Summary, conclusions and recommendations

This report attempts to integrate the results of an HIV/AIDS regional study conducted in six southern African countries. The WK Kellogg Foundation (WKKF) funded the study to generate information on HIV/AIDS in countries where it is supporting the implementation of the Integrated Rural Development Programmes (IDRP). The Human Sciences Research Council (HSRC), in partnership with the Centre for Applied Social Studies (CASS), of the University of Zimbabwe co-ordinated and conducted the study. The purpose of the study was to investigate availability of HIV/AIDS policies and strategic plans and programmes in each of the six countries and the extent to which these guiding documents were being implemented. The study was conducted between September 2000 and March 2003.

The overall aim of the study was to review HIV/AIDS policy, legislation, financing[1] and the implementation of programmes in the following six countries: Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe. The specific objectives are as follows:

- Review existing national policies, strategic plans and prevention and care programmes on HIV/AIDS.
- Generate primary level data to assess to what extent HIV/AIDS policies, strategic plans and programmes are being implemented at district level.
- Review drug policies in relation to prevention and care, taking into account the latest WHO recommendations of essential drugs list for HIV/AIDS in resource-poor settings.
- Review legislation affecting people living with HIV/AIDS, including the human rights of people living with HIV/AIDS in the six countries, as well as policy and strategy recommendations.

Leaders in these six countries were party to the Declaration on the Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS held on June 25–27 2001, which stated that by 2003 countries should have developed multisectoral national strategic plans and financing that directly address the HIV/AIDS epidemic. These strategic plans are expected to be developed with the participation of key stakeholders that may include the government, NGO sector, private sector, donors, people living with HIV/AIDS, researchers and academics. This report attempts to measure progress of countries in meeting this commitment.

All the six countries have met the commitment they made with the international community to develop policies and strategic plans on HIV/AIDS by 2003. All but Swaziland and South Africa do not clearly indicate the extent to which these policies were developed in a consultative manner, engaging the key stakeholders in the process. While we conclude that policies and strategies have been developed, it is important to indicate that there are major gaps in some of the policies. Some of these gaps relate to legislation to protect people living with HIV/AIDS, which are glaringly absent in all countries studied, except South Africa. Detailed policies are also lacking. Specifically, policies on orphans and rape are seriously lacking in many of these countries, implying that mitigating the impact of HIV/AIDS and preventing new infections in women are likely to be hampered by lack of enabling policies on these two issues.

Many countries have policies on testing and centres where testing is available. However countries vary in the extent of coverage or access to voluntary counselling and testing

1 A separate report was published on financing of HIV/AIDS in the SADC region and hence this subject has not been covered extensively in this report. *A comparative analysis of the financing of HIV/AIDS programmes in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe. (2003), HSRC: Pretoria.*

(VCT). Some countries have access that is good in urban areas and coverage that is poor in rural areas. The availability of VCT does not guarantee that people will access the service. There are many barriers to access. Stigma and discrimination against PLWHAs are high on the list. Lack of privacy, lack of trained and compassionate health workers who understand confidentiality, are among the challenges identified in the sites studied. Distances between home and hospital sites that provided PMTCT mean that some mothers can not access PMTCT in some rural areas where Kellogg is operating. In South Africa this might improve with the rollout of the PMTCT programme. It is important to note however that in many of the countries studied coverage for PMTCT remains very poor. There is an attempt to improve this with increased sites reported in countries such as Zimbabwe, Swaziland, Mozambique and Lesotho to date.

Having policies in the absence of guiding protocols for implementation render implementation difficult. The study findings indicate that while in some countries the process was underway to finalise these protocols, most countries do have them and hence have the capability to translate policy into action.

Many countries experience barriers to implementing policies. Some of these identified in the study are the inadequate supply of human and financial resources, lack of human resources with monitoring and evaluation skills to track implementation, lack of support of decision-makers to implement policies, stigma attached to HIV/AIDS and the daunting size of the HIV/AIDS burden.

Lack of adequate funding for HIV/AIDS programmes has also impacted on the ability of government to provide treatment for people living with HIV/AIDS. Treatment coverage remains very low in Southern Africa. Among the countries studied only Botswana had a universal access programme for ARV therapy at the time of the study. Since then there has been a lot of development in this area. South Africa has also made a pledge to make ARVs available through public health. Zimbabwe and Mozambique are also considering making ARVs available within their limited health budgets. Prolonging lives will have a positive impact in the efforts to deal with orphans. South Africa had a high number of orphans and at the time of the study only two countries had policies on orphans. The bulk of caring is still in the hands of families and communities through home-based care (HBC). In all the countries surveyed, HBC was something that was available in varying degrees and in various organisations. In some places the community-based movements were highly organised and had many resources. But for some other groups there are no resources to do their work. Government should therefore recognise these efforts and encourage them by allocating appropriate funding, as many health systems struggle under the strain caused by high numbers of patients with AIDS.

Violence and abuse of women remains a challenge in many countries. Women are made vulnerable to HIV because they are not adequately protected from sexual violence and other forms of abuse. Many still do not have access to services and drugs that can save their lives. In many countries ARVs are available in private practice and only in limited quantities in public health services. Health workers are often able to access these drugs in case of needle injuries. However these drugs are not always available in all countries to rape survivors. This situation is expected to improve in countries that have rolled out ARVs.

Many governments have taken a stand and channelled resources towards fighting and mitigating the impact of HIV/AIDS. The funds are insufficient but they do indicate the will of politicians to deal with HIV/AIDS. We are yet to experience the full impact of the epidemic, as more people begin to die from HIV-related conditions and AIDS. But we have also come a long way in our understanding of the disease and in our efforts to fight it.

Legislative aspect

The six countries present some of the highest HIV prevalence trends in the world. Nevertheless, the respective legal systems in the countries under review have not responded to the epidemic, as they should. Their initial response to address the issue is to enact criminal legislation that does not meet the requirements of the tenets laid down in Guideline 4 of *UNAIDS International Guidelines on HIV/AIDS and Human Rights.*[2]

Although the six countries are party to numerous international and regional conventions and agreements, none of them seems to have been enacted into national laws to make them enforceable. Commitments have also being made at several forums. At the United Nations Special Session on HIV/AIDS (UNGASS) Declaration on Commitment on HIV/AIDS, heads of State and government committed themselves to 'by 2003 [to] enact, strengthen or enforce as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and freedoms by all people living with HIV/AIDS. (para 58).[3] Despite these, numerous legislative and customary law provisions still exist in most of the six countries that advance the spread of the epidemic as well as gender inequality. South Africa has legislation that could and has impacted on the epidemic and/or the lives of people with HIV/AIDS. But most legislative acts in force in the other five countries are criminal laws related to HIV/AIDS. Recent debates in South Africa show the country may be regressing to follow suit with other countries in the region.

The HIV/AIDS situation remains serious within the SADC region but there is some hope emerging since the data collection in 2002. The latest figures from most Southern African countries and indeed most of Africa show that the prevalence among pregnant women visiting antenatal clinics has levelled over several years. Many national studies within this region have shown that HIV prevalence is lower than what has been believed. Even the latest data from UNAIDS has confirmed this finding and emphasised the need to continue research and increase understanding of methods used to estimate prevalence. While the new figures are good news, there are still challenges. Those infected years ago are beginning to get ill and death rates are increasing.

Overall recommendations

Several barriers were identified to implementation of policies. These are recapped here: inadequate supply of human and financial resources; lack of human resources with monitoring and evaluation skills to track implementation; lack of support of decision-

2 UNAIDS & Antiparliamentary Union Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in view of devastating Human, Economic and Social Impact, ibid, p.24.
3 Declaration on Commitment to HIV/AIDS UNGA Special Session on HIV/AIDS, 25–26 June 2001, p.9

makers to implement policies; stigma attached to HIV/AIDS; and the daunting size of the HIV/AIDS burden.

Lack of decision making

To address challenges related to this problem, it may be better to decentralise decision-making including budget decisions; this will improve implementation. The national co-ordinating agencies and government departments may need to move from operations and implementation to co-ordination monitoring and evaluation.

Greater involvement of communities in all HIV/AIDS initiatives would help accelerate programme implementation.

Human resource deficits

To provide good prevention and care requires that countries have adequate supply of counsellors and health workers that are free from overwhelming stress and have high morale. To address this it may be necessary to institute the following: training of counsellors, some of them at degree level; stress management workshops for counsellors; refresher courses; public education on VCT; and promotion of local ownership of the programme by engaging local co-ordinators.

General barriers to implementation of policy

The study identified general barriers to implementation of HIV/AIDS programmes that were common to all countries. We present the barriers below and recommend what can be done to improve the challenges:

- Lack of or inadequate financial resources impacted on the ability to implement policies. There is thus a need for a rigorous resource mobilisation strategy from both the internal and external sources. A clear strategy is needed to partner with the private sector on HIV/AIDS financing. The improvement of the best practices to increase accountability of official authorities in management of HIV/AIDS funds and programmes.
- Limited human resource and professional capacity needs were identified together with gaps in various areas of health care and related skills, such as counselling. This can be dealt with by introducing in-service training where qualified health workers can increase their knowledge on HIV/AIDS. The health budget needs to increase to allow more health workers and counsellors to be employed within the area of HIV/AIDS.
- Poor service infrastructure, especially in the rural areas, was found to limit access to services for a majority of the population. Greater decentralisation and involvement of district and regional structures in implementation of HIV/AIDS programmes can assist in increasing coverage of programmes by targeting rural areas for implementation of programmes.
- Traditions and cultural norms prevent openness and militate against effective implementation of prevention and impact mitigation measures. This can be done by strengthening programmes of mass public education on the rate of HIV infection, as well as on lifestyles that promote the spread of HIV, in order to increase openness about HIV/AIDS among partners, children, in the workplace and in communities. Such programmes will contribute to the removal of stigma among the infected and affected persons.

- Poor or lack of community involvement in programmes continues to undermine many efforts to fight HIV/AIDS. Stigma continues to undermine and influence the uptake of intervention programmes. This can be strengthened by the involvement of communities. Traditional and religious leaders can improve community participation in all HIV/AIDS initiatives and increase the awareness of the HIV/AIDS epidemic at community level. Greater leadership commitment from the government would help to uproot stigma and silence, and promote open disclosure of HIV/AIDS status.
- Weak care and support services, especially lack of strategies and programmes to assist PLWHAs and caregivers in most countries, except South Africa and Botswana. This can be assisted by donors who can also play a more supportive role by working within the framework of the national strategic plan, by channelling resources to meet national priorities, rather than focusing on their own projects, as is the general perception.
- Poor monitoring and evaluation of the effectiveness or lack of intervention in programmes was identified as a weakness in many of the countries. This can be improved by strengthening monitoring and evaluation systems. There should also be training in and development of strategic planning skills and capacity of implementing agencies so that they are better organised to channel resources for effective implementation of HIV/AIDS programmes
- There is a continuing increase in rape cases and violence against women. There is also a lack of policies and inadequate mechanisms in most countries to prevent rape and assist victims. Key areas of action include the need to strengthen the services by establishing 'all in one' support centres, so that rape victims do not get further traumatised by having to go from one centre to another before getting help. Also, there is a need for training on gender and human rights issues to health care workers.