambia, Zimbabwe, South Africa, and the Democratic Republic of Congo. Up to now, JICA has provided equipments for 7 laboratories of these 15 countries, and these have gained a high reputation among those African countries that do not have such facilities.

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

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

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

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

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

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

Above these, projects in Kenya and Tanzania have proven that improving facilities of screening of blood transfusions are very effective prevention measures despite fixed conditions.

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

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

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

As a result, Japan has achieved a history of overcoming and eradicating infectious disease including malaria, schistosomiasis, filariasis, poliomyelitis and intestinal helminthiases within a surprisingly short period of time.

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

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

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

Japan s Initiatives for Infectious Diseases Control

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

His Excellency, ladies and gentlemen,

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

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

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

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

(Slide)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Japan's Initiatives for Infectious Diseases Control

YASUHIDE NAKAMURA

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Japan's experience as a developing country

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

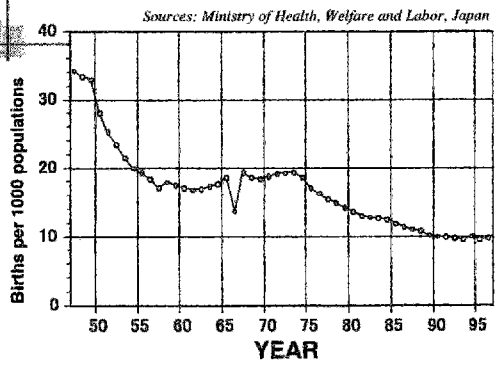
The Number of Patients with infectious diseases in Japan

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

Sources: Ministry of Health, Welfare and Labor, Japan

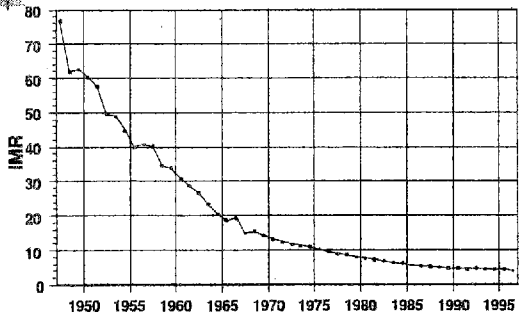
Birth Rate in Japan

Sources: Ministry of Health, Welfare and Labor, Japan

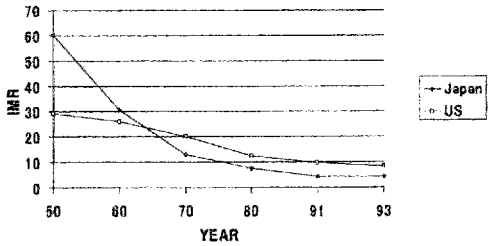


Infant Mortality Rates in Japan

Sources: Ministry of Health, Welfare and Labor, Japan



IMR in Japan and the United States



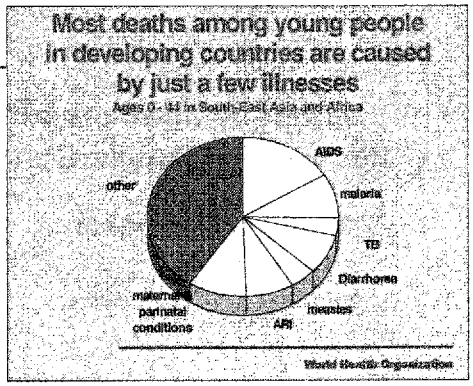
Sources: U.S. Department of Health and Human Services
Ministry of Health, Welfare and Labor, Japan

Possible Explanations for Japan's Low Infant Mortality Rate

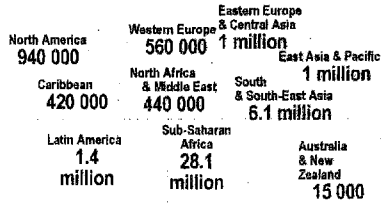
1 Narrow socio-economic distribution
2 National health insurance
3 Maternal and Child Health Handbook
4 Population-based screening and health check-ups
5 High value placed on childbearing

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

source: World Health Organization



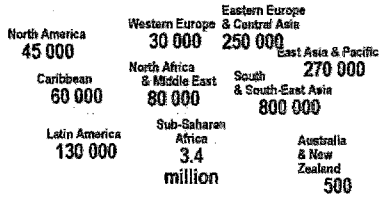
Adults and children estimated to be living with HIV/AIDS as of end 2001



Total: 40 million

Sources: WHO, UNAIDS

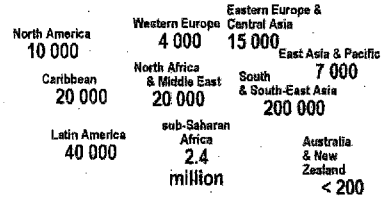
Estimated number of adults and children newly infected with HIV during 2001



Total: 5 million

Sources: WHO, UNAIDS

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



Total: 2.7 million

Sources: WHO, UNAIDS

Okinawa Infectious Diseases Initiative (Okinawa IDI: July 2000)

Basic Policy

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

Okinawa Infectious Diseases Initiative Basic Strategy

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

Okinawa Infectious Diseases Initiative HIV/AIDS

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

After Okinawa IDI

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

The Characteristics of Japan's Role

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

HIV/AIDS

in ZAMBIA

Background
Evolution of
Interventions
Networks
At what cost
Some results
Challenges

NATIONAL HIV/AIDS/STD/TB COUNCIL

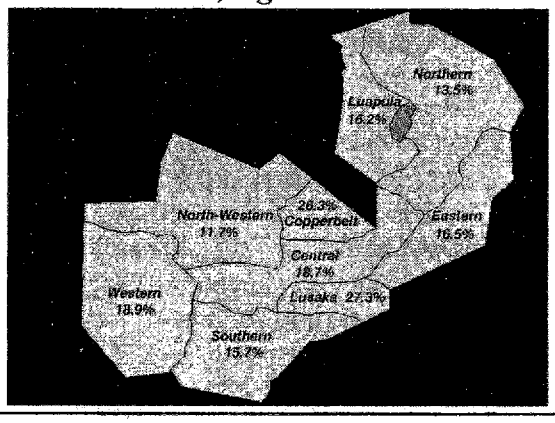
Background

- Area size-752,612 &Pop –10,3 million
- Population density-13.7
- Poverty levels- 80%
- Mortality
  - Infant per 1000 live births 114
  - Under 5 per 1000 live births 187
  - Maternal per 100,000 live births 650

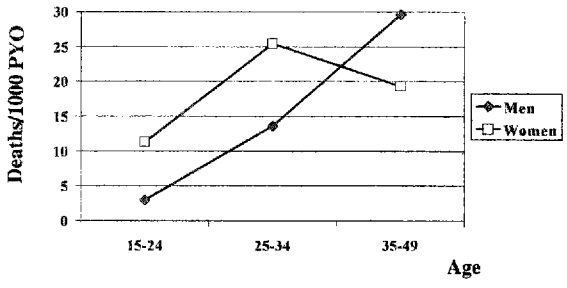
Background

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

HIV Prevalence, Ages 15 to 49 - 1998



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



The Epidemic Is Fueled By

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

Evolution of response-approaches

- **Medical**

-Treated first case 1984

- **Public health-**

-National AIDS Prevention and Control Programme-1986

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

-First and Second medium Term Plan 1988-1998

- **Developmental and multisectoral**

-National Strategic Framework 2001-2003

Goals Of The National AIDS Plan

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

SO AS TO

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

Preventive and care interventions:

National strategies/plans

↓

Prevention

↕

Support/Care/mitigation

↕

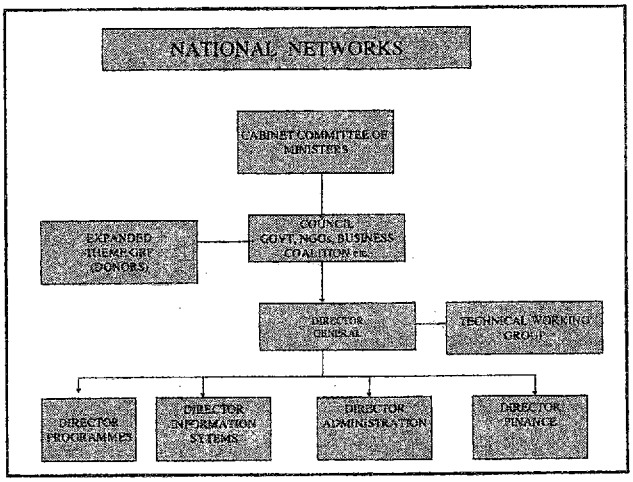
Strengthening health care systems

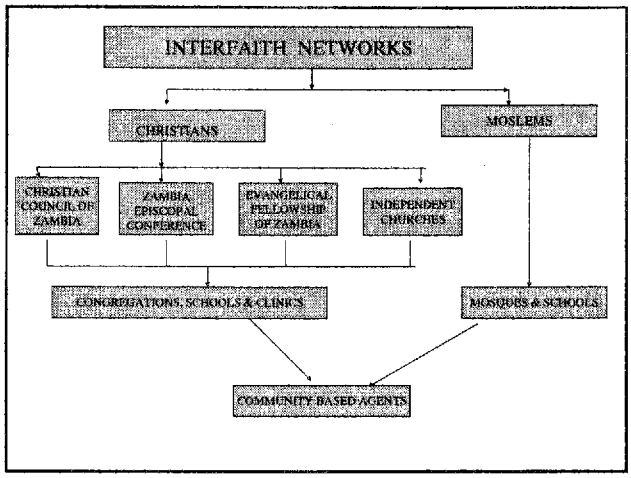
Interventions

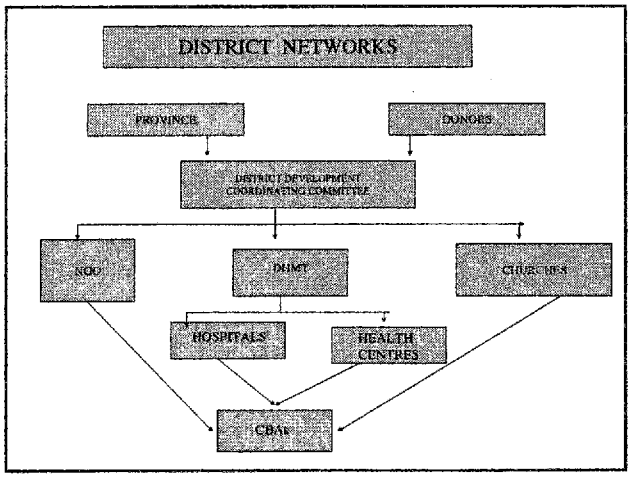
- **Multisectoral BCC campaign**
- **Condom promotion and distribution**
- **STI Management**
- Blood transfusion services
- **Voluntary Counselling and Testing**
- **Prevention of Mother to Child Transmission**
- **Community Home based Care**
- **Strengthening existing Projects** for OVC/NZP+
- Opportunistic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

Partners in the fight

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







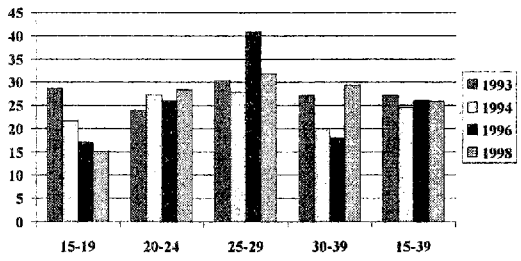
AT WHAT COST

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

Research, Monitoring and surveillance

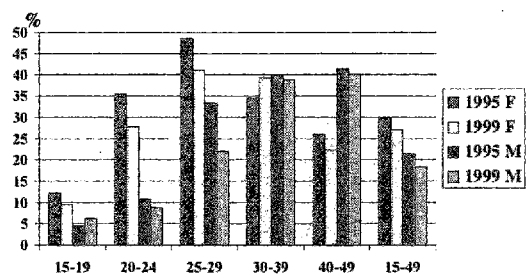
- Sentinel Surveillance
- Sexual behavioural surveys
- Strengthen existing information systems
- Program specific research

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



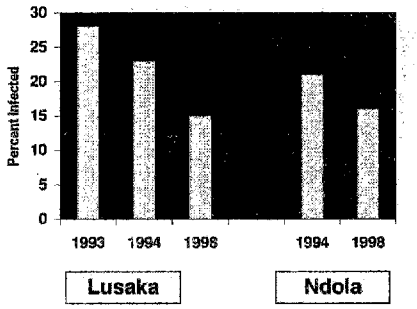
Sample size: 1993-98: 292, 443, 532, 776

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

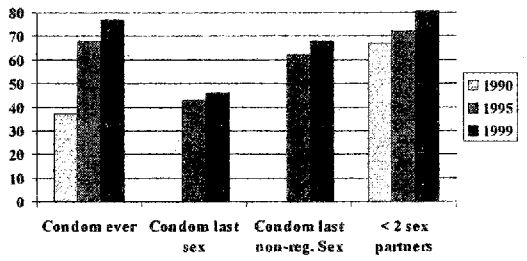


Sample size:1995/96: 2115; 1998/99: 2011; 15-49=Crude rate

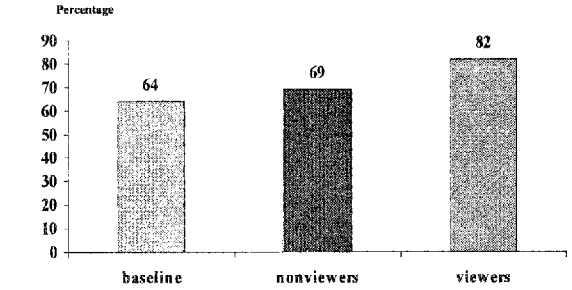
Estimated HIV Prevalence in Lusaka and Ndola, Ages 15 to 49



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

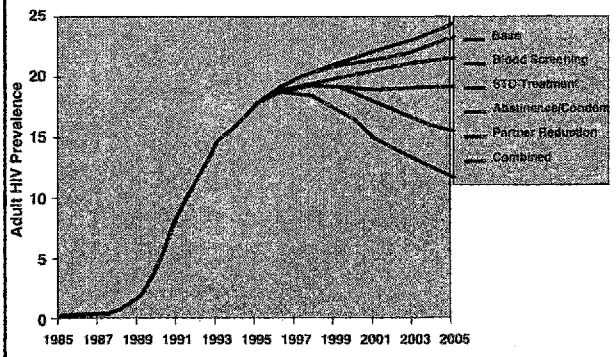


No to unwanted sex by youths



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

Cumulative Effects of Interventions



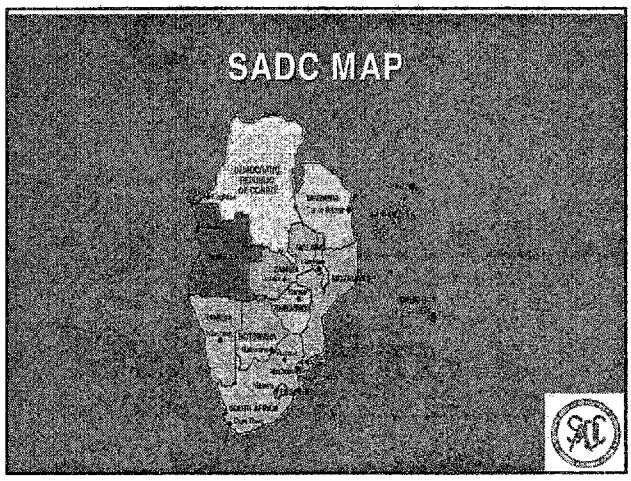
Challenges

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

REGIONAL WORKSHOP ON HIV/AIDS/AIDS FOR SOUTHERN AFRICA

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

- Lusaka 20-21 March 2002
-



Country	Estimated number of people living with HIV/AIDS, end 1999: Adults and children	Adults 15-49	Adult rate %	Women 15-49	Children (0-14)	Orphans (cumulative)	Estimated AIDS deaths: Adults and children, 1999
Global Total	34,300,000	33,000,000	1.07	15,700,000	1,300,000	13,200,000	3,500,000
sub-Saharan Africa	24,500,000	23,400,000	8.57	12,900,000	1,000,000	12,100,000	2,200,000
SADC level	11,950,000	11,430,000	17.95	6,384,000	431,500	4,728,000	992,100
Angola	160,000	150,000	2.28	52,000	7,900	58,000	13,000
Botswana	290,000	280,000	35.80	150,000	10,000	66,000	24,000
Dem. Republic of Congo	1,100,000	1,100,000	5.07	600,000	53,000	680,000	95,000
Lesotho	240,000	240,000	23.57	130,000	8,200	35,000	16,000
Malawi	800,000	760,000	15.96	420,000	40,000	500,000	78,000
Mozambique	1,200,000	1,100,000	13.22	630,000	52,000	340,000	98,000
Namibia	160,000	150,000	19.54	85,000	6,600	67,000	18,000
South Africa	4,700,000	4,500,000	19.94	2,300,000	95,000	420,000	250,000
Swaziland	130,000	120,000	25.25	67,000	3,800	12,000	7,100
United Rep. of Tanzania	1,300,000	1,200,000	8.09	670,000	90,000	1,100,000	140,000
Zambia	970,000	930,000	19.95	530,000	30,000	650,000	99,000
Zimbabwe	1,500,000	1,400,000	25.06	800,000	56,000	900,000	160,000
SADC level	11,950,000	11,430,000	17.95	6,384,000	431,500	4,728,000	992,100

Source: UNAIDS, 2000

population 1999

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

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

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

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

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

Vision

SADC society with reduced HIV/AIDS

Overarching Goal

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

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

Main Objectives

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

Three major categories of activities undertaken as follows:

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

Policy/Advocacy

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

Policy/Advocacy ....

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

Mobilisation of Economic & other SADC Sectors

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

Initiation of the regional response

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

Initiation of the regional response ...cont'd

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