Free download from www.hsrcpress.ac.za

AN AUDIT OF HIV/AIDS POLICIES

IN BOTSWANA, LESOTHO, MOZAMBIQUE, SOUTH AFRICA, SWAZILAND AND ZIMBABWE

FUNDED BY THE WK KELLOGG FOUNDATION

EDITED BY NOMPUMELELO ZUNGU-DIRWAYI, M.A., OLIVE SHISANA, SC.D, ERIC UDJO, PH.D, THABANG MOSALA, PH.D & JOHN SEAGER, PH.D

RESEARCH MONOGRAPH

SOCIAL ASPECTS OF HIV/AIDS AND HEALTH RESEARCH PROGRAMME

Free download from www.hsrcpress.ac.za

Compiled by the Social Aspects of HIV/AIDS and Health Research Programme of the
Human Sciences Research Council (HSRC)

Funded by the WK Kellogg Foundation

Published by HSRC Publishers
Private Bag X9182, Cape Town, 8000, South Africa
www.hsrcpublishers.ac.za

© 2004 Human Sciences Research Council

First published 2004

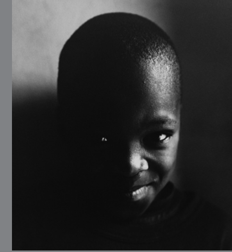
All rights reserved. No part of this book may be reprinted or reproduced or utilised in any
form or by any electronic, mechanical, or other means, including photocopying and recording,
or in any information storage or retrieval system, without permission in writing from the publishers.

ISBN 0 7969 2066 4

Cover by Fuel Design
Cover photograph by Nick Aldridge
Production by comPress

Distributed in Africa by Blue Weaver Marketing and Distribution,
PO Box 30370, Tokai, Cape Town, 7966, South Africa.
Tel: +27 +21-701-4477
Fax: +27 +21-701-7302
email: booksales@hsrc.ac.za

Distributed worldwide, except Africa, by Independent Publishers Group,
814 North Franklin Street, Chicago, IL 60610, USA.
www.ipgbook.com
To order, call toll-free: 1-800-888-4741
All other inquiries, Tel: +1 +312-337-0747
Fax: +1 +312-337-5985
email: Frontdesk@ipgbook.com



Contents

List of tables vi
Abbreviations vii
Contributors x

Executive summary 1

Research context 5

The research 7

Rationale for this study 7
Objectives of the study 7
The problem of HIV/AIDS in selected SADC countries 7
- Botswana 7
- Lesotho 8
- Mozambique 9
- South Africa 9
- Zimbabwe 10
- Swaziland 11

Factors fuelling the epidemic in the SADC region 12

Methodology 15

Generic research instruments 15
Policy review 15
Review of implementation of HIV/AIDS programmes 15
Legislation review 15
Ethics of conducting the study 16
Approval for the study from government 16
Methodology: country specific 16
- Botswana 16
- Lesotho 17
- Mozambique 17
- South Africa 18
- Swaziland 18
- Zimbabwe 19

HIV/AIDS national policies and legislation 21

Rationale for policies 21
HIV/AIDS policy and strategic plans 21
- Botswana 21
- Lesotho 23
- Mozambique 25
- South Africa 26
- Swaziland 30
- Zimbabwe 31

Summary 34
General conclusions on the policy aspects 34
Recommendations 35

Free download from www.hsrcpress.ac.za

©HSRC 2004

Implementation: Guidelines, barriers and proposed solutions 37

Guidelines: voluntary counselling and testing (VCT) 37
Guidelines: prevention of mother-to-child transmission of HIV (PMTCT) 37
Guidelines: treatment of opportunistic infections 37
Guidelines: infant feeding of HIV positive mothers 38
Guidelines: nutrition for people living with HIV/AIDS 38
Existence of guiding documents 38
Existence of policies on orphans and rape 39
Existence of ministerial policies 40
Barriers to implementation of HIV/AIDS policies and strategic plans 40
- Botswana 40
- Lesotho 40
- Mozambique and Swaziland 40
- South Africa 40
- Zimbabwe 41

Recommendations for addressing barriers to implementation of HIV/AIDS policy and plans 41

HIV/AIDS drug policy 43

Background 43
Level of development of national drug policies for six SADC countries 45
Patent laws and their effect on drug policies for HIV/AIDS and availability of drugs 46
Methods that can be used to circumvent the patent protection obstacles 47
- Parallel importation 47
- Voluntary license 47
- Compulsory license 47
- Civil disobedience 47

Conclusion 48

Services and programmes 49

- Botswana 49
- Lesotho 51
- Mozambique 52
- Swaziland 53
- South Africa 56

Summary 58

Findings of the legislation review 59

- Botswana 59
- Lesotho 60
- Mozambique 60
- South Africa 60
- Swaziland 62
- Zimbabwe 62

Conclusion 62

Free download from www.hsrcpress.ac.za

©HSRC 2004

Recommendations 63
Gender and HIV/AIDS 64
General conclusions on the legislative aspects 65
Recommendations on legislative aspects 66

Summary, conclusions and recommendations 67
Legislative aspect 69
Overall recommendations 69
General barriers to implementation of policy 70

Appendices 73

References and documents reviewed 85

Free download from www.hsrcpress.ac.za

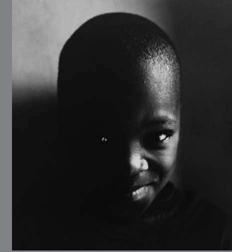
©HSRC 2004

List of tables

Table 1: Prevalence rates of HIV/AIDS in 2002 5
Table 2: HIV/AIDS policies and process of development 35
Table 3: HIV/AIDS strategic plans and process of development 36
Table 4: Summary of findings on the existence of guiding documents 39
Table 5: Antiretroviral drugs on the WHO Essential Drugs List 44
Table 6: Summary of the level of development of drug policies in the four main areas 45
Table 7: Drug availability in the country 47
Table 8: International conventions on HIV/AIDS 63

Free download from www.hsrcpress.ac.za

©HSRC 2004



Abbreviations

ACHAP	African Comprehensive HIV/AIDS Programme
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance Of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Ante-Natal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Zidovudine
BCC	Behaviour Change Communication
BHRIMS	Botswana HIV/AIDS Response Information Management System
BONASO	Botswana Network of AIDS Service Organisations
BONEPWA	Botswana Network of People Living With AIDS
BOTUSA	Botswana and USA Partnership
CASS	Centre for Applied Social Studies
CBO	Community Based Organisation
CHBC	Community Home-Based Care
CSO	Central Statistic Office
DENOSA	Democratic Nurses of South Africa
DSMCA	District Multisectoral AIDS Committee
EDM	Essential Drugs and Medicines (WHO)
ELISA	Enzyme Linked Immunial Sorbent Test
FAMSA	Family and Marriage Services Association of South Africa
FP	Family Planning
GSK	GlaxoSmithKline
HAART	Highly Active Antiretroviral Therapy
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
IRDP	Integrated Rural Development Program
LAPCA	Lesotho AIDS Programme Co-ordinating Authority
MCC	Medicines Control Council
MOH	Ministry of Health
MOHCW	Ministry of Health and Child Welfare
MOHSW	Ministry of Health and Social Welfare
MONASO	Mozambican Network of Organisations against AIDS
MRC	Medical Research Council

Free download from www.hsrcpress.ac.za

©HSRC 2004

MTCT	Mother-to-Child Transmission
MTP	Medium-Term Plan
NAC	National AIDS Council
NACA	National AIDS Co-ordinating Agency
NACP	National AIDS Control Programme
NDP	National Drug Policy
NERCHA	National Emergency Response Committee on HIV/AIDS
NGOs	Non-Governmental Organisations
NIP	National Integrated Plan
NITF	National Interdisciplinary and Inter-sectoral Task Force
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitors
NP	National Policy
NPC AIDS	National Programming for Combating AIDS
NRTI	Nucleoside Reverse Transcriptase Inhibitors
NSP	National Strategic Plan
PBC	Planning and Budgeting Committee
PEP	Post-occupational Exposure Prophylaxis
PLWHA	People Living With HIV/AIDS
PMB	Prescribed Minimum Benefits
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RDP	Reconstruction and Development Programme
RH	Reproductive Health
RHM	Rural Health Motivators
RSA	Republic of South Africa
SADC	Southern African Development Community
SAHA	Social Aspects of HIV/AIDS and Health
SAHARA	Social Aspects of HIV/AIDS and Research Alliance
SALC	South African Law Commission
SAMA	South African Medical Association
SANC	South African Nursing Council
SAPS	South African Police Services
SASO	Swaziland AIDS Support Organisation
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
STP	Short-Term Plan
SWAGAA	Swaziland Action Group Against Abuse
TAC	Treatment Action Campaign

Free download from www.hsrcpress.ac.za

©HSRC 2004

TB	Tuberculosis
TBA	Traditional Birth Attendants
UNAIDS	United Nations Programme of HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	The United States Agency for International Development
VAWnet	Violence Against Women Network
VCT	Voluntary Counselling and Testing
WHO	World Health Organisations
WKKF	WK Kellogg Foundation

Free download from www.hsrcpress.ac.za

©HSRC 2004

Contributors

Sponsor of the multi-country study: Olive Shisana

Editors: Nompumelelo Zungu-Dirwayi, M.A.
Olive Shisana, Sc.D
Eric Udjo, Ph.D
Thabang Mosala, Ph.D
John Seager, Ph.D

Country research teams

Botswana

Dr Sheila Tlou, of the University of Botswana, was the project director for the Botswana study and worked with senior research fellows.

Lesotho

The Lesotho study was conducted by Ron Cadribo, Department of Political and Administrative Studies (Team Leader) and Mokhantso Makoae, Department of Sociology, both at the National University of Lesotho.

Mozambique

Dr Joel Gudo, of Maputo Central Hospital, was the project leader in Mozambique and worked along with Amilcar Tivane, Maria Ester, Moisés Ernesto, Avertino Barreto and Francisco Mbofana.

South Africa

The South Africa team was led by Efua Dorkenoo, OBE., then Director of the Social Aspects of Health division of the SAHA programme of the HSRC. It included the following people: Mthobeli Guma, Prudence Ditlopo, Shandir Ramlagan, Nelson Kamoga, Evodia Mokoko, George Petros, and Ayanda Nqeketo.

Consultants: Jobi Makinwa (legislation policies), Henry Fomundam (Drug Policy)

Swaziland

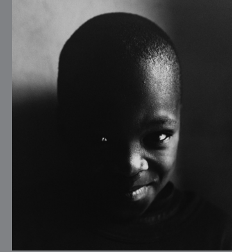
The project leader for Swaziland was Rudolph Maziya of Alliance Of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) and his team included the following: S Dlamini, Z Hlanze and I Ziyane.

Zimbwabwe

The Zimbabwean team was led by Brian Chandiwana and included S Mtero-Munyati, Alfred Ching'ono, George Chitiyo and Farai Chieza, all from the Biomedical Research and Training Institute's Centre for International Health and Policy (BRTI-CIHP), in collaboration with the Blair Research Institute.

Free download from www.hsrcpress.ac.za

©HSRC 2004



Executive summary

This report is the result of a three-month study, commissioned by the Centre for Applied Social Studies (CASS), through the WK Kellogg Foundation. The aim was to review and analyse HIV/AIDS policy, legislation, financing and the implementation of programmes in six selected Southern African Development Community (SADC) countries, namely Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe. African leaders were party to the Declaration on the Commitment on HIV/AIDS at the United Nations General Assembly, Special Session (UNGASS) on HIV/AIDS, held on June 25–27 2001, which stated that, by 2003, countries should have developed multisectoral, national strategic plans which directly address the HIV/AIDS epidemic. Hence, an underlying theme of this study was to assess to what extent each of the heavily affected Southern African countries has met this goal.

The Social Aspects of HIV/AIDS and Health Programme of the Human Sciences Research Council (SAHA) was selected to supervise and direct the project. Accordingly, research teams were identified in the six countries, whose role it was to direct and supervise the preparation of country reports and case studies, to illuminate salient aspects of the research topic. These included the University of Botswana, the National University of Lesotho, the National Blood Transfusion Service in Mozambique, the University of Witswatersrand, and the Centre for International Health and Policy of the Biomedical Research and Training Institute in Zimbabwe and AMICAALL in Swaziland.

Free download from www.hsrcpress.ac.za

Staff of SAHA, and specifically of the recently established Social Aspects of HIV/AIDS Research Alliance (SAHARA) provided generic research tools, designed to guide the research in the selected countries and to encourage standardisation, so that study results could be effectively compared and conclusions drawn. Research instruments were also customised to meet the specific needs of each country in the study, through consultation with the research teams, and were outlined and explained in an operational handbook, prepared for use in the field. For Mozambique, the research guidelines were translated into Portuguese. SAHARA staff also supported a literature search on thematic areas, organised a review workshop, at which in-country research teams presented their findings, and elaborated this final report.

This report is based on:

1. National reviews of current policies, strategic plans and actual programmes, on HIV/AIDS.
2. Key informant interviews (conducted with staff of governmental departments and Ministries, Non-Governmental Organisations (NGOs), Civil Society Based Organisations (CBOs), Voluntary Counselling and Testing centres (VCTs), Prevention of Maternal to Child Transmission (PMTCT) and other health facilities, People Living With HIV/AIDS (PLWHA), as well as with patients at various levels of health care delivery) were administered to assess to what extent the above policies were actually impacting at the district level in the countries targeted and to determine the general state of prevention and care services.
3. Detailed analysis of in-country drug policies in relation to prevention and treatment of the disease, and gauging the extent to which these comply with the latest WHO recommendations on essential drugs for resource-poor settings. Analysing the level of existing infrastructure for the provision of antiretroviral drugs and options for increasing access to essential drugs were also explored.

©HSRC 2004

4. A review of documentation from state financial institutions in the selected countries, combined with strategically selected interviews with relevant policy makers, to assess the state of financing for programmes designed to combat the disease, and to present recommendations for expanding these programmes appropriately.
5. A review of national legislation affecting those living with HIV/AIDS in the selected countries.
6. Information elicited at workshops that were organised with relevant key informants on the implementation of programmes at Kellogg sites.

The results of this research demonstrated that, in all of the six countries surveyed, there is some level of commitment to the management of the HIV/AIDS epidemic. HIV/AIDS policies and strategic plans have been developed in most of the countries, through participatory and consultative processes. In all countries, multi-sectorial structures have been established, to co-ordinate and direct prevention and care activities. With the exception of Lesotho, and to some degree, Swaziland, most countries have developed protocols and guiding documents on these activities. Various mechanisms also exist in all countries to finance HIV/AIDS related activities.

However, serious constraints have been identified in the implementation of HIV/AIDS policies, strategies and programmes. In most countries, with the possible exception of Botswana, services such as VCT and PMTCT are inadequate in rural areas. Antiretroviral drugs are primarily available in private hospitals and are accessible only to the relative few who can afford them. In all countries, the fear of stigmatisation and discrimination, as well as traditional cultural norms, continue to impede more effective provision of support to those affected by the disease.

With the exception of South Africa, there is a chronic lack of financial resources to implement necessary programmes. Adequately trained staff, including medical, counselling and support personnel are also in short supply in all countries. People Living With HIV/AIDS and caregivers are not, in general, receiving the level of support that they require. Poor service infrastructure, especially in rural areas, severely limits access to care. There is a desperate need for increased community involvement in programmes to enhance the effectiveness of such access. Data also indicated that the level of monitoring and evaluation of existing intervention programmes is inadequate. There was also general agreement that the rate of spread of the epidemic is unlikely to diminish unless ways are rapidly developed to decrease the high level of violence against women in all of the countries studied, as rape is a primary exacerbating factor in the levels of infection.

The following is a summary of the specific recommendations, which are expanded upon in the report:

1. 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.
2. Involvement of communities as well as 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.
3. Programmes of mass public education on the rate of HIV infection, as well as on lifestyles that promote the spread of HIV should be strengthened. This will increase openness about HIV/AIDS among partners, in work places, among children and in

Free download from www.hsrcpress.ac.za

©HSRC 2004

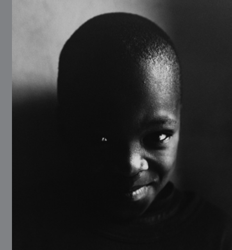
communities. Such programmes will contribute to the removal of negative stigma associated with infected and affected persons.

4. Existing community-based programmes should be strengthened, including income-generating projects. There should also be improved life skills, such as training youths in home-based care, and support to orphans.
5. Donors also need to play a more supportive role by working within the framework of the national strategic plan and channelling resources to meet national priorities, rather than focusing on their own projects, as is the general perception.
6. Monitoring and evaluation systems should be strengthened.
7. There should be greater leadership commitment from the government. This would help uproot stigma and silence and promote open disclosure of HIV/AIDS status.
8. Best practices should be improved to increase accountability of official authorities in management of HIV/AIDS funds and programmes.
9. Greater decentralisation is recommended, as well as the involvement of district and regional structures in implementation of HIV/AIDS programmes.
10. There is 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.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za



Research context

Countries in the Southern African Development Community (SADC) are the hardest hit by the HIV/AIDS epidemic. At the end of 2002, it was estimated that 29.4 million, out of 42 million people living with HIV/AIDS, lived in sub-Saharan Africa. In 2002 alone, about one million people in sub-Saharan Africa were infected. This constitutes a rise of two million people from the end of 2001 (UNAIDS, 2002). The figures rose by another million by the end of 2002, from 28.5 million in 2001, suggesting that, despite all the prevention campaigns in the region, the epidemic is not yet under control (UNAIDS, 2002).

New infection rates are still very high. In 2002, five million new infections were recorded globally, of which 3.5 million were in sub-Saharan Africa. Similarly, the number of deaths due to AIDS is high. Of the three million deaths reported worldwide in 2002, 2.4 million were recorded in the sub-Saharan region (UNAIDS, 2002).

Within the SADC region, the countries that have the highest HIV/AIDS prevalence rates among the adult population are Zimbabwe, Zambia, South Africa, Botswana, Lesotho and Swaziland (UNAIDS, 2002). The prevalence rates among adults in these countries range from 15 per cent to 38 per cent (UNAIDS, 2002). Table 1 illustrates the severity of the epidemic in each country. Botswana has the highest prevalence rate, while South Africa is home to the highest number of people living with HIV/AIDS in the world.

The major mode of HIV transmission in sub-Saharan Africa is heterosexual (UNAIDS, 2001). A high prevalence of sexually transmitted infections, unsafe sex and multiple partners remain the most common causes of new HIV infection rate in the region (UNAIDS, 2002).

Table 1: Prevalence rates of HIV/AIDS in 2002 (Source: UNAIDS, 2002)

Country	Total population 2001 (thousands)	Population of PLWHA (adults and children)	Adults (15–49) prevalence	No of children orphaned	Estimated AIDS deaths	Sero-prevalence	Year
Botswana	1 554 000	330 000	38.8%	69 000	26 000	44.9%	2001
Lesotho	2 057 000	360 000	31.0%	73 000	25 000	42.2%	2000
Mozambique	18 644 000	1 100 000	13.0%	420 000	60 000	14.4%	2000
South Africa	43 792 000	*4 500 000	15.6%	660 000	360 000	24.3%	2000
Swaziland	938 000	170 000	33.4%	35 000	12 000	32.3%	2000
Zimbabwe	12 852 000	2 300 000	33.7%	780 000	200 000	31.1%	2000

**Nelson Mandela/HSRC HIV/AIDS study*

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za

The research

Rationale for this study

Currently, there is no scientific documentation on SADC countries' HIV/AIDS policies, legislation, financing and the implementation of programmes, even though this information may be crucial for several reasons. Firstly, in terms of assisting countries to design effective and efficient interventions for curbing the epidemic; and secondly, the progression of the HIV/AIDS epidemic in each country is different. This provides us with a unique opportunity for learning from those countries that have dealt with the epidemic for a longer period. It also provides an opportunity to share experiences and expertise from each country in the fight against HIV/AIDS. Thus, there is clearly a need to scientifically document this crucial data within the region.

In view of this gap in knowledge and as part of its commitment to assist economic and social development in Southern Africa, the WK Kellogg Foundation has established an Integrated Rural Development Programme (IRDP), managed by the Universities of Zimbabwe and Pretoria. An important component of this programme is designed specifically to contain the spread and mitigate the impact of HIV/AIDS in rural communities. With this goal in mind, WK Kellogg, acting through the Centre for Applied Social Sciences, at the University of Zimbabwe, commissioned the Social Aspects of HIV/AIDS and Health Research programme of the Human Sciences Research Council (HSRC) to undertake a review of the HIV/AIDS epidemic in six Southern African countries (Botswana, Lesotho, Mozambique, South Africa, Swaziland, and Zimbabwe). The primary goal was to put forward recommendations to Kellogg on how best to strengthen their policy in this area, and also to guide future policies on HIV/AIDS and Rural Development.

Free download from www.hsrcpress.ac.za

Objectives of the study

1. To conduct key informant interviews, to elicit additional primary data.
2. To undertake a detailed case study on financing of HIV/AIDS programmes in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe, with a view towards identifying commendable practices.
3. To conduct a review of legislation affecting people living with HIV/AIDS in the six countries.
4. To review national HIV/AIDS policies and strategic plans in the six countries and document case studies.
5. To investigate access to HIV/AIDS prevention and care services in all six countries, based on surveys of the population.
6. To review pharmaceutical policies and infrastructure for the provision of antiretroviral drugs in the six Southern African countries.

The problem of HIV/AIDS in selected SADC countries

Botswana

It is estimated that 330 000, of a total population of 1.554 million (i.e., 14 per cent of the population), are living with HIV/AIDS (UNAIDS, 2002). The country is currently experiencing one of the fastest growing rates of HIV infection in the world. About one in four of its sexually active and economically productive adults are living with HIV/AIDS.

©HSRC 2004

According to estimates and projections made by the U.S. Bureau of Census, life expectancy in Botswana has declined to 45 years, from a projected 61 years in 1996, as a result of the HIV/AIDS epidemic. By 2010, it is estimated that life expectancy will decline further, to 33 years. In 1996, as a result of lowered fertility and the premature death of children and adults from AIDS, the population growth rate dropped from an estimated 2.6/1000 to 1.6/1000 per annum. The HIV epidemic is expected to have serious macro-economic repercussions. Households will face large financial burdens, due to loss of income from family members who die from the disease, as well as because of increasing costs of treatment for HIV/AIDS and associated opportunistic infections.

In Botswana, as in other countries, the HIV epidemic disproportionately affects people and communities who are economically and socially disadvantaged. Heterosexual intercourse has been the predominant mode of HIV transmission. In addition, vertical transmission, from mother-to-child, has contributed to the rapidly growing epidemic. Women have been hardest hit by HIV infection. Recent data indicate that 58 per cent of infections in the age group 15–49 years occur in women. In addition, women face the physical and emotional burden of bearing HIV-infected infants and are also expected to assume much of the care-giving burden for people living with AIDS. Poverty, unemployment, legal and socio-cultural disadvantages, dependence on partners for financial support, and lack of empowerment in negotiating sexual and reproductive matters, all contribute to an increased vulnerability to HIV infection among women. If women refuse to have unprotected sex with their partners, they may be at risk of physical and sexual violence.

Free download from www.hsrcpress.ac.za

Lesotho

UNAIDS (2002) estimates that 360 000, out of 2.057 million people (i.e., 17.5 per cent of the population), are living with HIV/AIDS. The overall prevalence rate is estimated to be 31 per cent with 24 per cent of adults infected. Rates among females in the 15–49 age group are higher than those for males in the same age group. In women aged 15–19, the prevalence rate is estimated to be between 25 per cent and 51 per cent. The rate of progression from HIV infection to AIDS is also reported to be faster among women than men (UNAIDS, 2002).

Since the first case of AIDS was reported in 1986, the disease has spread rapidly throughout the country. In 1997, there were 2 203 reported cases. There was an increase of 30 per cent (to 3 242) in the number of AIDS cases reported in 1998. By December 2000, the Ministry of Health reported 14 880 cases of AIDS. Reported cases are estimated to be less than one quarter of all AIDS cases in Lesotho. A joint estimate by WHO and UNAIDS placed the number of Basotho aged 15–49 years living with HIVAIDS at 40 000 in 1994, increasing to 79 000 by 1997, 92 000 by 1998 and 240 000 by 2000, (representing a sero-prevalence of 23.5 per cent of all adults aged 15–49). Sentinel surveillance in several sites in the country showed that, over the years, there has been a steady upward trend in the proportion of individuals testing HIV positive among pregnant women aged 20–24 years, with sero prevalence rising from 3.9 per cent in 1992 to 26 per cent in 1996. HIV prevalence among persons attending antenatal care clinics (ANC), as well as clinics for sexually transmitted infections (STI) also increased over time. For STI patients, the increase ranged from 4.8 per cent to 7.1 per cent in 1991, and from 34.9 per cent to 63.5 per cent in 2000. For women attending ANCs, increases were dramatic, ranging from 0.7 per cent to 5.5 per cent in 1991, and from 15.8 per cent to 42.2 per cent in 2000. Of all

©HSRC 2004

the AIDS cases in Lesotho reported to date, 45.1 per cent were male and being 54 per cent female. In 1998, 69.5 per cent of persons with AIDS were married, 16.6 per cent were single, 75 per cent were separated, 5.4 per cent were widowed and 1.1 per cent were divorcees. It is observed that the rate of HIV infection in sexually active adults continues to double every two years, and is concentrated in people between the ages of 15 and 49.

One of the tragic consequences of AIDS is the death of parents, leading to a high number of orphans. UNAIDS estimates for 2001 indicate that the country experienced 25 000 AIDS deaths. In 2001, it was estimated that 73 000 Basotho children were orphaned, mainly due to AIDS. However, the figures provided by UNICEF are higher. The latter estimates that Lesotho has as many as 117 000 AIDS orphans.

Forces driving the spread of HIV/AIDS in Lesotho are associated with cultural, traditional, behavioural, economic, technical and biological factors. Among these are: unprotected sex, wife inheritance, polygamy, traditional medicine practices, (such as scarification and ritual shavings at funerals), biological factors, such as the physiology/anatomy of women, blood transfusions and mother-to-child transmissions.

Free download from www.hsrcpress.ac.za

Mozambique

UNAIDS estimated that there are 1.1 million people (about 6 per cent of the total population) living with HIV/AIDS in Mozambique. The prevalence of HIV in Mozambique has increased dramatically from 4 per cent in 1992 to 12.2 per cent in 2000 for the adult population. In the central corridor provinces (Manica, Sofala and Tete), the prevalence is even higher (21 per cent in the Manica Province, the capital of which, Chimoio, is a Kellogg site).

In 1992, only 662 cases of AIDS had been recorded. However, by the end of 1998, the number of recorded cases was 10 863 and by 2001 the figure had risen to 1 100 000. It is projected that, without an effective response and if the rate of infections remains at 500 infections per day, there will be 100 000 new HIV infections by the end of 2003.

The epidemic is resulting in a high number of orphans, straining households' coping capacity, changing the dependency ratio, and increasing poverty. Estimates in 1998 showed an average of 1 770 cases of AIDS per hospital and an occupation rate of seven cases per hospital bed.

The number of opportunistic diseases, including pulmonary tuberculosis, is increasing, thereby raising the morbidity rates even further. Studies have revealed an increase in the prevalence of HIV among patients with TB. For example, in 1994, the prevalence of HIV ranged from 2.9 per cent to 30.3 per cent in different parts of the country. By 1997 the range was from 10.5 per cent to 37.8 per cent.

South Africa

The first reported cases of HIV in South Africa occurred in the early 1980s. Today, South Africa is reported to have the largest number of people living with HIV/AIDS in the world (UNAIDS, 2002). It was estimated at the end of 2002 that there were 4.5 million people aged two years and older and about 11.4 per cent of the population, living with HIV/AIDS. Of these, 15.6 per cent were adults. (Shisana et al, 2002).

©HSRC 2004

Free download from www.hsrcpress.ac.za

The reasons for the rapid spread of the epidemic in South Africa are complex and often imbedded in historical, socio-cultural and psychosocial factors. These include: the policies of separate development, which encouraged discrimination and the abuse of Human Rights in the country; high levels of untreated STIs; a low level of condom usage; and social norms that permit and encourage high numbers of sexual partners (Nelson Mandela/HSRC HIV/AIDS Study, 2002). Widespread unemployment, poverty and low levels of income among certain demographic groups are driving forces behind the commercial sex industry. Lack of adequate education, which leads to disempowerment, further entrenches gender and race inequality. The system of migrant labour, which also encouraged men (and later women) to leave their communities, countries and families in search of employment, leading to the breakdown of families, was another compounding factor.

The national antenatal studies, conducted by the Department of Health, suggest a HIV sero-prevalence of 24.8 per cent among pregnant women at the end of 2001 (Department of Health, 2001). Kwa-Zulu Natal has the highest antenatal-based HIV prevalence figure (33,5 per cent), followed by the Free State, with a prevalence of 30.1 per cent .

There were 660 000 orphans and 360 000 deaths in 2001 alone (UNAIDS, 2002). According to a report from the Medical Research Council (MRC), there has been a shift in the pattern of mortality from natural causes in previous decades such that more young people, particularly women, are dying now than older people (Dorrington, et al, 2001).

Zimbabwe

The first officially reported case of AIDS in Zimbabwe was in 1985. Since then, HIV infection has spread rapidly throughout both urban and rural areas. By the end of 1999 an estimated 1 500 000 were living with HIV/AIDS and 200 000 persons had died from AIDS. Ninety-three per cent of PLWHA were adults, of whom 800 000 were women in the reproductive age group and 56 000 were children, aged 0–15. Today, an estimated 2 300 000 Zimbabweans, i.e., about 18 per cent of the population, are living with HIV/AIDS.

The Ministry of Health and Child Welfare records show that the prevalence of infection for women aged 15–19 is 27.8 per cent and that five times more women are infected as men in this age group, with about 1.5 times more in the 20–29 age group. Based on the 2000 sentinel survey of pregnant mothers, the current sero-prevalence rate in women of child bearing age is 35 per cent, while women aged 15–19 years have a prevalence rate of 27.8 per cent. This represents a substantial and rapid increase from the 29 per cent recorded in the 1997 survey. Reports to the Ministry of Health (MOH) show that 70 per cent of all reported cases of HIV related disease are in the 20–49 age group. The peak age of HIV infection in adults is reported to be 20–29 years for females and 30–39 years for males. About 32 per cent of people aged 15–24 years, in both urban and rural areas, are HIV positive. These are the actively reproductive population as well as adults with young families. High HIV prevalence in these age groups results not only in high prevalence of HIV infected young children, but also in the tragedy of young orphans, some of whom are also HIV infected. This group also constitutes the majority of the country's workforce. High mortality in this group has adverse effects on the economy.

Viewed together with the 20 per cent increase in the sero-prevalence rate between 1997 and 2000, the epidemic is undoubtedly on the increase. It is projected that the number of PLWHA will rise to 2 million by 2005. Those who have progressed to AIDS will rise to 1.3

©HSRC 2004

million and cumulative deaths are estimated to reach 1.2 million by 2005. Studies reveal that the leading mode of HIV transmission in the country is heterosexual, which accounts for 92 per cent of all infections. This is followed by mother-to-child transmission (MTCT), which is responsible for approximately 7 per cent of all infections. All other modes of transmission account for about 1 per cent of HIV infections.

The number of known AIDS orphans has increased rapidly, from a small number in 1990 to about 200 000 in 1995. UNAIDS/WHO have estimated that, by 1999, some 900 000 children under 15 years of age had lost either their mother or both of their parents to AIDS and there were 623 883 surviving orphans under 15 years of age.

The epidemic in Zimbabwe is fuelled by historical, political, psychosocial, economic, cultural and other factors. These have been discussed in detail in a previous report and thus will not be extensively covered here. However, it is worth reiterating cultural factors, as they still play a key role in the current state of the epidemic in Africa as a whole.

Swaziland

Swaziland is a landlocked Southern African country. It shares borders with the Republic of Mozambique on the east and with the Republic of South Africa on the south, north and west. Swaziland is a comparatively small country that extends over an area of 17 364 square kilometres and has a total population of 980 722 (CSO, 1997). Of this population, 44 per cent are children under the age of 15 years, while 48 per cent are adults who are aged 15–49 years. Up to 78 per cent of the population resides in rural Swaziland. The population of Swaziland grows at a rate of 2.9 per cent per annum (CSO, 1997). According to the Swaziland census, fertility was estimated to be 4.8 births per woman, while contraceptive use was reported to be 34 per cent in 1998 (MOH&SW, 1998). Teenage pregnancy is believed to account for approximately 28 per cent of all annual births.

Available data suggest that the quality of life of the people of Swaziland has been increasing steadily over the years. Between 1966 and 1977, life expectancy at birth increased from 44 years 58.8 years in 1977. The crude death rate decreased from 20.5 per 1 000 population in 1966 to 8.4 in 1991, while infant mortality declined from 156 per 1 000 live births in 1976, to 72 in 1991. Similarly, under-five mortality declined from 218 in 1976, to 89 in 1991. Maternal mortality is estimated to be 229 per 100 000 live births using the sisterhood method. In discussing these indicators, it is important to note that even though the quality of life has improved over the years, many current indicators are still unacceptably high and are poorer than those of countries with a commensurate economic standing. Morbidity and mortality continue to be driven by preventable environmental factors, even though non-communicable diseases are also becoming a challenge, suggesting that the country is experiencing an epidemiological transition. Leading reasons for outpatient clinic visits include respiratory conditions, diarrhoeal diseases, skin disorders, STIs, and digestive disorders.

Swaziland is a lower middle-income country with an income per capita of US$1 170 (1995). Economic growth has declined from an average of 8 per cent in the 1980s. The decline has been especially pronounced in the period that corresponds to the independence of the Republic of South Africa. Job creation has been consequently slow. According to official statistics, unemployment is 22 per cent and is unofficially believed to

Free download from www.hsrcpress.ac.za

©HSRC 2004

be much higher. It would appear that employment in the informal sector has increased even though data are not available. A significant number of Swazis work in the Republic of South Africa as migrant labour. Poverty is common in the country, with almost half of all Swazis (48 per cent) living below the food poverty line.

The country generally lacks data on progress indicators. Available data is limited to HIV prevalence among antenatal clinic attendees, aged 15–19 and 20–24 years. HIV sentinel surveys are carried out every two years. HIV prevalence among antenatal attendees aged 15–19 increased from 25.6 per cent in 1998 to 26.3 per cent in the year 2000. Among people aged 20–24 it increased from 38.4 per cent in 1998 to 42.5 per cent, in the year 2000.

Factors fuelling the epidemic in the SADC region

The SADC region is made up of 14 countries, which are in close proximity to one another. The region is economically and socially intertwined. There is also a political interlink between countries. The interdependence can be traced to historical ethnic conflicts, with certain ethnic groups and clans from the South migrating to settle in the areas over the Limpopo, today known as Mozambique and Zimbabwe. Later the interdependence was caused by economic migration, with many men from Lesotho, Malawi, Mozambique and Namibia migrating to South Africa and Botswana in search of work in the gold and platinum mines.

Today economic- and civil war-induced migration remains the major reason for movement of people within the SADC region and in Africa as a whole. The migration of labourers, while boosting the economies of the region, has also had the unintended consequence of transporting diseases. This risk is not new and it was recognised before the emergence of HIV/AIDS. In the past, conditions such as TB were rampant within the mining communities. The high prevalence of TB among miners could be explained by poor housing and the overcrowded conditions that existed in the single-sex mine hostels.

In Africa, the major mode of transmission of HIV is heterosexual, followed by mother-to-child transmission and, to a lesser extent, blood transfusion. Unsafe sex and multiple partners remain the most common cause of new infections in this region. The ongoing movement of people, whether due to economic reasons or because of war, continues to destabilise the region. The influx of refugees into local communities exposes both the refugees and the locals to the risks of contracting HIV. Within the contexts of conflict, HIV/AIDS prevention programmes are often suspended, as finances are redirected towards survival and coping mechanisms. Access to health care is also affected, as the priority is shifted towards attending to the casualties of war. Quality reproductive health care services may not be available, thus fuelling the spread of STIs, which, in turn, increase the risk of contracting the HIV infection.

However, there has been a debate on the role of heterosexual transmission involving multiple partners and unsafe sex in propelling the epidemic. Recently, researchers have questioned this theory and provided evidence of cases in which children had become infected and the mode of transmission had not been sexual. Also, research suggests that in many developing countries, health systems are inadequate. In many sub-Saharan countries, for example, there are alarming signs of deterioration of health systems, evidenced in the rise in maternal and child mortality rates, one of the principal measures of national development.

Free download from www.hsrcpress.ac.za

©HSRC 2004

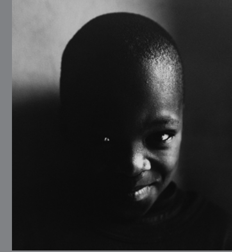
Research has indicated that dirty needles and poor health delivery systems may be partly responsible for fuelling the HIV/AIDS epidemic in sub-Saharan Africa, especially in the SADC region. Therefore, more research on the role of poor health delivery systems and dirty needles in fuelling the HIV epidemic, particularly in developing countries, is urgently needed.

Previously, economic migration was driven by the economic boom, with many men leaving their homes and countries to work in diamond, gold, coal and platinum mines. Today, however, migration is primarily a consequence of famine, which has led to acute poverty in the sub-Saharan region. The drought in Africa has had a negative impact on regional food security. Rural communities are most affected, because of their dependence on subsistence farming. The United States Agency for International Development (USAID) estimates that Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe will be in need of humanitarian food aid in 2003. Food insecurity causes migration to other areas. This type of migration can be within or outside of the country. Both types of migration expose people to vulnerable situations. Being separated from family increases the risk of HIV infection, as those left behind, as well as those who have migrated, are more likely to seek other sexual partners, who may be infected with HIV.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za



Methodology

Generic research instruments

The study had four components, namely a policy review, a review of implementation of HIV/AIDS programmes, a review of financing policies and a review of legislation. The instruments were designed to illicit data on all aspects of the study. Workshops were also organised with relevant key informants on the implementation of programmes at Kellogg sites and on legislation in the six countries.

Research instruments in policy, financing and programming were developed by SAHA and refined in consultation with the other six countries' research teams. An operational handbook was developed for all the instruments and the research teams from the six countries used this. Each instrument was accompanied by detailed guidelines on how to implement it, as well as the rationale for each question. In Mozambique, all questionnaires were translated into Portuguese, revised and adjusted to the local needs.

Policy review

SAHA developed a semi-structured questionnaire and adapted it for use in the six countries. The questionnaire examined to what extent different HIV/AIDS policy documents existed at the national level and to what extent the government had responded to the epidemic. This questionnaire had to be directed to the managers responsible for HIV/AIDS policy in different governmental departments at the national level. These included the Health-HIV/AIDS Directorate, the Medicines Control Council, the Chief Financial Officer, Trade and Industry, Education, National Treasury, Agriculture, Labour, Land Affairs, Justice, Social Development and Transport. Content analysis was used to analyse data.

Review of implementation of HIV/AIDS programmes

A qualitative interview schedule was employed to elicit to what extent HIV/AIDS policies, strategic plans and programmes were being implemented at district level. It should be noted that key informants were selected according to the key areas of service provision on HIV/AIDS. These included VCT, PMTCT, STIs, Care and Support of HIV/AIDS infected and affected people and Violence against Women. The key informants' interviews also attempted to determine the extent to which service providers were involved in policy and strategic plan formulation. The interview schedule was directed to district facilitators, religious leaders, district training managers, professional nurses and midwives, traditional healers, counsellors, social workers, provincial administrators, national administrators, PLWHA and police officers.

Legislation review

A semi-structured questionnaire, designed to assess whether the country has legislation protecting the rights of people living with HIV/AIDS, was directed to Justice departments, NGOs working on Law, Human Rights, Women's groups and organisations for PLWHA. In South Africa, the Legal Resources project at the University of the Witwatersrand was commissioned to review legislative aspects. The review attempted to assess to what extent legislation protected rights of PLWHA from discrimination and other negative manifestations.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Ethics of conducting the study

Prior to commencing data collection, clearance to conduct the study was sought from relevant national authorities in each country, such as research ethics authorities and HIV/AIDS co-ordinating bodies. Consent was obtained from the respondents for the key informant interviews.

Approval for the study from government

Prior to commencing data collection, clearance to conduct the study was sought from the heads of different national government departments. With regards to Policy, Finance and Legislation reviews, letters were written to the relevant officials. Regarding the key informants' interviews, access to the Kellogg sites was made possible through the assistance of the University of Pretoria, WKKF Integrated Rural Development Programmes and District Facilitators, located in the respective provinces.

Methodology: country specific

The present investigation was co-ordinated by the HSRC through the SAHA programme, which mandated its recently established Social Aspects of HIV/AIDS Research Alliance (SAHARA) to both identify partners in the countries, as well as to facilitate sharing of expertise in conducting the multi-country, operational social sciences research. SAHARA identified the following partnerships: the University of Botswana, the National University of Lesotho, the National Blood Transfusion Service in Mozambique, the Social Aspects of HIV/AIDS and Health programme of the HSRC, the University of Witwatersrand, the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) in Swaziland and the Centre for International Health and Policy of the Biomedical Research and Training Institute in Zimbabwe.

To ensure that the review was of a high quality, and that comparable standards were applied in all six countries, the HSRC was responsible for the following:

- Supporting country teams with literature searches on the thematic areas identified.
- Providing generic research instruments for adaptation to countries' specific needs.
- Organising two tele-conferences for in-country research team leaders to review the methodology and finalise the review tools.

The study was conducted between September 2002 and March 2003.

Botswana

The national policies, strategic plans and programmes on HIV/AIDS were reviewed, as well as Botswana's drug policies in relation to prevention and care, taking into account the latest WHO recommendations on essential drugs for HIV/AIDS in resource-poor settings and options for increasing access to HIV/AIDS drugs. Documents from the Ministry of Finance, Local Government and Housing, and from the National AIDS Co-ordinating Agency (NACA) were also reviewed, with a view to designing a case study, outlining how HIV/AIDS programmes are being financed.

Free download from www.hsrcpress.ac.za

©HSRC 2004

The sites chosen for the study were Gaborone, Lobatse, Molepolole, Mmopane, Mochudi, Francistown and Letlhakeng village, (the last being one of the communities in which the WK Kellogg Foundation programme is based). Thirty-six key informants were interviewed in these sites in Botswana to investigate to what extent HIV/AIDS policy, strategic plans and programmes were being implemented at district level. The key informants included staff of hospices, VCT centres, clinics, traditional healers, co-ordinators of civil society organisations and organisations of PLWHA. Four policy makers were also interviewed on National Policy on HIV/AIDS as well as on the Strategic Plan.

Lesotho

In Lesotho, the documents reviewed included the National HIV/AIDS Policy, the Strategic Plan and Health Sector Development Plan and the Health Sector Plan. These were reviewed, along with a number of other reports, including the HIV Sentinel Surveillance Report, AIDS Epidemiology, HIV/AIDS and STDs Situation in Lesotho, and Sexually Transmitted Infections Prevention and Control Programme Annual Report. These provided the basic information on Lesotho's social and economic profile and an HIV/AIDS situational analysis. In addition, the UNDP Human Development Report and the UNAIDS Situation Reports were reviewed. Reports were also obtained from various government departments, including the Ministries of Health, Finance, Planning (especially the Bureau of Statistics), police departments and the Lesotho AIDS Programme Co-ordinating Authority (LAPCA).

Most of the HIV/AIDS activities were still largely concentrated in the capital city, Maseru; thus, the study was limited to interviews of informants there, with the exception of Maluti Hospital in the Leribe district. The latter is one of the three sites at which VCT and PMTCT programmes are operational. A visit was conducted to the Kellogg Integrated Rural Development Programme site in Semonkong. Policy makers interviewed included 12 employees of government Ministries and departments and the Chief Executive of LAPCA. Fifteen key informants were also interviewed. These included HIV/AIDS service providers, religious organisations and NGOs, such as the Lesotho Red Cross, as well as the Association of Nurses and Doctors, and a representative sample of traditional medical practitioners. Key informant interviews were also carried out in two clinics at the Kellogg IRDP site, located in Semonkong.

Mozambique

Staff from Nati Representatives from the National Aids Council, the Ministry of Health (staff working in the programmes, such as HIV/AIDS Control Programme, Blood Transfusion programme, TB, Essential Drugs, and others), other Ministries, policy makers, trade Unions, UN Agencies, NGOs, CBOs, PLWHA, Clinics, VCT centres, health facilities, and PMTCT services were consulted.

A list of potential individuals and organisations working on HIV/AIDS was compiled. For the policy review, interviewees who were policy makers were selected according to their ability to supply adequate information, as well as to their availability. For the financial review, the same criteria were used. For the key informants' interviews, due to the lack of services at Chimoio City (Kellogg site), all organisations and institutions working or related to HIV/AIDS were visited.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Managers of organisations answered specific questions related to policy and strategic plan implementation. The key informants were also invited to participate in the study. In government institutions and NGOs, people responsible for the implementation of HIV/AIDS activities were interviewed. All organisations and individuals that were approached agreed to be interviewed. The HIV/AIDS financing questionnaires were completed with senior staff from the Ministry of Planning and Finance and the Ministry of Health. The latter were interviewed to obtain information about both the availability of funding, as well as on how this funding is being channelled to users.

South Africa

In South Africa, the qualitative interview schedule was designed to determine to what extent HIV/AIDS policies, strategic plans and programmes were being implemented at Kellogg sites. Key informant interviews were conducted in three provinces: the Eastern Cape, Kwa-Zulu Natal and Limpopo. The selection of these provinces was based on the provincial districts in which the Kellogg Foundation Integrated Rural Development Programmes were operational. The Kellogg sites visited were Greater Nyandeni, Manguzi district in the Maputaland region and Mohlanatsi district in the Giyani region. The organisations that took part in this study were: Comprehensive Health Care (Choice), Family and Marriage Services Association of South Africa (FAMSA), Treatment Action Campaign (TAC), Democratic Nurses of South Africa (DENOSA), South African Nursing Council (SANC), Violence Against Women Network (VAWnet), South African Medical Association (SAMA) and religious bodies.

Key informants were selected according to the key areas of service provision on HIV/AIDS. These included VCT, PMTCT, STIs, Care and Support of HIV/AIDS infected and affected persons and Violence against Women. The key informants' interviews also attempted to determine to what extent service providers were involved in policy and strategic plan formulation. The interview schedule was directed to district facilitators, religious leaders, district training managers, nurses and midwives, traditional healers, counsellors, social workers, provincial and national administrators, and PLWHA and police officers.

Swaziland

In Swaziland, the key informants, who participated in the study, were drawn from agencies that were implementing programmes, such as VCT services, PMTCT, health professional associations at national and regional level, senior Ministry of Health officials at national, regional and community levels, traditional healers and development partners. Community level informants were drawn from Tikhuba. The policy and finance questionnaires were completed by senior officials at the Ministry of Health and Social Welfare, including the official at the Swaziland National AIDS Programme, the Ministry of Finance and the National Emergency Response Committee on HIV/AIDS.

The study in Swaziland was based in the Lubombo region and the Tikhuba community. The site in Tikhuba was selected as the WK Kellogg Foundation supports it. Additional informants were drawn from organisations that were providing VCT and PMTCT services. As a result, the study included a total of 48 key informants, instead of the usual maximum of 36.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Zimbabwe

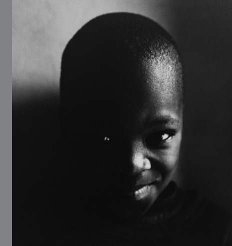
In Zimbabwe, the study took place at the two Kellogg districts sites of Chimanimani and Bulilimamangwe. Interviews were conducted with key informants and policymakers. Such national-level planners and managers, mainly at the Ministry of Health were interviewed face to face. This process was designed to capture data on preparatory consultations planning and the implementation of activities surrounding the national HIV/AIDS policy framework. Hence, both government files, as well as senior civil servants were consulted. The key informant interviews were conducted with VCT clinic staff, PMTCT midwives, health staff at District Hospitals, UNICEF programme officers, health professionals' bodies, the country's Association for Doctors and the Association for Nursing Professionals, the Organisation of PLWHA as well as orphans, traditional healers and members of trade unions and religious bodies. The level of involvement and contributions to the development of national HIV/AIDS policy and strategic framework document were analysed.

The final aspect of the study examined the financing of HIV/AIDS programmes and document flows of funds from the Ministry of Finance, state expenditures and from the national AIDS co-ordinating structures. This included the sources of financing and recommendations for sustainable financing, as well as information on population, GNP, inflation rates, and the National Health budget accounts and allocations from the Ministry of Finance.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za



HIV/AIDS NATIONAL POLICIES AND LEGISLATION

Rationale for policies

Policies and strategic plans on HIV/AIDS are the foundations for any meaningful and sustained response to the epidemic. A policy provides an operating framework for people whose jobs entail prevention, treatment, care, support and generally reducing the impact of the epidemic on the population. Policies can include principles on Human Rights for all and, specifically, the rights of persons living with HIV/AIDS. They can also include strategies for reducing vulnerability to HIV/AIDS for specific groups. A country's policy on HIV/AIDS is a useful guide to domestic and international resource allocation to support specific programmes. Without a policy, those managing the response to HIV/AIDS have no sense of national direction. The policy directs the creation of strategic plans and the allocation of funds to activities aimed at achieving the stated objectives of the management of the HIV/AIDS situation.

As referred to earlier, African leaders 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 2000, which stated that, by 2003, countries should have developed multisectoral national strategic plans and financing that directly address the HIV/AIDS epidemic. Such plans must be developed jointly with key stakeholders. These may include the government, the NGO sector, the private sector, donors, PLWHA and other partners such as researchers and academics. It is important to measure the progress of countries in attaining this goal.

This multi-country study has generated an inventory of HIV/AIDS related policies, guidelines and protocols that exist in each of the six countries. It has also identified areas in which the countries need to develop policies and guidelines.

HIV/AIDS policy and strategic plans

The section below presents information that was researched and compiled by the respective country teams, listed in the contributors list.

Botswana

National policy

The first national policy on HIV/AIDS in Botswana was developed in 1992 and was revised in 1998 in order to keep pace with developments. The HIV/AIDS policy emphasises a multisectoral approach to the epidemic and an international Human Rights approach for addressing stigma and discrimination against PLWHA.

The key elements of the National AIDS Policy are the following: prevention of HIV/AIDS/STI transmission; reduction of personal and psycho-social impact of HIV/AIDS and STIs; mobilisation of all sectors and of all communities for HIV/AIDS prevention and care; provision of care and support for the infected and/or affected; and reduction of the socio-economic consequences of HIV/AIDS and STIs.

The policy advocates the involvement of all government Ministries at policy and operational levels, as well as NGOs, CBOs, the private sector, parastatals, the United Nations and other development partners as stakeholders in the HIV/AIDS epidemic. The Office of the President and each Ministry has defined roles. For example the Ministry of

Free download from www.hsrcpress.ac.za

©HSRC 2004

Education's role focuses on the integration of institutes. There is a new draft policy that is being discussed by the various stakeholders and, when finalised, will replace the 1998 version as a guide for all HIV/AIDS programmes.

The policy spells out the ethical and legal implications of HIV/AIDS, including those relating to testing confidentiality, and outlines how programmes and activities will be co-ordinated through the National Aids Council. The policy emphasises the need for additional resources for both the government and NGO sector and states: 'If necessary, government will contribute funds to NGOs towards HIV/AIDS prevention and care, which they will have to account for.' (National Policy on HIV/AIDS in Botswana, 1998)

HIV/AIDS strategic plan

In response to the AIDS epidemic, in 1987 the Government developed a Short-Term Plan (STP 1987–1989), which focused on increasing national public awareness of HIV/AIDS, as well as on clinical protocols for the management of infected people. This Emergency Plan was followed by a five year Medium-Term Plan (MTP I). This plan was health sector oriented and driven. It later became apparent that this approach was not adequate to address all issues relating to HIV/AIDS. A new multisectoral strategic plan, MTP II, was then developed.

Key elements of the strategic policy are divided into thematic areas of HIV/AIDS interventions and they include the following: firstly, blood safety, aimed at reducing the risk of HIV transmission associated with transfusing infected blood; and secondly, care and support, which includes clinical management, PMTCT, VCT, antiretroviral (ARV) therapy programme, home-based care (HBC), community home-based care (CHBC) and social and psychological support for PLWHA and their families. National guidelines exist for the PMTCT, ARV, VCT, CHBC, orphan care, and the TB treatment programmes. All these programmes are offered free of charge to all citizens of Botswana.

The third theme is prevention, which includes condom availability and ensuring that quality condoms are distributed to all health facilities, at district level. PMTCT ensures that HIV positive women are provided with ARV therapy during pregnancy and infant formula for two months following birth. National guidelines exist for the integration of PMTCT into routine antenatal and postnatal services. The Sexually Transmitted Diseases (STD) prevention and care programme aims at reducing the incidence and prevalence of sexually transmitted infections and forms part of the prevention strategy. Another emphasis is VCT services, the main goal of which is to equip each district with at least one VCT centre, staffed by trained counsellors.

The last theme has to do with the Orphans and Vulnerable Children programme. It focuses on mitigating the impact of parental death on the lives of the children and their caregivers.

Other policies

<u>Orphans and vulnerable children</u>

There is a national policy on orphans and vulnerable children, through which orphans are provided with food, uniforms and other supplies to help their caregivers cope with the impact of HIV/AIDS on family income. Education is free for all children, including orphans.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Rape
Botswana has no national policy on rape. A bill on gender-based violence was discussed in Parliament at the time that this research was being conducted. It will guide the establishment of shelters, crisis centres, and other services for rape survivors. Interventions such as counselling services, training of health workers and law enforcement agencies are mainly based in urban areas. Most rural areas lack some of these amenities, although some crisis centres are operated by NGOs.

Ministerial policies
The Public Service Code of Conduct on HIV/AIDS in the workplace was formulated and released in 2001 and provides an overview of the rights and obligations of Public Service Management and employees with regard to HIV and AIDS. Based on the National policy, individual policy documents have been produced by most (i.e., 80 per cent) of the Ministries and sectors, such as the Botswana Police Service, the Botswana Defense Force, Botswana Power Corporation, Botswana Prisons and Rehabilitation Service, the University of Botswana, Botswana College of Distance and Open Learning, and the Department of Sports and Recreation, as well as by the private sector. All Ministries are allocated funds to carry out HIV/AIDS activities, through the National AIDS Co-ordinating Agency (NACA).

Free download from www.hsrcpress.ac.za

Lesotho

National policy

The Government of Lesotho Policy Framework on HIV/AIDS Prevention, Control and Management was published in September 2000. The policy was developed against the background of the rapid and devastating advances of the HIV/AIDS epidemic. By the late 1990s, the epidemic had reached crisis proportions, in spite of the implementation of prevention and control measures from the late 80s, when the first incidence of AIDS was reported.

The AIDS Programme was initiated in 1996, and is co-ordinated by the Ministry of Health and Social Welfare. The main achievement of this earlier HIV/AIDS response was seen in the joint effort between the Government of Lesotho, NGOs and the UN theme group, especially in the area of residential care and support of orphans and HIV-infected children.

In 1999, a process towards development of a National AIDS programme was initiated through a Core Group led by the Ministry of Health. A Committee of Principal Secretaries was established to guide the process. The process involved consultations with all stakeholders, including the various government sectors, the NGOs and UN agencies, as well as PLWHA.

The key elements of the HIV/AIDS Policy are expressed in the following: 'To create a conducive policy environment for the prevention of the further spread of HIV/AIDS and other sexually transmitted infections and to mitigate the adverse impact on the infected and affected individuals, families and communities.' (The Government of Lesotho Policy Framework on HIV/AIDS Prevention, Control and Management, 2000)

The major pillars of the expanded national HIV/AIDS response, as spelt out in the policy are: political commitment; multisectoral approach; co-ordination; co-ordinating structures; information education and communication; HIV testing; comprehensive health care and support; human rights and non-discrimination; and research and surveillance.

©HSRC 2004

The National Policy incorporates specific policies on HIV counselling and testing, confidentiality, comprehensive health care and support, human rights and non-discrimination as well as research and surveillance, as some of the key pillars of its strategy. It presents its position on specific issues, including: safe blood supply; STI prevention and control; condom promotion and utilisation; parents' involvement in HIV/AIDS prevention; HIV/AIDS and counselling; HIV/AIDS and insurance; HIV/AIDS and international travel; HIV/AIDS and the workplace; HIV/AIDS and sex workers; HIV/AIDS and homosexuals; HIV/AIDS and people in institutional care; HIV/AIDS and prisons; HIV/AIDS and youth; HIV/AIDS and men; HIV/AIDS and women; PMTCT; breastfeeding; orphans; security forces; the disabled; traditional practices; married couples; migrant workers; poverty and HIV/AIDS and the media.

A crucial aspect of the policy is the commitment by Government to allocate human, material and financial resources for HIV/AIDS and STI prevention and control through the regular budget of government sectors, institutions and organisations. There is also a commitment to set up a fund to take care of the HIV/AIDS programme. The policy also informs all existing laws and commits the government to devise appropriate mechanisms for the monitoring and evaluation of HIV/AIDS and STI related policies. The Policy, together with the HIV/AIDS Strategic Plan and the Lesotho AIDS Programme Co-ordination Authority, a multisectoral organisation structure, constitute the cornerstone of the expanded national response to the HIV/AIDS crisis.

HIV/AIDS strategic plan

The National HIV/AIDS Strategic Plan is a Three Year Rolling Plan. The current plan covers the period 2002/2003 to 2004/ 2005. Specific targets for reaching plan goals are reflected in the strategic aims. The total estimated budget over the three-year period is 1.431 billion Maloti (US $ 172 million).

Key elements of the Plan are: the commitment of all stakeholders, accountability to the nation and transparency at all levels; effective communication among all sectors; empowerment and involvement of all stakeholders; sensitivity to culture; networking and exchanging of experiences. Service provision will be based on non-discrimination, professionalism, high quality services and care, accessibility of services to all, confidentiality of patients and innovation. The approach towards PLWHAs will be guided by mutual trust and openness, quality and compassionate care, interpersonal interaction, empowerment and engagement.

The Strategic plan identifies 19 strategic objectives. These are then amplified in the logical framework, which puts forth the indicators of achievement, time schedules and financial resource requirements of the strategic action plan. It also identifies target groups, stakeholders and the most vulnerable groups.

The strategic aims include the following:

- HIV/AIDS prevalence reduced by 5 per cent by March 2003.
- Rates of delayed sexual activities by adolescents (10–15 years) increased by 30 per cent by March 2003.
- Condom usage increased by 50 per cent by March 2003.
- 100 per cent coverage of PLWHAs through support, counselling and care by March 2003.

Free download from www.hsrcpress.ac.za

©HSRC 2004

- 50 per cent of orphans, due to HIV/AIDS, cared for by March 2003.
- Spread of HIV/AIDS among 15–49 years of age reduced from 10 per cent to 5 per cent by March 2003.
- Gender sensitive policy enacted by 2003.
- Baseline study/update survey by December 2002.

These strategic aims, together with the objectives, provide useful yardsticks for assessing progress in the implementation of the strategic plan.

Mozambique

National policy on HIV/AIDS

Mozambique has an overall HIV/AIDS policy. It was developed during the National HIV/AIDS Strategic Plan framework, led by the National AIDS Control Programme (NACP/MOH). The Strategic Plan Document was initially meant for the period of 2000–2002. However, as a result of delays in implementation, this period was changed to 2001–2003. The main objective of the National Strategic Plan was to increase and improve the coverage of services. The plan stipulates targets for prevention. It aims that, by the end of 2003, at least 1.6 million people who are sexually active and 15 000 people (living with HIV/AIDS and their families, living along the corridors in the north, centre and south of the country), will have access to good quality services aimed at the prevention of STD/HIV/AIDS and at reducing the impact of these on the country.

HIV/AIDS strategic plan

When the first case of AIDS was diagnosed in Mozambique in 1986, the Government began its campaign against the epidemic through the Ministry of Health. The first inquiry into HIV was made in 1987, and in 1988, the National Programme for Combating AIDS (NPC AIDS) was created. In 1989, the Provincial AIDS Nuclei were created. In 1988, the National AIDS Commission was created, composed of 50 members. The members were Government representatives, community and religious leaders, representatives of peoples' mass organisations, politicians, academics and others, representing virtually every sector of society.

In 1990, the HIV/AIDS Surveillance system was established. In the same year, MONASO (the Mozambican Network of Organisations against AIDS) was created. In 1995, a programme to control Sexually Transmitted Diseases was integrated into the National Programme for Combating AIDS. A unified programme was created, known as the National Programme for Combating STD/AIDS. In the same year, a Programme for the Social Marketing of Condoms began to operate in Mozambique.

In 1996, a Day Clinic at Maputo Central Hospital was created, offering health care to PLWHA, including home-based care. In 1998, the Inter-Ministerial AIDS Commission, involving eight ministries, was officially established. In 1998, the first associations for people living with HIV/AIDS were created: Kindlimuka in Maputo and Kubatana in Manica. Before 1999, the NPC STD/AIDS, an organisation under the auspices of the Ministry of Health, directed and co-ordinated the entire Governmental response. The NPC STD/AIDS defined its activities on specific plans (Medium-Term Plans or MTP), aimed at achieving objectives defined by WHO.

Free download from www.hsrcpress.ac.za

©HSRC 2004

In 1998, the Inter-Ministerial AIDS Commission was created. This comprised: the Ministry of Health, the Ministry of Culture, Youth and Sport, the Ministry of Planning and Finance, the Ministry of Justice, the Ministry for the Co-ordination of Social Affairs, the Ministry of Education, the Ministry of Labour and the Ministry for the Co-ordination of Environmental Affairs. The objective of the Commission was to involve these Ministries in the fight against AIDS in their particular areas of influence. Parallel to the government's response, the community has also organised a response to the epidemic. There are 58 programmes in the area of HIV/AIDS in Mozambique. Twenty-nine of these are managed by NGOs and other national organisations. Nine are managed by international NGOs. Seven of these programmes and projects were supported by United Nations agencies and 13 of them by the Government.

In 1999, the NPC STD/AIDS developed a decentralisation process for its activities by initiating Regional Co-ordination in three large regions of the country. The general objectives of the NPC STD/AIDS were to prevent HIV infection and provide health care to PLWHA and their families. Its main activities were divided into six main components: the prevention of sexual transmission; the prevention of transmission via blood; health care and social support for PLWHA; programme planning and management; and monitoring and evaluation of the programme of epidemiological surveillance.

In March of 1999, the Ministry of Health initiated and led the National Strategic Plan framework, which terminated in February 2000, when the Government of Mozambique adopted the National Strategic Plan to Combat STD/HIV/AIDS, 2001–2003. This plan was the result of a participatory process of strategic planning, involving 400 national and foreign professionals, and representing 50 institutions or projects in the three economic regions of the country. The process consisted of three basic stages: situation analysis, national response analysis and formulation of strategies for the period 2001–2003 (www.NAC.org.mz).

The plan prioritises the following activities:

- Implementation of essential activities to prevent infection, directed towards young people, particularly girls, highly mobile individuals, and those involved in commercial sex.
- Implementation of impact-reduction activities, aimed at people living with HIV/AIDS and orphans.
- Improving the quality and coverage of essential activities.
- Implementation of activities in the transport corridors in the northern, central, and southern regions of Mozambique and overcoming the principal obstacles (political, cultural, social, institutional, and financial) identified in the National Strategic Plan.

South Africa

South Africa has a national HIV/AIDS policy (Department of Health, 1997). However, from the 1980s, there have been regressive regulations on HIV/AIDS. Many policy revisions have taken place with the view to improving upon and expanding the national response to the HIV/AIDS epidemic.

In 1987, the government of the RSA responded to HIV/AIDS by issuing regulations that had the effect of adding AIDS to the list of communicable diseases. Under the regulations,

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za

a person either actually suffering or even suspected of suffering from AIDS could be placed under quarantine for up to 14 days; with a possibility of the Director General of Health extending this period should this be required. Relevant authorities included the medical officers, public health authorities, the principals of the schools as well as immigration officers. The regulation of 1987 also made it illegal for employers to hire immigrants that were HIV-positive. In 1988, government established the AIDS Unit within the Department of Health, whose role was to promote awareness. A National Advisory Group (NACOSA) was also established for the purpose of advising the government on AIDS policy. In 1992, the government dismantled the AIDS Unit and replaced it with the AIDS Programme.

In 1994, following a countrywide consultation and with the assistance of international health bodies (WHO Global Programme on AIDS, CDC and USAID) NACOSA launched the National AIDS Plan for South Africa.

The AIDS Plan was based on three main objectives, which were as follows:

1. Prevention of HIV through a range of activities, which included education programmes, communication and information, mass media campaigns, distribution of condoms, improving accessibility to early detection and effective treatment of STDs.
2. Reducing the transmission of STI and HIV through appropriate care, treatment and support for those infected.
3. Mobilising local, provincial, national and international resources against HIV/AIDS.

The new Government of National Unity, acting through the Department of Health, in 1994 adopted the NACOSA AIDS Plan. It renamed it the HIV/AIDS and STDs Programme 1995–1996. The government elevated the political profile of combating HIV/AIDS, by making it one of the 22 presidential lead projects, falling within the Reconstruction and Development Programme (RDP). The Programme was allocated its own directorate, within the Department of Health. Three potentially important structures were proposed under the Programme, with a view to engaging and involving civil society. These were:

- The HIV/AIDS, and STD Advisory Group, which reviewed the Programme policies and activities and encouraged linkages between the programme and other role players.
- The Committee on NGO Funding, which encouraged the contributions of NGOs and CBOs.
- The Committee on HIV/AIDS and STD Research, which was established with a view to developing a research policy, complementary to the Programme.

In 1997, a meeting to review the national strategy against HIV/AIDS was conducted by the Department of Health. The meeting was a culmination of a national HIV/AIDS and STDs consultative and review process. One of the key objectives of the review was to revisit the NACOSA AIDS Plan, with a view to identifying gaps and redefining priorities.

The review made several recommendations, amongst which were:

- The need to heighten political leadership and public commitment (including assigning a special leadership role to the Deputy President).
- To ensure prioritisation of responses to the epidemic.
- Adopting a more inclusive approach to HIV/AIDS, (especially the involvement of PLWHAs in programme design, implementation and evaluation).

©HSRC 2004

- Developing inter-departmental and intersectoral responses, so that responses do not remain essentially confined to the Department of Health and focused exclusively on Health.
- Protecting the human rights of PLWHAs, and removing stigmatisation.

National policy on HIV/AIDS

The government has a National AIDS Control Programme, aimed at reducing the transmission of STDs and HIV infection, and providing appropriate care, treatment and support for those affected (Department of Health, 1997). The Programme endeavours to co-ordinate the efforts of all role-players to ensure the optimal use of resources. The implementation of the National AIDS Control Programme focuses on five central objectives. These are:

1. To prevent the spread of the epidemic, through the promotion of safer sexual behaviour, adequate provision of condoms and control of STDs.
2. To protect and promote the rights of PLWHAs, by ensuring that discrimination against such people is outlawed.
3. To use the mass media to popularise key prevention concepts and develop life skills education for youth in and out of school.
4. To reduce the personal and social impact of HIV/AIDS through the provision of counselling, care and social support, including social welfare services for persons with HIV/AIDS, their families and the community.
5. To mobilise and unify local, provincial, national and international resources to prevent and reduce the impact of HIV/AIDS.

NGOs have played a major role in the development of policy and strategy on HIV/AIDS in South Africa and NACOSA played a critical role. According to the senior civil servants interviewed for this review, NGOs were involved in the entire process of the formulation of the national HIV/AIDS policy. They included the Organisation for People Living with HIV/AIDS, faith-based organisations, women's organisations, health consulting organisations, statutory bodies such as the health professionals body, South African Medical Association, South African Nursing Council and South African Dental Association, research-based institutions, academic institutions, health professionals, international donor representatives, political parties and human rights representatives. Other groups that participated were the civil/military alliance, the media, labour organisations and representatives from the business sector and insurance companies.

HIV/AIDS strategic plan for 2000–2005

South Africa has had a National Strategic Plan for HIV/AIDS and STD since 2000. The development of this plan was initiated by the Minister of Health, Dr Manto Tshabalala-Msimang in July 1999, in response to President Thabo Mbeki's challenge to all sectors of society to become actively involved in initiatives designed to address the HIV/AIDS epidemic. This is a five-year plan, with specific targets set for attaining goals. The plan is structured around four main areas. These are: prevention, treatment, care and support, and legal and human rights, as well as monitoring, research and surveillance. The plan is also an operational manual, with a set of indicators for monitoring the success of the country in response to the epidemic. The plan is currently in its third year of implementation. The plan draws not only on all government sectors at national and provincial level, but also upon all other sectors. The plan has two primary goals, namely reducing new infections, (especially among the youth) and reducing the impact of HIV/AIDS on individuals, families and communities.

Free download from www.hsrcpress.ac.za

©HSRC 2004

The plan has specific strategies that are emphasised and they are: effective and culturally appropriate information, education and counselling and increasing access and acceptability of VCT. On the question of STIs, the plan emphasises improving the management of STIs and promoting condom use to reduce STI transmission. The last two address the care and treatment of people living with HIV/AIDS and promote a better quality of life so as to limit the need for hospital care.

To ensure the adequate prioritisation of the key objectives, the government launched the National Integrated Plan (NIP) fund in January 2000. The NIP is a joint venture between the Departments of Health, Education and Social Development. The NIP has three key interventions from the National Strategic Plan: life skills education, VCT and home/community-based care and support through the NIP funds. Separate from the regular budget process, the NIP funds are a special allocation, which has a different funding source, separate funding mechanisms and a unique intersectoral implementation plan.

A national strategic framework is also in place for children infected and affected by HIV/AIDS. This structure is geared to ensure that children infected and affected by HIV/AIDS have access to integrated services that address their basic need for food, shelter, education, health care, family alternative care, and protection from abuse and mistreatment. The emphasis is on an inter-sectoral strategy that involves all sectors of South African society in its response. Furthermore, the Department of Social Development has set up a child support grant that gives caregivers of orphans and vulnerable children a monthly income of R130 (approximately US $19) for each dependent child between the ages of 0 and 7 years old.

Beyond the health sector, other national government departments have begun translating the national HIV/AIDS policies into their areas of focus. The following government departments: Agriculture and Land Affairs (DOA), Labour (DOL), Education (DOE), Transport (DOT); Justice (DOJ) have draft policies on HIV/AIDS. At the time of this survey, the Department of Social Development (DOSD) did not have a specific policy on HIV/AIDS, as it was being prepared. They did possess, however, a draft national strategic framework for children infected and affected by HIV/AIDS.

Other policies

Policy on rape

There are a number of legislative measures available that aim to protect victims of rape. One such measure is referred to as the Criminal Law Amendment Act (No.105 of 1997). This Act provides for a higher minimum sentence for the first offender rapist, who knows that he has HIV, in the absence of substantial and compelling circumstances, than for a first offender, who does not have HIV. Furthermore, the Criminal Procedure Second Amendment Act (No. 85 of 1997) provides for an application of stricter bail measures. It denies bail to a rape accused, who knows he has HIV, unless exceptional circumstances are established.

National policy guidelines on rape

In 1998, the government issued national policy guidelines for victims of sexual offences. The Department of Justice, together with relevant role players, such as magistrates, judges, prosecutors, members of the South African Law Commission (SALC) and other

Free download from www.hsrcpress.ac.za

©HSRC 2004

personnel from within the Department, as well as parliamentarians and staff working with the Departments of Welfare and Safety and Security, the South African Police Service (SAPS) and relevant NGOs came together to devise practical plans for improving the treatment of women within the legal system.

They recommended the creation of a high level Intersectoral Task Team to develop uniform national guidelines for all role-players handling rape and other sexual offence cases. The Department of Justice convened such a team, comprising personnel from the SAPS, the Departments of Health, Welfare and Correctional Services, representatives from different branches of Justice – prosecutors, magistrates and appellate courts – and an NGO representative from the National Network on Violence Against Women. Complete sets of the guidelines were forwarded to the central offices of relevant Departments in the provinces, as well as to other places where they would be easily accessible to people working in the field of sexual violence. At ground level, the applicable guidelines were made available to departmental personnel who used them in their daily work (eg., police stations were given the police guidelines, health clinics were given the health guidelines). The guidelines on rape also contain an information brochure for victims. This explains in simple language what are the best legal steps to take in the process. Victims of rape can obtain additional information on this process from the resources available to them in their area and from material prepared locally.

This document was the first attempt at developing a cohesive framework for dealing with sexual offences. The Department of Health has now developed national draft documents on Management Guidelines for Sexual Assault Victims and on Sexual Assault Policy.

Drug policy

The South African Medicines Control Council (MCC) has an essential drug policy within its National Drugs Policy (NDP). The list of essential drugs will be used as a foundation for the basic health care package of the National Health System for Universal Primary Care procurement and use of drugs.

The National Drugs Policy also allows for drugs that are not on the essential drug list to be requested for specific patients, by placing additional drugs on a supplementary list to be regularly reviewed. To date, 17 Antiretroviral (ARV) drugs are registered with it.

Swaziland

National policy on HIV/AIDS

Swaziland's National Policy on HIV/AIDS was issued in 2001. The National General Policy guidelines are based on political commitment, a multisectoral approach, co-ordination and Information, Education and Communication (IEC). The policy has the following objectives:

- To maintain a sustained political commitment at all levels for HIV/AIDS prevention and control.
- To expand the national response to the HIV/AIDS epidemic, by strengthening and maintaining the multisectoral approach.
- To improve co-ordination of HIV/AIDS prevention and control activities at all levels.
- To ensure that the general public has access to appropriate IEC programmes on HIV/AIDS and STDs.
- To increase the capacity of women, youth and other vulnerable or disadvantaged groups, eg., disabled persons, sex workers, street children, etc., to protect themselves against HIV/AIDS and other STDs.

Free download from www.hsrcpress.ac.za

©HSRC 2004

- To ensure that HIV testing is used to maximise prevention and care.
- To provide comprehensive health care and social support for people with HIV/AIDS and their families.
- To safeguard the human rights of PLWHAs.
- To promote HIV/AIDS related research and surveillance activities.

There are specific areas that are covered by the national Policy on HIV/AIDS and they include the following: condom promotion and utilisation, safe blood supply, HIV/AIDS and youth and women and STD prevention and control. The policy also covers HIV/AIDS and breastfeeding, HIV/AIDS in the workplace, insurance, prisons, international travel and orphans.

National strategic plan on HIV/AIDS
The country has a strategic plan for the prevention and control of HIV/AIDS, which was produced in the year 2000. The goal of the National Strategic Plan is to reduce the incidence of HIV/AIDS in Swaziland and mitigate the impact on the infected and affected individuals, families and communities.

The objectives of the National Strategic Plan are: to decrease the spread of HIV/AIDS through information and education; to mobilise community resources and capacity to meet the counselling and care needs of AIDS orphans, PLWHAs and their families; and to bring about longer term behavioural and social changes that will slow the rate of new infection, thus alleviating the impact of the epidemic. The strategic plan extends over 5 years, from 2000–2005.

Zimbabwe
National policy on HIV/AIDS
According to the document Addressing HIV/AIDS in Zimbabwe – Policies and Strategies of December 1999, the National HIV/AIDS policy 'guides the individual and collective actions required to address the epidemic and provides guidance based on our values and on human rights'. The policy document acknowledges, 'as the epidemic develops and more experience is gained, some policies may need to be serviced in accordance with prevailing circumstances.'

The National HIV/AIDS policy can be grouped according to the following themes, each with related guiding principles, which are supported by a set of strategies.
The first theme, Public Health, includes issues concerning the prevention and management of STIs, ensuring safe and rational use of blood transfusion, condom promotion, procurement and availability and PMTCT, including VCT and issues around breastfeeding. The second theme pertains to the care of people infected with and the affected by HIV/AIDS. This deals with the issues of medical and nursing care, community home-based care, counselling and psychosocial support, referral and discharge planning and care of the carers. The third theme is Human Rights, including issues such as mandatory testing, confidentiality, partner notification, special population groups, and wilful transmission of HIV.

The policy also includes gender issues around sexual health and gender violence. Awareness is another theme, including issues of IEC, materials and message development and the mass media. The other themes are research and management/co-ordination.

Free download from www.hsrcpress.ac.za

©HSRC 2004

While Short-Term Plan (STP) and Medium-Term Plan (MTP) 1 and 2 provided the framework for the National Aids Co-ordination Programme efforts to prevent, control and mitigate the impact of HIV/AIDS, the review of progress made under MTP2 highlighted the need to extend the response to the epidemic beyond the Ministry of Health and Child Welfare. This review coincided with the establishment, by an Act of Parliament – whose mandate was to co-ordinate a national multisectoral response to AIDS – of the National AIDS Council (NAC). To fulfil its mandate, the NAC needed a strategic framework that would galvanise the national response to HIV/AIDS and which was both broad-based and all-inclusive.

National strategic plan on HIV/AIDS

Zimbabwe's response to the HIV/AIDS epidemic began as far back as 1985, following the identification of the first AIDS case in the country, with the universal screening of blood for HIV before transfusion. The Ministry of Health and Child Welfare (MOH&CW) then saw it fit to establish the National AIDS Co-ordination Programme (NACP) to assume leadership in what was then a health-sector focused HIV/AIDS prevention initiative.

Between 1987 and 1988, an emergency STP was implemented, with the twin objectives of creating public awareness through IEC and training of health personnel. The STP was followed by MTP1, from 1988–1993, and MTP2 from 1994–1998. MTP 1 'focused on consolidated and expanding interventions initiated during the STP, motivating appropriate behaviour change among specific population groups, counselling and caring for people with HIV/AIDS and monitoring the epidemic through epidemiological surveillance.' MTP2, however, adopted a multisectoral approach, based on 'recognition of the worsening AIDS situation and the need to mobilise other sectors to participate actively in the fight against AIDS.' (National HIV/AIDS Policy Document – Republic of Zimbabwe, 1999).

It was during the review of the implementation of MTP2 that the need for a comprehensive policy on HIV/AIDS was identified as an urgent priority. The NACP responded by establishing an HIV/AIDS Policy Unit to spearhead the development of a national HIV/AIDS policy for the Republic of Zimbabwe.

Although the HIV/AIDS policy unit within the NACP became the focal point for policy development, it was accepted from the very outset that the process of developing the policy had to be broad-based, participatory and consultative. To this end, the HIV/AIDS policy unit facilitated the establishment of the National Interdisciplinary and Inter-sectoral Task Force (NITF), which then assumed the leadership mantle and provided technical assistance throughout the policy development process.

NITF identified broad policy issues for consideration and, to facilitate closer scrutiny of these issues, NITF constituted seven expert groups, whose task was to come up with policy briefs for their respective themes and areas of expertise. Membership of these expert groups was multisectoral and adequate care was taken to ensure that relevant stakeholders were represented in all of the thematic groups.

The next stage in the process involved taking the initial policy briefs emanating from the expert groups and subjecting them to nation-wide public scrutiny and debate. In all, 84 public meetings were held at national, provincial, district and sectoral levels and over 6 000 people are said to have participated at these meetings and debated the policy

Free download from www.hsrcpress.ac.za

©HSRC 2004

issues. In addition, organisations, sectors, and members of the public were invited and encouraged to make written submissions on the policy issues and it is reported that more than 70 written submissions were received.

The policy development process took three years of consultations to reach some measure of consensus on the essential policies on HIV/AIDS. These policies and related guiding principles were then put together, heralding the birth of the National HIV/AIDS Policy of the Republic of Zimbabwe, which was officially launched on World AIDS Day, on December 1, 1999.

The crafting of the National HIV/AIDS strategic framework for the Republic of Zimbabwe started with the commissioning of four key studies on the socio-cultural, socio-economic and political, as well as the health contexts of the HIV epidemic in Zimbabwe. These studies were carried out around the time that the MTP2 programme implementation was being reviewed. The findings of both the review and the studies were circulated to various stakeholders, who were subsequently invited to submit written comments and suggestions on the best way to proceed. In addition, workshops were held for various sectors, out of which came sectoral position papers on the best approaches to HIV/AIDS prevention, control and impact mitigation. The first draft was circulated to key stakeholders for comment, before the National HIV/AIDS strategic framework was finalised.

The strategic framework highlights the epidemiological and the socio-cultural propellers of the epidemic. It explores the vulnerability issues of different population groups, suggests opportunities for a more effective response to the epidemic and analyses the response, to date, within the various sectors.

Unlike other countries that have drawn up strategic plans with goals, expected outcomes, responsible persons, time frames and budgets, Zimbabwe opted for a strategic framework, with broad-based objectives and strategies. The idea of the strategic framework was to provide the NAC with a conceptual framework that it would use to facilitate the development of sector-specific AIDS Action Plans. Thus, the National HIV/AIDS Strategic Framework for the Republic of Zimbabwe was developed to serve as a working document for the NAC.

A total of 80 districts (57 rural and 23 urban) prepared a Strategic Plan and 2002 Work-Plan for HIV/AIDS, with the participation and involvement of village and ward communities. Some of the district proposals were submitted in the CCP for possible funding. On the bilateral front, a country district management-training programme is ongoing through the co-operation of the Italian and Zimbabwean governments. Twenty-three districts are already trained and the rest will be covered by 2003.

The strategic framework has been adopted, in varying degrees, by various sectors. In the public sector, it has informed the drawing up of District Strategic Plans. Adherence to the national strategic framework has also been a major contributing factor to the approval of funding on the part of the National AIDS Trust Fund of District AIDS Action Plans.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Summary

All six countries have HIV/AIDS policy frameworks and strategic plans at various stages of development. (The HIV/AIDS policies and strategic plans and their respective current levels of development are summarised in Tables 2 and 3.) In five of the countries, stakeholders had been widely involved in the development of a policy framework and the national strategic plan. Swaziland was the only country that did not have adequate consultation during this process. The time frames of Strategic Frameworks/Plans in the different countries for HIV/AIDS range from 3 to 5 years. Botswana's plan is coming to an end in 2003, and it is reported that a new one is in the process of being developed, this time with close involvement of the districts.

General conclusions on the policy aspects

All Governments are committed to the management of the HIV/AIDS epidemic. HIV/AIDS Policy and Strategic Plans have been developed in most countries, through participatory and consultative processes. In all countries, multisectoral structures have been set up to co-ordinate and manage the HIV/AIDS epidemic. With the exception of Lesotho and to some extent Swaziland, most countries have developed protocols and guiding documents on HIV/AIDS management. Various mechanisms also exist in individual counties to finance HIV/AIDS programmes.

However, in all countries, serious constraints have been identified in the implementation of HIV/AIDS policies, strategic plans and programmes. In most countries, with perhaps the exception of Botswana, services such as VCT and PMTCT are largely unavailable in rural areas. At the time of writing, antiretroviral drugs were only available in private hospitals and accessible to the few who can afford them except in Botswana. In all countries, the fear of stigmatisation and discrimination, as well as traditional cultural norms, continue to be serious obstacles to more effective provision of support to victims of HIV/AIDS.

In general, the following barriers to implementation of HIV/AIDS programmes seem to be common to all countries:

- Lack of or inadequate financial resources.
- Limited human resource and professional capacity. Gaps have been identified in all countries, in various areas of health care and related skills, such as counselling.
- Poor service infrastructure, especially in the rural areas, limits access to services for a majority of the population.
- Traditions and cultural norms prevent openness and militate against effective implementation of prevention and impact mitigation measures.
- Poor or lack of community involvement in programmes.
- Weak care and support services, especially lack of strategies and programmes to assist PLWHAs and care givers in most countries, except South Africa and Botswana.
- Poor monitoring and evaluation of the effectiveness or lack of intervention programmes.
- Continuing increase in rape cases and violence against women and the lack of policies and inadequacy of mechanisms in most countries to prevent rape and assist victims.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Recommendations

The following summary represents generic recommendations that apply to all of the countries. Individual country recommendations are provided in detail in the country reports.

1. Training and development of strategic planning skills and capacity of implementing agencies and PLWHA, so that they are better organised to channel resources for effective implementation of HIV/AIDS programmes, is needed.
2. Increased involvement of communities is also needed. 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.
3. Strengthening programmes of mass public education on the rate of HIV infection, including lifestyles that promote the spread of HIV, openness about HIV/AIDS among partners, children, at work places and in communities is required. Efforts must be made to remove stigma among the infected and affected persons.
4. Community-based programmes, including income-generating projects, improved life skills, such as training youths in HBC and support to orphans, should be strengthened.
5. Donors need to 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 pet projects, as is the general perception.
6. Strengthen monitoring and evaluation systems.
7. Greater leadership commitment from the government would help uproot stigma and silence, to promote open disclosure of HIV/AIDS.
8. The improvement of best practices to increase accountability of official authorities in management of HIV/AIDS funds and programmes is required.
9. Greater decentralisation and involvement of district and regional structures in implementation of HIV/AIDS programmes is needed.
10. There is need for a rigorous resource mobilisation strategy from both internal and external sources. A clear strategy is needed to partner with the private sector in HIV/AIDS financing.

Table 2: HIV/AIDS policies and process of development

Country	HIV/AIDS policy – yes/no	Title of policy	Participation of stakeholders
Botswana	Yes	*National Policy on HIV/AIDS*	All stakeholders involved
Lesotho	Yes	*Policy Framework on HIV/AIDS Prevention, Control and Management*	Participative – NGOs, PLWHAs and all stakeholders involved in all stages
Mozambique	Yes	*HIV/AIDS Policy*	A wide array of stakeholders involved
South Africa	Yes	*White paper Transformation of Health Systems*	Wide spectrum of stakeholders involved
Swaziland	Yes	*National Policy on HIV/AIDS*	NGOs involved to some extent
Zimbabwe	Yes	*National HIV/AIDS Policy*	Broad based, participatory and consultative

Free download from www.hsrcpress.ac.za

©HSRC 2004

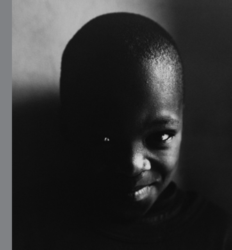
Table 3: HIV/AIDS strategic plans and process of development

Country	Strategic plan	Title and time frame	Participation of stakeholders
Botswana	Yes	*Medium-Term Plan 2* 1997–2002	Stakeholders involved. New Strategic Plan being currently developed
Lesotho	Yes	*National HIV/AIDS Strategic Plan* 2002/03–2004/05	Participative and consultative process
Mozambique	Yes	*National Strategic Plan to Combat HIV/AIDS* 2001–2003	A wide array of Stakeholders involved
South Africa	Yes	*National Strategic Plan for HIV/AIDS* 2000–2005	No reference to participation
Swaziland	Yes	*National Strategic Plan on HIV/AIDS* 2000–2005	No reference to participation
Zimbabwe	Yes	Not specified	Stakeholders involved

Free download from www.hsrcpress.ac.za

©HSRC 2004

Implementation: guidelines, barriers and proposed solutions



Policies and strategic plans must be supported by broad goals and objectives, as well as by detailed guidelines for turning principles into practical operations. The guidelines are usually developed using evidence from scientific studies. National and international guidelines that tend to be generic should be localised through a process of consultation. The guidelines become useful if they can be implemented locally. That is, the resources must be available and personnel must have the necessary competence to implement them. This may necessitate training of staff.

The existence of guidelines implies that those in the front line of service delivery have an explicit and detailed set of instructions to use in delivering the service. Without these guidelines, the frontline workers may be unable to provide quality service.

A brief description of guidelines is provided, followed by the findings for each country.

Free download from www.hsrcpress.ac.za

Guidelines: voluntary counselling and testing (VCT)

VCT is 'the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. The decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.' (UNAIDS Technical Update, May 2000)

VCT is necessary because:

- Research has shown that it is an effective strategy for HIV/AIDS prevention and care.
- People want to know their HIV status.
- It is a useful prevention measure for those who are HIV positive (i.e., it prevents further infections) and for those who are HIV negative.
- Knowing one's HIV status helps one to plan for the future.
- It is an entry point for care.

Guidelines: prevention of mother-to-child transmission of HIV (PMTCT)

There are best practice guidelines for PMTCT, developed by UNAIDS, WHO and UNICEF. The programme comprises VCT, short-course ARV therapy, and options for infant feeding. The guidelines aim to reduce transmission of HIV from mother-to-child, based on protocols that are nationally affordable to a country. The guidelines may be specific for women who receive antenatal care, as well as for those who do not. The guidelines may also have related interventions, such as good antenatal care services, information, education and communication, primary prevention of HIV to specific high-risk groups, family planning, prophylactic treatment, monitoring and evaluation and laboratory testing. (http://www.cdc.gov/nchstp/od/gap/text/strategies/2_2_preventing_mtct.ht)

Guidelines: treatment of opportunistic infections

A key component of the management of HIV/AIDS-related illness is prevention and treatment of opportunistic infections and associated malignancies. If these conditions are not adequately treated, they can lead to increased morbidity and mortality for PLWHAs. If they are treated, PLWHAs can have a better quality of life, contribute to society and prevent further spread of communicable diseases, such as TB.

©HSRC 2004

There are guidelines for prevention and treatment of HIV/AIDS related infections, which require steps to be taken at national, hospital or clinic and at community/home level. These include standard clinical guidelines used by clinicians to provide care in public health settings, training of medical staff, medicines in the essential drugs list, access to affordable medicines and ensuring adequate laboratory services. At community level, the guidelines may include basic education on the prevalence of HIV/AIDS-related infections, referral mechanisms and treatment for TB. As highly active ARV therapy reduces the occurrence of opportunistic infections, it is critical that the guidelines also include provision of this type of treatment. Such treatment must be coupled with palliative care and psychosocial support services.

Guidelines: infant feeding of HIV positive mothers

WHO, UNICEF and UNAIDS issued guidelines on infant feeding options for consideration by HIV-positive mothers. They include:

- Replacement feeding with commercial formula or home prepared formula.
- Traditional exclusive breastfeeding for at least the first six months.
- Breastfeeding exclusively at first but early cessation.
- Use of heat-treated expressed breast-milk.
- Wet-nursing.

Timely and adequate inclusion of complementary feeding is also emphasised. The guidelines do not require women to use one option over others, but simply to require that women take an informed decision based on the information provided. Such a decision would be influenced by availability of resources. (WHO/FRH/NUT/CHD; 1998)

Guidelines: nutrition for people living with HIV/AIDS

The World Health Organisation and the Food Agricultural Organisation recently (February 2003) published a new manual, which offered guidelines for balanced nutrition that can help the body fight back against the disease and maintain the level of body weight necessary to support drug treatment. (http://www.fao.org/DOCREP/005/Y4168E/y4168e02.htm)

Medical nutritional therapy includes both assessment and appropriate treatment, aimed at improving their nutritional status. The American Dietetic Association and Dieticians of Canada (2000) maintain that the diet for PLWAs may include diet therapy, counseling, or the use of supplemental nutrition (oral, enteral, and/or parenteral delivery of nutrients.

Existence of guiding documents

The summary in Table 4 indicates that only South Africa has all the protocols and guiding documents. Botswana has most of them, however, no mention is made in the report on VCT protocols and manuals, so it is not clear whether these are available. Similarly, in Zimbabwe and Mozambique, most of the documents are reported to be available. In Swaziland, some of the documents are available, many in draft form, and others are yet to be completed. In Lesotho, only STI case management guidelines are available. Most of the other documents were reported to be in the process of the development.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Table 4: Summary of findings on the existence of guiding documents

Document/ Country	B	L	M	SA	Sz	Z
National VCT Protocol.	✓			✓	✓	✓
National VCT Curricula/ Manual.	✓		✓	✓	✓	✓
National VCT Facilitators and Participants manual.	✓		✓	✓	✓	✓
National HIV/AIDS Testing Manual.	✓		✓	✓	✓	
National Guidelines on PMTCT.	✓		✓	✓		✓
National Training manuals on prevention of opportunistic diseases and HIV related diseases in adults.	✓		✓	✓	✓	
National Guidelines on infant feeding of HIV positive mothers.	✓			✓	Draft	✓
Guidelines on nutrition for People living with HIV/AIDS.	✓		✓	✓	Draft	
Home-based care.	✓		✓	✓	Draft	✓
Orphan care.	✓			✓		
Case management guidelines for HIV illness and AIDS.	✓		✓	✓	Draft	✓
HIV/AIDS and Prisons.	✓			✓	Draft	
STI case management guidelines.	✓	✓	✓	✓	Draft	
Condoms	✓		✓	✓	Draft	
Youth manuals on HIV/AIDS.	✓			✓	Draft	
Dual manual on TB and HIV.	✓		✓	✓	✓	
Clinical management of HIV in children.	✓			✓		

✓ Indicates existence of a document
Botswana (B), Lesotho (L), Mozambique (M), South Africa (SA), Swaziland (Sz) and Zimbabwe (Z)

Free download from www.hsrcpress.ac.za

Existence of policies on orphans and rape

Of the six countries studied, only Botswana and Zimbabwe lack a national policy on rape. However, in Zimbabwe, as well as South Africa and Mozambique, there are systems and co-ordinated strategies for assisting rape victims.

Existence of ministerial policies

In Botswana, 80 per cent of Government Ministries have HIV/AIDS policies; while in South Africa, a majority of departments are reported to have draft policies. In Swaziland, only the Ministry of Defence has a policy, in draft. In Mozambique, most ministries are

©HSRC 2004

reported to have draft policies, while many have operational plans. In Lesotho, few ministries have HIV/AIDS polices in draft, while the Zimbabwe report makes no reference to ministerial HIV/AIDS policies.

Barriers to implementation of HIV/AIDS policies and strategic plans

Botswana

There were several factors that were identified as barriers to effective implementation of the policy. These included: lack of proper monitoring and evaluation, absence of trained professionals in the area of HIV/AIDS and poor access to financial resources. The inadequate commitment of some service providers was another serious impediment. Ignorance of policies among communities, as well as excessive governmental bureaucracy has also been observed. There is also low utilisation of existing services, such as PMTCT, VCT, HBC and orphan care programmes. This is compounded by heavy workloads among people in service areas other than HIV/AIDS and contributes negatively to the implementation process.

Lesotho

Apart from the lack of financial and skilled human resources, stakeholders and key informants have identified a number of barriers to the implementation of the National Policy and Strategic Plan. Government bureaucracy is one of these. Lack of human resources, poor organisation of agencies and lack of support at decision-making levels of government for the multisectoral approach were also deemed to be seriously undermining policy implementation. Lastly, institutional rivalry and duplication of efforts, among the various NGOs and other implementing agencies, were just some of the other issues of concern.

Mozambique and Swaziland

These two countries had essentially similar constraints that were identified as barriers to implementation of HIV/AIDS Policy and Strategic Plans. A lack of participation in policy development at local level was cited. Inadequate awareness of the national AIDS policy, limited funds for implementing programmes, together with inadequate human resources management skills, were identified as barriers to implementation. Finally, negative cultural and traditional norms, and objectives that were perceived as too ambitious were seen as contributing to the problem of implementation.

South Africa

The barriers to the implementation of HIV/AIDS policy were identified as inadequate human resources, poor infrastructure and lack of awareness. All these factors impacted on the quality of VCT. It was noted that there was a problem of lack of confidentiality because of present infrastructure that does not allow for privacy. Most hospitals and clinics could not provide special rooms for VCT. Stigma was another problem impacting implementation. This manifests itself in low numbers of people requesting testing. The stigma also impacted on PMTCT with relation to infant feeding, because culturally, a woman is expected to breast-feed the child, and family members were forcing mothers to breast-feed, to comply with the culturally expected maternal role.

Free download from www.hsrcpress.ac.za

©HSRC 2004

There was generally a lack of awareness of HIV/AIDS Policy and Strategic Plan. For example, key informants, representing the various organisations, were not aware of the existence of either the policy document on HIV/AIDS or the HIV/AIDS Strategic Plan.

Zimbabwe

There was a belief among NGOs that the agenda was determined by donors, rather than by the strategic AIDS plan. Although NGOs are represented in the various structures, it is accepted that the agendas of donors tend to have a major influence on which aspects of HIV/AIDS programmes the NGOs end up focusing on, eg., in the areas of prevention, control, care and or impact mitigation.

It was also reported that awareness is very low at the grass roots level. Many people are not aware of, let alone familiar with, the national policy on HIV/AIDS. Several reasons have been cited, including the inaccessibility of the document and the fact that it is not user-friendly. It was also believed that commitment was lacking, among the various sectors and players, to the full implementation of the National Policy on HIV/AIDS.

One particular obstacle to the full implementation of the HIV/AIDS policy that has been identified by the NAC, is the absence of a legal framework, constituted by an Act of Parliament, which would make the policies binding. Although the NAC was constituted by an Act of Parliament, its mandate is the co-ordination of a multisectoral response to the epidemic. It does not have policing powers. Legal provisions, such as the Statutory Instrument 202 of 1998 and the Labour Relations (HIV and AIDS) Regulations 1998, are examples of what is needed to enforce full implementation of the national HIV/AIDS policy. Another obstacle that was identified is the constant staff turnover and brain drain of those who had represented the various organisations during the policy development process, resulting in loss of institutional memory.

Recommendations for addressing barriers to implementation of HIV/AIDS policy and plans

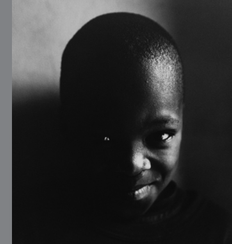
Only Botswana and Mozambique made separate recommendations to address barriers, although many of these are relevant to the other countries, as well. In other countries, solutions are discussed in relation to specific HIV/AIDS programme areas and activities.

Botswana is considering the decentralisation of decision-making, including budget decisions, to be one of the key ways of improving the implementation processes. The country foresees a need to create units within Ministries and departments, which deal primarily with HIV/AIDS. The National AIDS Co-ordinating Agency (NACA) has to move from operations and implementation to co-ordination monitoring and evaluation. In Mozambique, key issues that need to be addressed include dissemination of the policy and developing appropriate mechanisms of funding for HIV/AIDS activities. Greater involvement of communities in all HIV/AIDS initiatives would help accelerate programme implementation.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za



HIV/AIDS DRUG POLICY

Due to the prevalence, morbidity and mortality rates of HIV/AIDS on the continent, there has recently been a major effort from the individual governments, pressure from advocacy groups and support from the international community to address the issue of HIV/AIDS treatment. Policies, including drug policies on HIV/AIDS are very dynamic with progressive measures being taken by several countries in Africa on the treatment of HIV/AIDS. There may be some changes to the drug policy in individual countries since this data was collated from 6 countries in the SADC region.

Background

Drug regulation, procurement, distribution, affordability, availability, storage and rational use remain a major challenge to health delivery in Africa. This challenge is more evident with infectious diseases including HIV/AIDS whereby inappropriate pharmaceutical care can lead to drug resistance and therapeutic failure thereby increasing the cost of health care tremendously. Inadequate health care financing, infrastructure and human resources are serious impediments to health care delivery and thus pharmaceutical care in Africa.

Effective health care requires a judicious balance of preventive and curative services. A crucial and often deficient element in curative services is an adequate supply of appropriate medicines. WHO published the first Model List of Essential Drugs in 1977. It identified 208 individual drugs, which together could provide safe, effective treatment for the majority of communicable and non-communicable diseases. Essential medicines are those that satisfy the priority health care needs of the majority of the population. They are selected with regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford. *(The Rationale for Essential Medicines, WHO 2002)*

The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations. Exactly which medicines are regarded as essential remains a national responsibility. The 12th Model List of Essential Drugs, prepared by a WHO expert committee in 2002, contains 325 individual drugs, including 12 antiretroviral medicines for the prevention and treatment of HIV. The list contains safe, effective treatments for the infectious and chronic diseases, which affect the vast majority of the world's population. The WHO Model List aims to identify cost-effective medicines for priority conditions, together with the reasons for their inclusion, linked to evidence-based clinical guidelines and with special emphasis on public health aspects and considerations of value for money. Submissions for ARVs have been made by the HIV/AIDS Department at WHO with assistance from the Essential Drugs and Medicines Policy Department of the WHO, and the Cochrane Collaboration *(Essential Drugs and Medicines Policy, WHO 2002)*. Guidelines for a public health approach for the use of ARV in resource-limited countries are available from the WHO in the following document: '*Scaling up anti-retroviral therapy in resource-limited settings: Guidelines for a public health approach*' (2003) (http://www.who.int/3by5/publications/arv_guidelines/en/). Until recently, most countries in Africa could not afford ARVs for the treatment of HIV and thus could only afford treatment of opportunistic infections and palliative care. Several of these countries however got limited ARVs for purposes of prophylaxis in the prevention of mother-to-child transmission (PMTCT), rape victims and post-exposure prophylaxis for health care workers.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Appendix 1 shows the drugs that are available on the national EDM list from 4 countries (Lesotho, Botswana, South Africa and Swaziland), compared to the WHO EDM list. Information was not available from Mozambique and Zimbabwe, during the data analysis. The table shows that these countries have most of the drugs on the WHO EDM list for the treatment of opportunistic infections. The availability of these drugs in the private, and especially the public sector, will be a more appropriate measure of drug accessibility and utilization.

Most of the WHO EDM drugs are on most membership countries EDLs, because they are inexpensive and affordable. However, with the advent of HIV/AIDS, a cost benefit, pharmaco-economic approach needs to be adopted, to ensure decreased hospitalisation and improved quality of life. For treatment of bacterial opportunistic infections, sensitivity and resistance patterns should be developed and more cephalosporins used, where applicable. ARVs are on some EDLs for purposes of prophylaxis only, due to the cost. When appropriately used, ARVs are known to improve the quality of life, and decrease both morbidity and mortality. Nationally and regionally, there needs to be a concerted effort to ensure generic drug availability.

Free download from www.hsrcpress.ac.za

Table 5: Antiretroviral drugs on the WHO Essential Drugs List

NRTIs	NNRTIs	PIs
Abacavir	Nevirapine	Indanivir/low dose ritonavir
Stavudine	Efavirenz	Lopinavir/Low dose ritonavir
Didanosine		Nelfanivir
Zidovudine		Saquinavir/low dose ritonavir
Lamivudine		
Zidovudine +Lamivudine		

Spending on pharmaceuticals represents less than one-fifth of total public and private health spending in most developed countries. It represents 15 to 30 per cent of health spending in transitional economies and 25 to 66 per cent in developing countries. Pharmaceuticals in most low-income countries are the largest public expenditure on health after personnel costs and the largest household health expenditure. And the expense of serious family illness, including drugs, is a major cause of household impoverishment. *(The Rationale for Essential Medicines, WHO 2002)*

Adopting the WHO Essential Drugs concept or putting in place a dynamic national formulary process will go a long way to ensure improved management on pharmaceutical expenditure. Over the past 25 years the Model List has led to a global acceptance of the concept of essential medicines as a powerful means to promote health equity. By the end of 1999, 156 Member States had official essential medicines lists, of which 127 had been updated in the previous five years. Most countries have national lists and some have

©HSRC 2004

provincial or state lists as well. National lists of essential medicines usually relate closely to national guidelines for clinical health care practice, which are used for the training and supervision of health workers. Lists of essential medicines also guide the procurement and supply of medicines in the public sector, schemes that reimburse medicine costs, medicine donations, and local medicine production. Many international organisations, including UNICEF and UNHCR, as well as NGOs and international non-profit supply agencies, have adopted the essential medicines concept and base their medicine supply system mostly on the model list *(WHO 12th Essential Medicines Model list)*. The challenges of developing a drug policy that addresses and satisfies the needs of the general population of a country goes far beyond adopting a WHO EDL or any national formulary. Affordability, availability and accessibility of these drugs remain a major challenge in developing countries.

'Lack of availability of essential drugs can have different causes including logistical supply and storage problems, substandard quality, irrational selection of drugs, wasteful prescribing and use, insufficient production, insufficient drug research and development (R&D) and prohibitive cost.' (Ellen t'Hoen, WHO drug policy consultant, *Third World Network Online*)

Free download from www.hsrcpress.ac.za

Level of development of national drug policies for six SADC countries

The ravaging effects of HIV/AIDs has forced an evaluation and revamping of health care delivery in most developing countries. While prevention messages have been the cornerstone for addressing the challenges of HIV/AIDs, there has been an increase in the incidence of the infection. Treatment of infected individuals is much needed and imminent, and has been a debate on the international scene for several years. Drug policies in several African countries are currently being revised or upgraded from a rudimentary stage in some countries (Lesotho) to a substantially functioning system in countries like South Africa. Table 6 shows a comparative analysis of drug policies in six SADC countries with respect to the National Drug Policy, Essential Drug List management, Drug Regulation and HIV/AIDS Drug Policy.

Table 6: Summary of the level of development of drug policies in the four main areas

	Botswana	Lesotho	Mozambique	South Africa	Swaziland	Zimbabwe
National drug policy	+	+/-	+/-	+	+	+
Essential drugs list	+	+/-	+/-	+	+/-	+
Drug regulation	+/-	-	-	+	-	+
HIV/AIDS drug policy	+	+/-	+/-	+/-	+/-	+/-

Key: + = present; +/- = under development; - = limited or absent

Based on the findings above, the following analysis can be made:

- Five out of six countries have a National Drug Policy, with Swaziland being the latest to adopt one and Lesotho is in the process of developing one.

©HSRC 2004

- Only Zimbabwe and South Africa have a fully functional Drug Regulatory Authority; The Zimbabwe Medicines Regulatory Authority is autonomous, while the South African one just became autonomous in May 2003.
- There was admittance from Swaziland and Lesotho that there is reliance on the South African and Zimbabwean authorities for decisions on registration of drugs and quality assurance studies, when the need arises. Swaziland does have a Quality Assurance laboratory; therefore they do conduct some of the quality assurance on pharmaceutical products. Even though Mozambique and Lesotho do not have a fully functioning Drug Regulatory Authority, they do have a limited registration process.
- All countries have an Essential Drug List, with Zimbabwe being the earliest to develop their first edition, and Swaziland being the latest to revise theirs. In South Africa, the present National EDL Committee is in the process of revising theirs. In Swaziland, there is a National Drug Advisory Committee, which is responsible for advising the department on matters of the EDL including monitoring and distribution. All countries have based their EDL on the WHO Model and all countries use international consultants, as part of their Essential Drugs Programme.
- Only Botswana has a National Policy on HIV/AIDS, which includes a component on ARV treatment for the general population and the policy is being implemented. South Africa is currently working on an ARV plan for the public sector. However, several ARVs (branded and generics) have been registered and are readily available in the private sector. Mozambique has recently approved such a policy and implementation is pending. Swaziland, Mozambique and Botswana have National Guidelines on the use of ARVs and these are based on recommendations from the WHO. South Africa and Lesotho are developing their guidelines. In South Africa, some provinces have already developed their own guidelines. All countries have guidelines on Post Exposure Prophylaxis and PMTCT.

Free download from www.hsrcpress.ac.za

Patent laws and their effect on drug policies for HIV/AIDS and availability of drugs

Patents were introduced as a way to promote innovation, research and development. Patents give the inventor the ability to determine the market price of its product. With respect to ARVs, this grants the monopoly on a drug for a number of years, thereby creating one of the major obstacles to public health care delivery in modern times. Millions of people have died, due to lack of affordability and availability of HIV/AIDS drugs. Patent laws are a large component of the problem. An example is the fact that the AIDS drug cocktail remains around $10,000 per annum in rich markets and has been reduced to $300 in countries that have no patent laws and manufacture generic ARVs (Drug Patents Under the Spotlight, MSF 2003). The table below shows the patent laws situation in six SADC countries.

©HSRC 2004

Table 7: Drug availability in the country

	NRTI							NNRTI			PI				Total
	AZT+ LMV	LMV	ZAL	ZDV	DDI	STA	ABC	DEL	EFV	NVP	AMP	IND	SAQ	NFL	
Botswana	X	X		X			X			X	X			X	6
Lesotho	X	X					X			X	X			X	6
Mozambique															0
Swaziland	X	X					X			X	X			X	6
Zimbabwe	X	X		X			X			X			X		6
South Africa	X	X		X	X	X	X	X	X	X	X	X	X	X	13

Source: Bannenberg and Gray 2002, (SAQ-Fortovase and Zimbabwe ref source is MSF 2003)
**BMS has a patent for stavudine, but has been asked by the original inventor (Yale University) not to exercise the patent protection in developing countries.*

Methods that can be used to circumvent the patent protection obstacles

Parallel importation

Parallel importation means patented drugs are bought in a country where the drugs are sold cheaper. To enable the supply of more affordable medicines and to protect the health of the public, the Minister of Health may grant a permit that allows parallel importation of medicines. An example is that, since Indian companies produce generics, the patent holders are forced to sell the innovator product cheaper, in order to be competitive.

Voluntary license

Voluntary licenses are granted by the patent holder and must be negotiated and thus depend on the goodwill of the patent holder. Since patent holders have the monopoly, they can set any conditions deemed necessary which may include levies or limited technology transfer.

Compulsory license

Due to extraordinary public health circumstances, the Minister of Health can get a compulsory license by convincing the patent commissioner that the request is reasonable and warranted. This is usually in the case of a national emergency.

Civil disobedience

This is a case where there is a deliberate violation of the patent laws. This option has been used, especially in countries where these patent laws exist, but are not enforced.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Conclusion

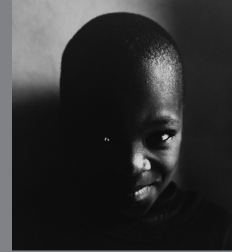
There is great variability in the capacity to carry out various functions to accomplish the goals of the National Drug Policy, especially Drug Regulatory affairs. There is a desperate need for ARVs and other drugs for the treatment of opportunistic infections, thus the attraction for adulterated or counterfeit drugs. Counterfeit drugs may result in drug resistance and safety problems including fatalities. Countries with inadequate Drug Regulatory capacities will suffer the effect of counterfeit drugs tremendously in Africa. There is thus an urgent need for countries to strengthen their regulatory systems and harmonise standards as fast as possible.

There is great disparity between the drugs on the EDL and the actual availability at the health facilities and thus accessibility to the patients in need. Drug products registered in a country may not necessarily be on the EDL and even if put on the EDL, this does not ensure accessibility to the patient. The decrease in morbidity and mortality seen in the HIV/AIDS population in developed countries is not realised in most developing countries, including the SADC countries, due to the cost of ARVs and inadequate implementation of the Drug Policies.

The capacity of the NDP needs to be strengthened to accomplish its goals of regulation and the EDL programme. The health system infrastructure needs to be strengthened, in order to accomplish the fundamental aspects of availability and accessibility of drugs on the EDL to patients. Treatment guidelines and drug affordability strategies (parallel importation, compulsory and voluntary licensing, technology transfer for generic manufacturing) need to be harmonised where applicable and addressed regionally.

Free download from www.hsrcpress.ac.za

©HSRC 2004



Services and programmes

Information in this section is based on assessments of key informants in individual countries on implementation of HIV/AIDS programmes.

In response to the epidemic, affected countries have initiated services and programmes geared at providing assistance to PLWHA. Some of these services and programmes are geared at prevention and others are geared to those that are infected and affected. The next section presents findings of the review in the six countries and was researched and compiled by the respective country research teams.

Botswana

Voluntary counselling and testing

The Botwana Red Cross Society offered VCT from 1994 and stopped in 2000, when service was taken over by BOTUSA. In 2000, two major VCT centres were launched in Francistown and Gaborone. The country currently has 16 VCT centres, one in every district. There are also mobile testing centres for remote areas.

Barriers to implementation
There is an acute shortage of counsellors in Botswana. This problem is compounded by the fact that the few who are available are expatriates, and do not speak Setswana. The commitment of some counsellors to respect client confidentiality is questionable. The balance between quality counselling and quantity of people seen is a major problem. Due to increasing demand for the service, counsellors need stress management to cope, especially if they have to operate the mobile clinic services in the absence of adequate overnight accommodation. This critical service is also threatened by low staff morale, as VCT might turn into a service provided by NGOs. Job insecurity has recently been affecting productivity.

Proposed solutions to barriers
The following activities are required: training of counsellors, some of them at degree level; stress management workshops for counsellors; refresher courses; public education on VCT; promoting local ownership of the programme by engaging local co-ordinators, so as to make them identify more with the programme; and efforts to empower couples to seek the service together, rather than as individuals.

STI services

Informants felt that health providers have been trained and they are in a position to use STI management protocols. The protocol has been reviewed.

Barriers to use of public STI services and management of STI
There is a lack of youth-friendly services to attract the large number of youth affected by STIs. Despite available information, there is still a lack of knowledge about how STIs are transmitted and their various symptoms. As a result, STI patients still have a problem bringing their sexual partners in for treatment. Opinion leaders like traditional healers and some churches do not advocate condom use.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Care and support

Caregivers in HBC programmes are mostly women. They are usually the patient's parents or grandparents. Occasionally boys (not adult males) are seen helping out. In a few instances, children of primary school-going age, especially girl children, are seen running errands and they also form an integral part of the support system. Other support systems are volunteers, ministers of religion and traditional healers. Family welfare educators are supposed to visit clients and to ensure that they do not run out of care supplies. Concerning food security, some informants felt that caregivers basically benefit by sharing the food basket with the chronically ill.

Barriers to implementation
Some of the key problems were identified as lack of transport for community home visiting. The absence of wills causes problems for orphans, as relatives usually want a share of the deceased's property. The poor find it difficult to access care and support facilities. Some families sell the food basket provided. This may lead to food shortages for the chronically ill and their caregiver. PLWHA are still discriminated against in communities. However, it was good to note that this trend was on the decrease. Efforts to encourage people to disclose their status include health talks by health facilitators and politicians.

Proposed solutions
People who disclose their status need to be protected from discrimination. There is a need for mass education on HIV/AIDS, so that people know they need not discriminate against those infected, as they themselves could be infected. There should be close monitoring of how supplies and food items are used to prevent misuse.

Violence against Women

Whilst violence against women still remains a big challenge, this is compounded by poor support systems for rape victims. For example, antiretroviral therapy in cases of rape is only provided in hospitals and clinics as prophylaxis. This vital service is not offered at any of the Crisis centres, which are run by NGOs.

Proposed Solutions
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 the other, before getting help. Also, there is a need for training on gender and human rights issues to health care workers.

Prevention of Mother-To-Child Transmission

In April 1999, PMTCT was launched in Francistown and Gaborone. Roll out to other districts started in July and was completed in November 2000.The strategies used include IEC and VCT. Services include: counselling, testing blood, educating the patient on PMTCT and tracing partners and monitoring the patient for up to 34 weeks, until they are referred to the hospitals.

Barriers to implementation
Some of the key problems include the need for continued follow-up of the mother and child once the patient has been referred for antiretroviral treatment, because counselling

Free download from www.hsrcpress.ac.za

©HSRC 2004

of patients stops after referral. There is also inadequate follow up of women after they have tested positive. This is one of the major challenges resulting in low AZT uptake.

Proposed solutions
Exposing nurses to PMTCT, especially research work on the issue. Botswana needs to train lay people as counsellors to cater for the growing need for counselling among families and communities. Those who are professional counsellors should be upgraded to meet the growing challenges of HIV/AIDS. Networking and collaboration are two important factors that are greatly needed in the HIV/AIDS fight. A successful PMTCT programme requires highly motivated, skilled and mentored PMTCT counsellors. The fight against HIV/AIDS also depends on encouraging people to test, so that they could know their HIV/AIDS status. The success for the PMTCT depends a great deal on quality counselling. The existing counselling curriculum has to be reviewed. In addition, a counselling manual may be helpful to improve counselling.

ARV Treatment

Key informants reported that drugs were available in the referral hospitals in Gaborone, Serowe and Francistown. None of the primary hospitals, however, are offering antiretroviral therapy. Even though antiretroviral therapies are available, a person living in areas where the drugs are not offered has to be referred to the place where they are offered. The whole process of accessibility takes time. When a person gets to the referral hospitals, they do not automatically get treatment. They make an appointment and a person may sometimes not be seen until after five or six months. Some people may die while waiting for their turn.

Stigma poses a problem for the accessibility of antiretroviral drugs. The main problem is that HIV/AIDS is still associated with sexual promiscuity. As a consequence, some people would rather die than have it be known that they are on these drugs. The whole process of testing and waiting for the results is highly stressful. Some people would rather go and seek help without knowing their status.

Lesotho

Sexually Transmitted Infections Programme

There is a National Referral Clinic for STIs at the Queen Elizabeth II Hospital. There is a second referral STI clinic in the northern part of the country, which has been established to address decentralisation. The Ministry of Health and Social Welfare (MoHSW) has developed the National STI Syndromes Management Protocol. The STI management regime is generally rated highly throughout the country. Currently, all health facilities are trained to use syndrome management of STIs.

Voluntary Counselling and Testing (VCT)

There are currently only three sites, with at least two functional VCT services, in two districts.

Prevention of Mother-to-Child Transmission Programme (PMTCT)

There is only one health facility with PMTCT programme, at present. This is one of the CHAL hospitals (Maluti Hospital) in the Leribe district referred to earlier in the report.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Care and Support

Government introduced HBC for chronic illnesses, especially for HIV/AIDS patients. There are five health service areas in which continuous care has been introduced. Support for PLWHA is generally weak.

There is no national policy on orphans and no documented evidence of government assistance to support caregivers. There is no national policy as yet on rape and HIV and no system exists to respond to the needs of rape victims. The only guideline document in existence is the National STI Syndromes Management Protocol, developed by MoHSW. Available information from LAPCA is that all these guidelines are in the process of being developed. It is not clear at what stages they are.

Mozambique

Voluntary Counselling and Testing Service

Chimoio City (a Kellogg Site) has only one VCT facility, which serves the population of Manica province. Most users of VCT services in Chimoio are male, youth and urban people.

PMTCT Programmes

A PMTCT programme is available as a pilot project in Eduard Mondlane Health Centre in Chimoio city. This is one of three pilot sites for PMTCT. The major barriers preventing the establishment of the PMTCT programme are: infrastructure requirements; inadequate human resources; a lack of equipment and storage of reagents; unavailability and cost of ART; and the prohibitive distances that pregnant women have to travel to get services.

STI services

STI services are offered in all health networks (public and private) in Chimoio City. The services are available for all groups and health workers are trained on syndromic management of STIs. The major barrier to managing STIs is partner tracing.

Free condoms are available at health facilities. Through PSI, condoms are available in private pharmacies and markets, kiosks, shops, bars/restaurants, and hotels. Millions of condoms have been distributed or sold. The major barriers to the use of condoms are cultural and behavioural. Men do not seek treatment. Communication for behaviour change needs to be intensified for all groups.

Treatment

ARV drugs and treatment for opportunistic infections for PLWHA are available in private pharmacies. In the public sector, treatment for opportunistic infections is free; however, the availability of such drugs is problematic.

Care and support

There are many initiatives to reduce the impact of HIV/AIDS in Chimoio. Several organisations are offering HBC for PLWHA and their families. These essentially provide training for the caregivers. The most important need of the affected families is food security, because the disease affects the productive people at household level. According to the key informants, grandmothers are the most involved in taking care of

Free download from www.hsrcpress.ac.za

©HSRC 2004

those suffering from AIDS. In many cases, husbands or wives abandon their sick partners and leave the responsibility to the grandmothers or children. Orphans are the biggest problem in the study site. There are initiatives at community level to deal with orphan problems, but the services are few and cannot cover all AIDS orphans.

Stigmatisation is very strong in communities. Organisations working with PLWHA are sensitising community members and leaders to advocate for PLWHA. Another mechanism is the establishment of PLWHA groups to advocate for human rights.

Violence against women

Counselling services at VCT trauma centres are available in Chimoio City. At least two organisations are working, in collaboration with the police, to support raped women. Provision of antiretroviral prophylaxis, training of health care providers and law enforcement agencies are not available in Chimoio City.

Free download from www.hsrcpress.ac.za

Swaziland

Voluntary Counselling and Testing Service

There are only two government pilot centres in Swaziland that are equipped to offer VCT services: one at Mankayane and another at Mbabane hospital. Only two NGOs, Family Life Association and The Aids Support Centre, offer VCT. These organisations are centralised, with minimal coverage. Respondents noted that VCT services were poorly developed in the country, because the government has no policy on VCT. Consequently, each institution is providing some form of counselling and testing, either using rapid testing and/or sending blood specimens to the nearest laboratory for ELISA testing.

At regional level, some form of VCT was offered at two company clinics, but there are problems relating to inaccessible laboratory equipment, delayed results and maintaining qualified staff to offer counselling. At Tikhuba clinic, untrained staff provide VCT counselling services. The infrastructure for counselling and testing is inadequate. As a result, blood specimens are sent to the central laboratory and the results may be delayed by one week.

The majority of users of VCT services were found to be women of childbearing age, including pregnant women, followed by the youth. Male clients who use VCT services tend to be those who are suffering from chronic illnesses and STIs or those who are members of the army.

Barriers to the use of VCT services
The study found that there was limited availability of VCT services, due to the lack of a national policy. Technical capacity to provide VCT was inadequate. In addition, lack of the requisite infrastructure support services was also a serious constraining factor. Among the people, general fear of knowing one's HIV status was a major deterrent to testing.

Availability of Prevention of Mother-to-Child Transmission of HIV infection

The majority of health delivery institutions (57.1 per cent) located within the Kellog site indicated that they did not offer PMTCT services. The only health facilities that reported to be offering PMTCT services were two private sector health facilities located in the Lubombo Region. Both private sector health facilities use the Zidovudine (AZT) protocol.

©HSRC 2004

Barriers to implementation of Prevention of Mother-to-Child Transmission of HIV infection
Respondents cited lack of funds and absence of a national PMTCT policy as major obstacles to the provision of PMTCT services.

STI Services

Men and women were identified as the intended clients of STI services in these institutions. However, only respondents from Good Shepherd Hospital and Tikhuba Health Centre identified youth as an intended client group of their institutions.

Barriers to the Use of STI services
Sexual partners of clients (men and youth) normally do not come for treatment because of fear of stigma associated with STIs. On the technical side, sporadic shortages of drugs and general poor case management of sexually transmitted infections did not encourage people to utilise available services.

Condom use

According to respondents, condom use is poor among adults, compared to young people.

Barriers to condom use
It was also indicated that Good Shepherd Hospital does not promote nor provide condoms. Respondents cited lack of education on condoms and culture as barriers to condom use.

Antiretroviral therapy

The majority of respondents indicated that treatment is not accessible in public health facilities. Antiretroviral therapy is available in some private health facilities, although affordability was a major issue. Similarly, treatment for opportunistic infections was perceived as inaccessible due to inconsistent availability of essential drugs. Respondents also indicated that the laboratory infrastructure for monitoring clients who were on antiretroviral therapy was limited. As a result, some clients travel to the Republic of South Africa to be monitored.

Antiretroviral therapy is not affordable to most people and there is no policy to ensure access for poor people. The WHO, however, indicated willingness to provide technical support in the development of a policy and respective protocols.

Care and support

The study revealed that the majority of caregivers at Tikhuba were female. Boys provide services to a lesser extent, but this was limited to sick parents. Some respondents reported that children ranging from the ages of 4–13 years were also providing care to sick parents. It was noted that men rarely provide care to sick relatives. For example, when a wife was sick, a female relative would look after her. Alternatively, she is sent to her home, to be looked after by her own relatives.

Community and HBC services

Community and HBC activities are available in most communities, including Tikhuba. Community and HBC services are provided by an array of organisations including Rural Health Motivators, Clinic and Community health nurses, Red Cross Volunteers, religious groups, relatives, neighbours and AIDS support groups. These groups provide minimal assistance and are grossly overworked and poorly monitored.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Food insecurity

The majority of rural households are experiencing food shortages. It was indicated that some people were begging as a survival strategy. Some were substituting maize with wild vegetables and roots of trees. Very minimal assistance is offered by NGOs although World Vision in Tikhuba is said to be providing limited food packages. Government food relief programmes were limited and poorly monitored to ensure that the most deserving cases received the service.

Situation of orphans and vulnerable children

The situation of orphans is extremely poor. Orphans are stigmatised, discriminated against by relatives and society in general. As a result some children are compelled to become heads of households with limited resources and minimal support from relatives or neighbours. Most of these children end up dropping out of school. Some end up experiencing sexual exploitation and being exposed to HIV infection.

There is very little assistance that is given to orphaned children through government, NGOs, or religious organisations. Some governmental organisations link orphaned children with sponsors.

Access to clean water and proper sanitation

All the respondents stated that accessibility to clean water and proper sanitation was limited. As such, families care for relatives without the benefit of clean water and sanitary facilities. Control of infections and maintaining good hygiene becomes a major challenge.

HIV/AIDS-related stigmatisation and discrimination

Some forms of discrimination and stigmatisation still exist in the society, according to all the respondents. There was an indication that some families at Tikhuba isolate AIDS patients. Some respondents reported that families have disintegrated and divorce occurs, as a result of disclosure of HIV status. Some women have been sent back to their families, after their HIV positive status became known.

Availability of support mechanisms for People Living with HIV/AIDS

There was no mechanism for supporting people who have disclosed their status, according to most respondents. The AIDS support groups were attempting to form a support network, but such services are not widely available in the country. At Tikhuba there is only one AIDS support member, whose office is at the regional office (Siteki).

Violence Against Women

The Swaziland Action Group Against Abuse (SWAGAA) is one of the few organisations providing services to deal with issues relating to violence against women. There is one national office at Manzini and regional co-ordinating centres in police stations, magistrate's courts and health care institutions.

According to the key informants, none of their organisations provide antiretroviral post-exposure treatment, using AZT. Services that are provided by these institutions range from counselling, referral to the police and to health facilities, legal advice and preparation for court hearings.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Capacity to conduct laboratory tests on survivors of violence is present in the National Public health Laboratories, regional hospitals and at a few private health centres. The district surgeon is available at Good Shepherd Hospital and is not accessible in Tikhuba Health Centre. The police sexual abuse services are available in the main urban areas, but inaccessible in the Tikhuba community. Prosecutors are trained in statement collection for rape cases. According to respondents, rape is a serious problem in communities.

South Africa

Responses by Key Informants from Nyandeni Region, Mohlanatsi District in Limpopo Province, and Manguzi District in Maputaland in KwaZulu-Natal Province.

VCT and PMTCT

In the sites studied, VCT was only available in the following sites: St Barnabas hospital, where no PMTCT service was available (St Barnabas hospital is a district hospital located in Ntlaza village); Manguzi District Hospital, where it is linked to PMTCT (which is offered in Pelandaba clinic and involves counselling, testing and provision of Nevirapine); and in Giyani Dzumeri Clinic in Limpopo, where it is used mostly by women. The Giyani Dzumeri Clinic did not have PMTCT services at the time of the study, although the respondent indicated that the rollout of this programme to the whole province started in October 2002. Lack of drugs was cited as the problem in implementation of PMTCT.

The barriers to the effective use of the VCT services identified by informants were stigma, inadequate care from health providers, weak follow-up mechanisms, long waiting period, lack of trained VCT counsellors and the unavailability of treatment. The age gap between the nurses and the youth utilising the service was also cited. Lack of an incentive for testing, such as access to ARV drugs when testing positive, discourages testing. The long distance that people have to travel to access VCT services, together with the stigma associated with disclosing one's HIV status, were seen as barriers to the use of services.

The barriers to the effective use of the PMTCT were, according to the respondent: the unavailability of ARV drugs in some of the facilities; and lack of trained professional nurses and midwives. Lack of access in rural villages and lack of awareness were other barriers cited by women.

Sexually transmitted infection (STI) services

All the sites' target populations for STI services were both youth and adults, who are sexually active, with a focus on adults between the ages of 32 and 35 years. According to the key informants interviewed, the barriers to utilising STI services by the public are a lack of privacy in clinics and health providers' inability to keep the patients' condition confidential. Health providers were also perceived as having negative attitude towards STI patients. The barriers to managing STIs are lack of working space and inefficient use of the syndromic approach. To overcome the barriers, it was suggested that more space should be provided to maintain privacy and confidentiality. Health providers should also be trained in the syndromic approach to STI management. In recognition of the dual use of services (health and traditional), it was suggested that the referral systems between informal settings (traditional healers) and public health institutions should be improved. Condoms were perceived as easily available.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Treatment for AIDS

In all the South African sites, the respondents indicated that antiretroviral drugs were not available to PLWHA in public hospitals. The only people with access were those who could get them from private practitioners and/or from chemists. In the views of the respondents, treatment for opportunistic infections for PLWHA is accessible, but not all of the time. Patients are given prophylactic antibiotics for pneumonia, skin conditions and TB.

Violence against women

In Nyandeni, there is a Thuthuzela Care Centre, which is an organisation focusing on violence against women. It offers HIV pre-test counselling to rape victims. Rape victims are informed on how to obtain ARV drugs and their cases are dealt with sensitively, working together with the police inspectors in Nyandeni district. In Manguzi, counselling and HIV testing is provided for rape victims in Manguzi district hospital. Although there are no rape crisis centres, health providers and community based women groups conduct awareness campaigns on violence and abuse. In Mohlanatsi, cases of rape are referred to relevant services, but there is no access to ARV drugs. In this clinic, antiretroviral drugs are for health workers who might infect themselves accidentally in the course of duty, and not for rape cases. This is due to the limited availability of these drugs. The clinic works in collaboration with the police.

Care and support

A religious leader interviewed in the Nyandeni region stated that parents are usually the caregivers for the chronically sick and family members dying from AIDS. In addition, PLWHA in the Nyandeni region can access the Transkei Hospice for care and support. The hospice is located in Umtata and it provides training and HBC kits to the caregivers of PLWHA. It was also noted that churches provided spiritual support to PLWHA. To supplement income, families can access the disability grant that is given to those who are terminally ill and to the households that do not have any form of income. Social workers provide food parcels for PLWHA, while they are waiting for their grant to be approved. There are no orphanages in this region and children orphaned by HIV/AIDS are taken care of by other family members. Care grants are also organised for orphans due to HIV/AIDS. The social worker indicated that to keep the orphans at school, they arrange with the schools not to discriminate against orphans if they are experiencing financial difficulties in meeting school fees. According to one social worker interviewed, hospitals are not accessible to the households caring for the chronically ill, as they are too far.

In the Manguzi district, mothers were identified as the main caregivers of the chronically ill and family members dying from AIDS. According to a nurse interviewed in Manguzi hospital, there are no programmes in place to provide support to the caregivers in the household. In this area, AIDS was associated with witchcraft or sorcery and there was discrimination and stigmatisation by the family and community. Surviving children of PLWHA suffer from family feuds and neglect, especially when the death of their parents is seen as a curse to other family members. Neglect of orphans is common and many are out of school.

Food security was an issue in this area and the respondents indicated that the dry climate in Manguzi district has resulted in food shortages. Previous supportive systems, such as food sharing, were no longer possible because of poverty. Furthermore, household

Free download from www.hsrcpress.ac.za

©HSRC 2004

expenditure has shifted from household necessities to caring for the sick members in the family. Disability grants were the only source of income for PLWHA.

In Mohlanatsi District, like in other districts, family members are the caregivers of the chronically sick and dying. The respondent indicated that the nurses give support to family members on how to care for People Living With HIV/AIDS. With regard to food security in the households, the family relies on the pension and children are mostly undernourished. The HBC volunteers, who often provide support to affected households, depend on food mainly from their small vegetable gardens that they share with the affected household. There are no sustainable food parcel programmes for these families in the area where this research was conducted. According to the respondent, people affected by HIV/AIDS do not have a clear understanding of how they could access food parcels. In addition, the conditions set for accessing government-sponsored support become a problem when people do not have birth or death certificates at hand.

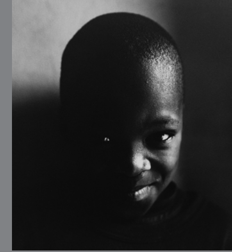
With regards to orphans, respondents indicated that there are many child-headed households, due to the increasing number of parents dying from AIDS. Orphans are mainly cared for by grandmothers. CHOICE volunteers facilitate the admission to local schools of those orphans without financial support, who often drop out of school. As stated by a respondent, 70 per cent of the households have access to clean water and the number of toilets built is growing.

Summary

The review found that, in most of the countries, there are programmes and services geared at PLWHA. However, not all sites had access to all services. In most of the sites, ARVs were not available to People Living With HIV/AIDS. PMTCT was also not universally accessible in all countries. VCT, while available in most of the sites, was not being taken full advantage of; there were still too many barriers preventing clients from using these services. The main ones are stigma, poor quality services and lack of human resources and transport problems. Care of PLWHAs was mostly on the shoulders of families, with little help from government institutions.

Free download from www.hsrcpress.ac.za

©HSRC 2004



Findings of the legislation review

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 in a holistic manner. Their initial response to addressing the issue has been to enact criminal legislation.

On the international level, the six countries are party to numerous international and regional conventions and agreements, but none of them seem to have been enacted into national laws to make them enforceable. Commitments have also been made at several forums. At the 2001 United Nations Special Session on HIV/AIDS (UNGASS) Declaration on Commitment on HIV/AIDS, heads of State and government committed themselves to 'by 2003 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). Nevertheless, numerous legislative and customary law provisions still persist in most of the six countries, which contribute to the spread of the epidemic, as well as to gender inequality. South Africa has much legislation that could positively impact on the epidemic and/or the lives of people with HIV/AIDS (and has actually done so). But in a number of decided cases brought to court in the other five countries, most of the limited legislation in force tends to be criminal legislation, as opposed to having a mitigating effect on the impact of HIV/AIDS.

Free download from www.hsrcpress.ac.za

Botswana

The Medical Council (Professional Conduct) (Amendment Regulations 1999) and the *Penal Code (Amendment Act)* of 1988 are the only specific legislations, which address HIV/AIDS and People Living With HIV/AIDS. In accordance with the Medical Council Regulations, medical doctors and dentists must be informed of the HIV/AIDS status of their patients.

Under the provision of the Penal Code *(Amendment Act)* of 1988, a rapist without HIV can be sentenced to a minimum imprisonment of 10 years. Rapists with prior knowledge and diagnosis of their HIV status receive a minimum sentence of 15 years.

Section 15 of the *Constitution of Botswana* can be used to protect the rights of People Living With HIV/AIDS. Found embedded in a chapter on *Protection of Fundamental Rights and Freedoms of the Individual*, it includes a section on: protection of the right to life, personal liberty, freedom of conscience, expression and movement and a general non-discrimination clause. The section can be used in cases of AIDS discrimination.

Section 164 of the Penal code criminalises homosexuality. Section 184 of the same Code provides that any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread infection of any disease dangerous to life, is guilty of an offence. Similarly, the provision of the *Penal code Amendment Act* marginalises the gay and lesbian community, while also severely limiting access to information on safer same-sex sexual practices and the dangers of HIV transmission through anal or oral sex. Section 84 provides that 'Any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread infection of any disease dangerous to life, is guilty of an offence.' A judge interpreted 'against the order of nature' to mean any act that pertains to anal or oral sex. Thus, in Botswana, only two pieces of legislation specifically address HIV/AIDS and People Living With HIV/AIDS.

©HSRC 2004

Lesotho

Lesotho is another country, in which the rights of PLWHAs are not protected. The country does not have any specific legislation on HIV/AIDS. However, the Sexual Offences Bill is soon to be enacted. It is envisaged that the Bill will widen the definition of rape to include an interpretation of marital rape. Sentences will also take into account the HIV status of the rapist, which can lead to the application of the death sentence. Free medical attention will be provided to rape survivors.

Mozambique

There is only one piece of legislation related to HIV/AIDS in Mozambique. The legislation, Act No. 5 of 2002, provides for non discrimination against employees 'with regards to their work, training and promotion right; no pre-employment testing; right to confidentiality with regards to HIV status in the workplace; guaranteed medical assistance, as well as adequate medication to be provided and paid for in the event of occupational exposure to HIV'. In addition, it is a requirement under the Act that all employees with HIV/AIDS be trained and redeployed, if unable to carry out their duties. Dismissal on the grounds of HIV/AIDS is 'regarded as dismissal without just cause'. Employers must provide HIV/AIDS education, information and advisory services to their employees.

Mozambique's Penal Code impacts on HIV/AIDS and PLWAs, because it criminalises abortion. PLWHAs that become pregnant as a result of rape cannot have access to abortion, or they would be committing an offence, as the latter is not legal in the country.

South Africa

South Africa, unlike other countries under investigation, has some legislation that specifically addresses HIV/AIDS. Under the *Employment Equity Act*, an employee or job applicant may not be discriminated against in any employment policy or practice on the basis of HIV status, unless it is an inherent requirement of the job. The Act prohibits unauthorised employment-related HIV testing. It requires an employer to apply to the Labour Court for permission and be granted the same by the Court, before the employer can ask a job applicant or a current employee to take an HIV test.

The *Code of Good Practice on Key Aspects of HIV/AIDS and Employment*, issued under the Act, provides for requirements of HIV testing, confidentiality, safe working environment, employee benefits, grievance procedures and other issues relating to HIV/AIDS and the workplace.

Other legislation impacting on HIV/AIDS and the rights of People Living With HIV/AIDS in South Africa are:

1. *The Criminal Law Amendment Act* (No. 105 of 1997), which provides for a higher minimum sentence for first offender convicted, of rape.
2. *The Criminal Procedure Second Amendment Act* (No. 85 of 1997) under which a person with HIV, and who is accused of rape, will be denied bail. S/he can only be allowed bail, under exceptional circumstances.
3. *Under the Medical Schemes Act* (No. 131 of 1998), medical schemes may not exclude any person who is able to pay the required contributions (this will include

Free download from www.hsrcpress.ac.za

©HSRC 2004

PLWHAs). In addition, HIV-associated diseases are now a category under the Prescribed Minimum Benefits (PMB). The PMB provides for the compulsory cover of medical and surgical management of opportunistic infections or localised malignancies.

4. Section 6 of the P*romotion of Equality and Prevention of Unfair Discrimination Act* (No. 4 of 2000) prohibits unfair discrimination on the grounds of disability (which may include an interpretation of HIV and AIDS, but this is not expressly defined in the Act). Section 34 (1) contains specific directive principles on HIV/AIDS. Section 32 provides for the establishment of an Equality Review Committee to meet within one year to make recommendations to the Minister of Justice on whether HIV status and AIDS should be included in the Act, as prohibited grounds of unfair discrimination.
5. *The National Policy for Health Act* (No. 116 of 1990) led to, the *National Policy on Testing for HIV* being introduced in August 2000. It describes the circumstances under which HIV testing may be conducted. Furthermore, it sets out requirements of pre-and post-test counselling procedures, as well as specifying what constitutes informed consent.
6. Under the rubric of the *National Education Policy Act* (No. 27 of 1996), the *National Policy on HIV/AIDS for Learners and Educators* was launched in 1999. The Policy contains guidelines on the management of HIV/AIDS in schools, and the support of learners and educators living with, or affected by, HIV/AIDS.

Legislation which indirectly impacts on HIV/AIDS and PLWHAs in South Africa are: the *Labour Relations Act* (No. 66 of 1995, Section 189); *Compensation for Occupational Diseases and Injuries Act* (No. 130 of 1993); *Occupational Health and Safety Act* (No. 29 of 1996); *Mine Health and Safety Act* (No. 29 of 1996); *Basic Conditions of Employment Act* (No. 137 of 1993); *Domestic Violence Act* (No. 116 of 1998); *Choice of Termination of Pregnancy Act* (No. 92 of 1996); *Child Care Act* (No. 92 of 1996); *Medicines and Related Substances and Control Amendment Act* (No. 90 of 1997); *Amendment of Public Service Regulations* (*Promotion of Equality of Unfair Discrimination Act* (No. 4 of 2000); *Medical Schemes Act* (No. 131 of 1998).

South Africa is the only country, of the six countries, in which legal actions have been brought on HIV/AIDS issues. Among these cases are: *Jansen van Vuuren and Another NNO v Kruger*, 1993 (4) SA 842 (A). In both, the Court held that the patient had the right to the confidentiality of his HIV status. The patient's HIV status was disclosed by his medical practitioner to two other medical practitioners, without his informed consent. The Court held that the 'public interest' does not warrant the disclosure of his HIV status.

In *Hoffman v South African Airways* (SAA) 1001 (1) SA (CC), the Constitutional Court held that the SAA had unfairly discriminated against Hoffman in rejecting his application for employment, on the basis of his HIV status. Consequently, the Court held that Hoffman's right to equality, dignity and fair labour practices had been violated.

Other cases include: *Applicant v Administrator, Transvaal and Others*, 1993 (4) SA 733; *Bilijon and Others v Minister of Correctional Services and Others*, CPD, 1997, (Unreported 11778/96); *C v Minister of Correctional Services* 1996 (4) SA 292; *S v Cloete*, 1995 (1) SACR 367 (W); *Venter v Nel* 1997 (4) SA 1014 (D); *A v SAA* ; and *Minister of Health and others (the Government) v Treatment Action Campaign and others* (Case CCT 8/02).

Free download from www.hsrcpress.ac.za

©HSRC 2004

Swaziland

Swaziland does not possess legislation, that makes express mention of HIV/AIDS, but there are proposed changes to current laws. The Employment Bill is likely to incorporate only those aspects of the various International Labour Organisation conventions to which Swaziland is a Party. The Bill will also incorporate the SADC Code on HIV/AIDS and Employment.

It is envisaged that the Public Health Bill will incorporate issues related to HIV/AIDS, while the Criminal and Correctional Services laws are to be amended to address the new challenges posed by HIV/AIDS.

Zimbabwe

Two pieces of legislation specifically address HIV/AIDS and PLWHAs in Zimbabwe. They are the *Sexual Offences Act* (Act 8 of 2001), and the *Labour Relations (HIV and AIDS) Regulations of 1998*.

In the *Sexual Offences Act*, Section 15 of the Act makes it a criminal offence to wilfully infect another with HIV. Section 16 provides for greater punishment for a rapist with HIV positive status. In addition, marital rape is included in the definition of rape.

The *Labour Relations (HIV and AIDS) Regulations of 1998*, requires that HIV/AIDS education and information be made available in the workplace. No pre-employment testing, nor unfair dismissal on grounds of HIV/AIDS is to be tolerated. It makes confidentiality on HIV/AIDS in the workplace essential.

Sections 9 and 11 of the *Sexual Offences Act* criminalise sex work.

The *Termination of Pregnancy Act* (1977), allows abortion, only if there is a threat to the woman's health, a strong possibility of foetal impairment or if the pregnancy is as a result of 'unlawful intercourse'. The two laws impact on HIV/AIDS and PLWHAs.

Conclusion

While the countries under study have responded to the epidemic with varying degrees of commitment and action, there is still a dearth of legislation that impacts directly on HIV/AIDS. As a consequence, there is no jurisprudence in the countries, apart from South Africa.

Some of the countries that have enacted legislation have enacted criminal legislation, under which the rights of PLWHAs are not addressed, and they have severely limited recourse to the law. Furthermore, numerous legal, as well as customary law provisions in these countries, serve to advance the spread of the epidemic, as well as of gender inequality. The criminalisation of homosexuality and the disregard for the lesbian and gay population, also exacerbate the spread of the epidemic. Also, in civil society, as well at the governmental level, there is little education on or understanding of human rights. All these fuel the epidemic.

The six countries have committed themselves to a number of international conventions/ agreements, but there is little evidence of the incorporation of the tenets of these

Free download from www.hsrcpress.ac.za

©HSRC 2004

international mandates into domestic laws. Few interviewees were aware of which conventions their governments had, indeed, even ratified.

International conventions

Table 8 shows the international conventions, with relevance to HIV/AIDS, to which the six countries have committed themselves by signature, ratification or accession.

Table 8: International conventions on HIV/AIDS

	International covenant of economic, social and cultural rights	International covenant of civil and political rights	Convention on the rights of the child	Convention on the elimination of all forms of discrimination against women	African charter on human and people's rights
Botswana		Sept 2000	March 1995 – ratification	Aug 1996 – ratification	July 1986 – ratification
Lesotho	Sept 1999 – accession	Sept 1992 – accession	March 1992 – ratification	Aug. 1995 – ratification	Oct 1992 – ratification
Mozambique		July 1993 – accession	April 1994 – ratification	April 1997 – accession	Feb 1989 – ratification
South Africa	Oct 1994 – signature	Dec 1998 – ratification	June 1995 – ratification	Dec 1995 – ratification	July 1996 – ratification
Swaziland			Sept 1995 – ratification		Sept 1995 – ratification
Zimbabwe	May 1991 – accession	May 1991 – accession	Sept 1990 – ratification	May 1991 – accession	May 1986 – ratification

Gender and HIV/AIDS

Women and young girls are disproportionately infected by HIV and affected by the AIDS epidemic. By the end of 2002, 58 per cent of sub-Saharan African adults with HIV were women. Women in sub-Saharan Africa, like women in the rest of the world, are generally responsible for the provision of physical and emotional care to family members, children, spouses and partners with HIV/AIDS.

This disparity between men and women results from an imbalance of power, due to unequal social structures and relations, and discriminatory attitudes and customs that marginalise women. For example, women generally have less power to negotiate safer sex than men. Women are more likely to be the target of violence, rape and sexual assault within a society. Women are often viewed as 'good' and 'virtuous' and therefore socially acceptable, if they display no knowledge of sex and safeguard their virginity until marriage, or by playing the role of the passive sexual partner. These gendered

Free download from www.hsrcpress.ac.za

©HSRC 2004

conventions ultimately limit women's access to, and knowledge of, safer sex practices. It has been argued that, a culture of silence that surrounds sex which dictates that 'good' women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive in negotiating safer sex. Also, the traditional norm of virginity for unmarried girls, that exists in many societies, paradoxically, increases young women's risk of infection, because it restricts their ability to ask for information about sex, out of fear that they will be thought to be sexually active.

While women's lower status in society and their greater vulnerability to HIV/AIDS are due to a complex interplay of factors, discriminatory laws and customary practices often compound the latter. Such laws and practices advance and strengthen the subordination of women both within society as well as within current gender relations. Ultimately, they make women more vulnerable to, and less able to resist, the contraction of HIV. Because unequal gender power relations fuel the epidemic, it was vital that the research for this report incorporated a gender perspective in its analysis of legal documents and of the extent to which legislation and international conventions are responsive to HIV/AIDS.

In all the countries included in the study, discriminatory customary laws were operating in one form or another. It was also evident that there were few serious efforts to reform these laws and customs. Yet, it must be noted that an investigation into customary laws and practices fell beyond the scope of this current research project and, while the importance of this component in an analysis of HIV/AIDS and legislation is recognised and stressed, only cursory references are made to it in the report itself.

General conclusions on the legislative aspects

In five out of the six countries under investigation, there is very little legislation that refers directly to HIV/AIDS, and no case law. Enacting criminal legislation seems to be the first response from the legal sector to the epidemic. In many cases, legislative provisions fall foul of the tenets laid down in Guideline 4 of the *UNAIDS International Guidelines on HIV/AIDS and Human Rights* (1998). This guideline entitled *Criminal laws and correctional systems* reads as follows: 'States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.'

Elliot provided a number of arguments as to why criminalisation of HIV/AIDS is detrimental to public health initiatives. In summary, criminalisation:

- Reinforces HIV/AIDS-related stigma.
- Spreads misinformation about HIV/AIDS.
- Acts as a disincentives to HIV testing.
- Hinders access to counselling and support.
- Creates a false sense of security.

People Living With HIV/AIDS have little recourse to law. This is because there is a marked absence of legal provisions to protect People Living With HIV/AIDS and their rights, and no legal aid to assist people who cannot afford legal action.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Gender inequality is a major problem and fuels the epidemic. It is clear that discriminatory customary laws play a potent role in reinforcing and, maintaining gender inequality.

There are very high levels of violence against women and children. The criminalisation of homosexuality or disregarding the lesbian and gay population exacerbates the spread of the epidemic. Guideline 4 of the UNAIDS International Guidelines on *HIV/AIDS and Human Rights* (1998) notes that:

> Criminal laws prohibiting specific sexual activity between consenting adults in private, such as adultery, sodomy, fornication or acts 'against the order of nature' or social order or morality can impede the provision of HIV/AIDS prevention and care programmes. Criminalising behaviour forces individuals to lead 'double lives' to hide it (particularly in isolated or rural communities where the threat of identification is very real), making access to educational programmes more difficult. Such laws place health workers and educators at the risk of aiding and abetting offences, because they can be accused of promoting or encouraging these sexual acts when, in fact, they are merely advising how to carry them out safely.

There is little education or understanding of Human Rights within civil society, as well as in the governments included in the study group. Few interviewees were aware of the various international conventions, which their governments had ratified.

Recommendations on legislative aspects

Based on the results of this survey, we would like to recommend the following:

1. Even where protective laws exist high levels of stigma and discrimination hinder people from taking advantage of them. Campaigns, therefore, need to be initiated that will decrease the social stigma and prejudice that surround the AIDS epidemic. People Living With HIV/AIDS will only demand protective laws and utilise them, if they can take legal recourse, without fear of recrimination from society.
2. A major finding of this research is that customary laws continue to render women particularly vulnerable to Human Rights violations and therefore, also to HIV infection. Vulnerability reduction, through policy interventions, should be a main area of governmental attention. It is, therefore, vital to advocate for laws and policies to be passed that are necessary for the reform of discriminatory customary laws. Laws and customs that entrench gender inequality should be of particular concern, while legal and policy reforms should be executed that will ensure that legislation and traditional practices are non-discriminatory, gender-sensitive and empowering to women. This will conform with the paragraphs 59–61 of the UNGASS Declaration of Commitment. We also recommend that SADC countries develop a Code on HIV and Gender, with strategies on the reform of civil and customary laws (following the example of the SADC Code on HIV/AIDS and Employment).
3. Civil society must be empowered with skills to translate existing legal and policy provisions into public dialogue issues to pressure their governments to domesticate international conventions and to enact legislation that would protect the rights of PLWHAs. Structures have to be created to monitor the implementation of legislation and conventions and to hold governments accountable. Particular attention should be given to meeting commitments made at UNGASS, regarding law reform and Human Rights.

Free download from www.hsrcpress.ac.za

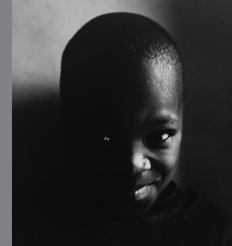
©HSRC 2004

4. All countries in the study group have national AIDS Councils in place, charged with co-ordinating and overseeing their governments' response to the epidemic. The Councils are well positioned to have an influential and substantial impact on the way their countries manage the AIDS epidemic. The National AIDS Councils need to be sensitised to play an active part in demanding and facilitating legal reforms in their respective countries.
5. NGOs and donor agencies need to diversify their activities and contribute towards legal assistance. They could also incorporate a Human Rights-based approach into their work, as well as bringing Human Rights information and education into their campaigns.
6. Funding for organisations to take up test cases on HIV/AIDS issues, in addition to contributing towards legal assistance. Also, explore strategies for increasing paralegal capacity, knowledge and presence, in both urban and rural areas.

Free download from www.hsrcpress.ac.za

©HSRC 2004

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.

Free download from www.hsrcpress.ac.za

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.*

©HSRC 2004

Free download from www.hsrcpress.ac.za

(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.

©HSRC 2004

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

Free download from www.hsrcpress.ac.za

©HSRC 2004

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.

Free download from www.hsrcpress.ac.za

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.

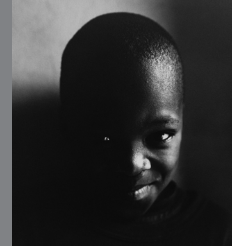
©HSRC 2004

- 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.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Free download from www.hsrcpress.ac.za



Appendices

Appendix 1: Drugs used in Botswana, Lesotho, South Africa and Swaziland compared to the WHO Essential Drugs and Medicines List

Key
WHO = W
Botswana = B
Lesotho = L
South Africa = SA
Swaziland = Sz

LEGEND
AREAS FOR WHICH DRUGS ARE RECOMMENDED

OIT	Opportunistic Infection Treatment
PC	Palliative Care
STI	Sexually Transmitted Infections
TB	Tuberculosis
ARV	Antiretroviral
PRO	Prophylaxis

DRUGS USED FOR HIV/AIDS IN 6 SADC COUNTRIES COMPARED TO THE WHO EDM LIST 2002						
DRUGS	OIT	PC	STD	TB	ARV	PRO
promethazine supension & inj.		W, B, L, Sz				
Codeine oral		W, B, SA, Sz				
morphine oral & inj		W, B, L, SA, Sz				
pethidine oral & inj		W, B, SA, Sz				
methadone		W, B				
chlorphenaramine oral & inj.	SA	W, L, SA, Sz				
dexamethasone	W, B, L, SA, Sz					
prednisone oral	W, B, L, SA, Sz	B				
carbamazepine oral		W, B, L, SA, Sz				
albendazole oral	W, B, SA, Sz					
mebendazole oral	W, L, SA	B				
tiabendazole oral	W	B				
amoxicillin oral	B, SA		B, L, Sz			
ampicillin inj.	W, B, L, SA					
benzathine benzylpenicillin inj.	SA		W, B, L, Sz			

Free download from www.hsrcpress.ac.za

©HSRC 2004

DRUGS	OIT	PC	STD	TB	ARV	PRO
benzylpenicillin inj.	W, B, L, SA, Sz		L, Sz			
cloxacillin oral inj.	W, B, L, SA, Sz					
phenoxymethylpenicillin oral	W, L, Sz					
procaine benzylpenicillin inj.	B		W, L, Sz			
cefixime oral			W, L			
cefotaxime inj.	Sz		W, L			
ceftriaxone inj.	SA, Sz		W, L, SA, Sz			
flucloxacillin oral	W					
chloramphenicol oral inj.	W, B, L, Sz					
ciprofloxacin oral	W, B, L, SA, Sz		W, L, SA, Sz	W, L, Sz		
doxycycline oral	B, SA, Sz		W, L, SA, Sz			
erythromycin oral	W, B, L, SA, Sz		SA, Sz			
gentamicin inj.	W, B, L, SA, Sz		W, L, Sz			
metronidazole oral	W, B, L, SA, Sz		W, L, SA, Sz			
nalidixic acid	W, B, L, Sz					
spectinomycin inj.			W, L, Sz			
sulfadiazine oral	W		W			W
trimethoprim oral inj.	W, B					
clindamycin oral & inj.	W, B, SA		W			W
azithromycin oral	W		W			W
sulfafurazole oral			W			
amikacin inj.	W, B, SA, Sz					
clofazimine oral	W					
didanosine					W, B, L	

Free download from www.hsrcpress.ac.za

©HSRC 2004

DRUGS	OIT	PC	STD	TB	ARV	PRO
efavirenz					W, B, L	
indinavir					W, B, L, SA	
lamivudine					W, B, L, SA	
nelfinavir					W, B	
ritonavir					W, B	
saquinavir					W, B, L	
stavudine					W, B, L	
zalcitabine					W	
diloxanide oral	W					
tinidazole oral	W, L					
Primaquine oral	W					
pyrimethamine oral	W, B, L					W
sulfamethox. + trimethoprim oral & inj.	W, B, L, SA, Sz		W			W, SA, Sz
Sulfadoxine+ pyrimethamine oral	W, L, Sz					W, B, Sz
pentamidine inj. & nebulizer	W, B					W
Spiramycin	W	B				W
bleomycin inj.	W, SA	B				
calcium folinate	W, SA	B				W
doxorubicin inj.	W, SA	B				
etoposide oral	W	B				
methotrexate oral	W, L, SA	B				
vinblastine inj.	W, SA, Sz	B				
vincristine inj.	W, SA, Sz	B				
methylrosanilinium chloride	W					
mupirocin 2% topical	W, SA					
calamine local application	W, L, SA, Sz	W, L, SA, Sz				
hydrocortisone 1% cream	W, L, SA, Sz	W, L, SA, Sz				

©HSRC 2004

Free download from www.hsrcpress.ac.za

DRUGS	OIT	PC	STD	TB	ARV	PRO
benzoic acid + salicylic acid topical	W, L, SA, Sz					
coal tar in salicylate ointment	W					
Podophyllin resin topical	W, L, SA, Sz					
trichloracetic acid	W, SA					
benzylbenzoate lotion	W, L, SA, Sz					
metoclopramide oral, inj.		W, B, L, SA, Sz				
atropine oral, inj.		W, L, Sz				
diphenoxylate oral		W, L				
Loperamide oral	B, SA	W, B, L, Sz				
chlorpromazine oral, inj.		W, L, Sz				
haloperidol oral, inj.		W, Sz				
amitriptyline oral		W, B, L, SA, Sz				
dapsone oral	W, B, SA, Sz			B		W, Sz
ethambutol oral				W, B, SA, Sz		
isoniazid + ethambutol oral				W, B, SA, Sz		
isoniazid oral	W, SA			W, B, SA, Sz		W, Sz
pyrazinamide oral				W, B, SA, Sz		
rifampicin + isoniazid oral				W, B, SA, Sz		
rifampicin oral				W, B, SA, Sz		
rifam.+isoni.+ pyrazinamide + ethambutol oral				W, B, L, SA		
rifampicin+ isoniazid+ pyrazinamide oral				W, B, SA		
streptomycin inj.			W, L	W, B, L, SA, Sz		

Free download from www.hsrcpress.ac.za

©HSRC 2004

DRUGS	OIT	PC	STD	TB	ARV	PRO
amikacin inj.	SA			W, Sz		
capreomycin inj.				W		
clarithomycin oral	W			B		W
cycloserine oral				W, B		
ethambutol oral	W			B, Sz		
ethionamide oral				W, Sz		
kanamycin inj.	B		W, B, L, Sz	W, B, L		
ofloxacin oral			L	W, L		
para-aminosalicylic acid oral				W		
prothionamide oral				W		
rifabutin oral	W, B					
terizidone oral				W, B		
amphotericin B inj.	W, B, SA, Sz					W
fluconazole oral inj.	W, B, L, SA, Sz					W, L, Sz
griseofulvin oral nystatin oral	W, L, SA					
ointment /pessaries	W, L, SA, Sz		W, B, SA, Sz			W, L, Sz
clotrimazole pes.cream	W, L, SA, Sz		W, B, SA, Sz			W, L, Sz
itraconazole oral miconazole pessary,	W, L, SA					W
ointment-cream 2%	W, L, SA		W, B, L			
flucytosine oral & inj.	W					
ketoconazole inj.						
oral cream	W, SA, Sz					
cidofovir inj.	W					W
foscarnet oral inj.	W					W
ganciclovir oral inj.	W, B					W
aciclovir inj. & oral	W, B, L, SA, Sz		W, L, Sz			W, L, SA

©HSRC 2004

Free download from www.hsrcpress.ac.za

DRUGS	OIT	PC	STD	TB	ARV	PRO
nevirapine oral					W, B, L	W, L, SA
zidovudine oral & inj.	W, L				W, B	W, SA
delarvudine					W, B	
diazepam oral & inj.		W, B, L, SA, Sz				

Free download from www.hsrcpress.ac.za

©HSRC 2004

Appendix 2: Summary of legislative aspects

Specific legislation on HIV/AIDS

Botswana

Medical Council (Professional Conduct) (Amendment) Regulations, 1999. Under the regulations, medical doctors and dentists must be informed of the HIV/AIDS status of their patients. The regulations do not apply to nurses. *Penal Code (Amendment Act) of 1988*. Minimum sentence for rapists without HIV is 10 years. Rapists' positive without prior knowledge and diagnosis of HIV status receive minimum sentence of 15 years. For rapists with prior knowledge of HIV status, the minimum sentence is 20 years.

Lesotho

None

Mozambique

Act No. 5 of 2002

- Non discrimination against employees 'with regards to their work, training and promotion rights'.
- No pre-employment testing.
- Right to confidentiality with regards to HIV status in the workplace.
- 'Guaranteed medical assistance as well as adequate medication' must be provided and paid for in the event of occupational exposure to HIV.
- All employees with HIV/AIDS must be trained and redeployed if unable to carry out their duties.
- Dismissal on the grounds of HIV/AIDS is 'regarded as dismissal without just cause'
- *Employers must provide HIV/AIDS education, information and advisory services to their employees.*

South Africa

Employment Equity Act (No. 55 of 1998)

- No person may unfairly discriminate against an employee or job applicant in any employment policy or practice on the basis of HIV status, unless it is an inherent requirement of the job.
- No unauthorised employment related HIV testing.
- An employer must apply to the Labour Court for permission and the permission must be granted before the employer could ask a job applicant or a current employee to take an HIV test.
- The *Code of Good Practice on Key Aspects of HIV/AIDS and Employment* issued under the *Employment Equity Act* provides for requirements of HIV testing, confidentiality, safe working environment, employee benefits, grievance procedures and other issues relating to HIV/AIDS and the workplace.

Criminal Law Amendment Act (No. 105 of 1997)

- Provides for a higher minimum sentence for first offender convicted of rape.

Criminal Procedure Second Amendment Act (No. 85 of 1997)

- Unless exceptional circumstances are established, a person with HIV who is accused of rape is to be denied bail.

Medical Schemes Act (No. 131 of 1998)

- Medical schemes may not exclude any person who is able to pay the required contributions (this will include PWAs).

Free download from www.hsrcpress.ac.za

©HSRC 2004

	• HIV-associated diseases are now a category under the Prescribed Minimum Benefits (PMB). The PMB provides for the compulsory cover of medical and surgical management of opportunistic infections or localised malignancies. *Promotion of Equality and Prevention of Unfair Discrimination Act* (No. 4 of 2000). • Section 6 prohibits unfair discrimination on the ground of disability (which may include an interpretation of HIV and AIDS, but is not expressly defined in the Act). • Section 34 (1) contains specific directive principles on HIV/AIDS. • Section 32 provides for the establishment of an Equality Review Committee to meet within one year of promulgation to make recommendations on whether HIV status and AIDS should be included in the Act as prohibited grounds of unfair discrimination. • Section 29 provides for 'illustrative list of unfair practices in certain sectors". This includes insurance services if it 'unfairly disadvantaged a person or persons, including unfairly and reasonably refusing to grant services on the basis of their HIV/AIDS status.' *National Policy for Health Act* (No. 116 of 1990) • Describes the circumstances under which HIV testing may be conducted. Sets out requirements of pre- and post-test counselling procedures and what constitutes informed consent. *National Education Policy Act* (No. 27 of 1996) • National policy on HIV/AIDS for Learners and Educators launched in 1999. It contains guidelines on the management of HIV/AIDS in schools, and the support of learners and educators living with or affected by HIV/AIDS.
Swaziland	None
Zimbabwe	*Sexual Offences Act* (Act 8 of 2001) • Section 16: Greater penalties for rapist with HIV status. The maximum sentence is 20 years. • Marital rape included in definition of rape. • Section 15 makes it a criminal offence to willfully infect another with HIV.

On-going policy discussion to establish legislation

Botswana	Information not available
Lesotho	None
Mozambique	Information not available
South Africa	Information not available
Swaziland o	• Employment Bill • Public Health Bill • Criminal and Correctional Services Law
Zimbabwe	Information not available

Free download from www.hsrcpress.ac.za

©HSRC 2004

Possible legislation that could impact on HIV/AIDS and PLWHAs

Botswana	*The Constitution.* Chapter on Protection of Fundamental Rights and Freedoms of the individual. Section 15 provides for non-discrimination. This section can be used in cases of AIDS discrimination.
Lesotho	Sexual Offences Bill soon to be enacted. The Bill will widen definition of rape to include marital rape; sentences will take account of HIV status of rapist, which sentence can include death.
Mozambique	*None*
South Africa	*Labour Relations Act* (No. 66 of 1995) • Section 189 protects all employees from being unfairly dismissed and from unfair labour practices. Services of an incapacitated employees can be terminated (eg., by an AIDS- related illness), after fair procedures are followed. *Compensation for Occupational Diseases and Injuries Act* (No. 130 of 1993) • A worker can claim compensation if s/he contacted HIV in the course of normal working activities. *Occupational Health and Safety Act* (No. 29 of 1996) & *Mine Health and Safety Act* (No. 29 of 1996) • Employers must provide a safe working environment to employees. *Basic Conditions of Employment Act* (No. 137 of 1993) • Every employee has the right to six weeks paid sick leave in every 3-year cycle. Possibility that employers and employees can renegotiate sick leave, for example to get more sick leave and less pay. *Domestic Violence Act* (No. 116 0f 1998). • It provides for the issuance of protection orders against perpetrators of domestic violence. • Section 2 definition of domestic relationships ensures that all children infected or affected by HIV/AIDS will be protected from abuse. • Women in emotionally and physically abusive relationships and children can apply for protection orders. *Choice of Termination of Pregnancy Act* (No. 92 of 1996) • Abortions available to women with unwanted pregnancies. • Girls under age 16 may terminate unwanted pregnancies without their parents' permission. It is advisable that they discuss with their parents or someone trustworthy. *Child Care Act* (No. 74 of 1983) • Section 39: Children over 14years can consent to "medical treatment" without the assistance of a parent or guardian. This would include HIV testing and treatment. *Medicines and Related Substances and Control Amendment Act* (No. 90 of 1997) • Allows the government to use measures such as parallel importation and generic substitution to lower the cost s of HIV/AIDS medication. *Amendment of Public Service Regulations* (No. R. 840) • HIV/AIDS is included in the Schedule under 'Principles'. It states that the working environment should support effective and efficient service delivery, while taking into account an employee's personal circumstances. It specifically notes HIV and AIDS as elements that fall under personal circumstances.

Free download from www.hsrcpress.ac.za

©HSRC 2004

	• Section entitled 'HIV/AIDS and Related Diseases' deals with occupational exposure, non-discrimination, HIV testing, confidentiality and a health promotion programme.
Swaziland	None
Zimbabwe	*Sexual Offences Act* (Act 8 of 2001). • Sections 9 and 11 criminalise sex work. *Termination of Pregnancy Act* (1977) • Abortion is allowed only if it there is a threat to the woman' health, a strong possibility of foetal impairment or if the pregnancy is as a result of 'unlawful intercourse'.

Criminalisation legislation

Botswana	*Penal Code*, Section 164 criminalises homosexuality. Any person who commits an act 'against the order of nature' commits an offence. This has been interpreted to mean any act that pertains to anal or oral sex. Section 184: 'Any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread infection of any disease dangerous to life, is guilty of an offence.' *Penal Code Amendment Act* substitutes the word 'male' for 'any other'. The legislation marginalises the gay and lesbian community, while also severely limiting access to information on safer same-sex sexual practices and the dangers of HIV transmission through anal or oral sex. *Public Health Act*, Section 11: any person 'while suffering from any communicable disease wilfully exposes himself without proper precautions against spreading the disease in any street, public place, shop or public convenience.
Lesotho	No information available
Mozambique	*The Penal Code* criminalises abortion.
South Africa	None
Swaziland	No information available
Zimbabwe	No information available

Assessment of status of women

Botswana	*The Protection from Domestic Violence Bill* is in the pipeline. Currently there is non-recognition of marital rape. Tribal courts treat adultery as a female crime only. A woman married in community of property is a legal minor. Consequently, she cannot contract without her husband's consent. *Penal Code*, Section 156 makes sex work an offence and Sections 160-162 prohibit abortions.
Lesotho	Pursuant to the *Deeds Registry Act* of 1967, most leases are written in the husband's names. Under customary law women are regarded as minors and married women fall under the guardianship of their husbands, while unmarried women are under the guardianship of their fathers.

Free download from www.hsrcpress.ac.za

©HSRC 2004

Mozambique	No legislation that provides specifically for the specialised needs of targets of domestic violence. Husband is the head of household. The wife is his subordinate. The property of the wife is given to the husband. The husband must authorise the wife before she can enter into commercial transactions.
South Africa	Information not available
Swaziland	Under Swazi common law and customary law, women are regarded as minors. Women cannot inherit from deceased husband's estate. Rural married women can only have access to land through a husband. If single, they can only acquire access through a male relative.
Zimbabwe	*Constitutional Amendment Act* of 1996 outlaws gender discrimination. Under customary laws, women can have access or rights to land through their husbands or male relatives.

Free download from www.hsrcpress.ac.za

Decided cases

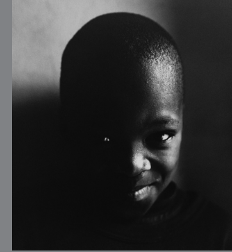
Botswana	No information available
Lesotho	None
Mozambique	None
South Africa	• Jansen van Vuuren and Another NNO v Kruger, 1993 (4) SA 842 (A). Held: Patient had the right to the confidentiality of his HIV status. • Applicant v Administrator, Transvaal and Others, 1993 (4) SA 733 the court ordered that the applicant receive the promised medication from a Provincial hospital. The decision applies to this case only and did not necessarily allow for all patients with HIV/AIDS to access the drug at state institutions. • Biljon and others v Minister of Correctional Services and Others, CPD, 1997. (Unreported 11778/96). Applicants awarded access to antiretroviral therapy. • C v Minister of Correctional Services 1996 (4) SA 292. Held that 'C's' right to privacy was violated when he was not provided with pre- or post-test counselling for an HIV test and with little time allowed for him to decide whether or not to have the test. • S v Cloete, 1995 (1) SACR 367 (W). A prisoner was allowed for early release because of his HIV status. • Venter v Nel 1997 4 SA 1014 (D). An unopposed judgment. Venter granted damages for having being infected with HIV during sexual intercourse. • A v SAA. Defendant reached a settlement agreement with 'A' who was refused employment on the basis of his HIV status. • Hoffman v South Africa Airways 1001 (1) SA (CC). In its decision, the Constitutional Court held that the respondents had been unfairly discriminated against because of his HIV status and his right to equality, dignity and unfair labour practices had been violated. • Minister of Health and others (the Government) v Treatment Action Campaign and others (Case CCT 8/02). High Court: The Court held inter alia, that the government violated Section 27 of the Constitution, which guarantees access to health care services including the right to

©HSRC 2004

	reproductive health care. Court ordered the government to provide a comprehensive mother-to-child transmission rollout plan. Constitutional Court: The Court upheld the decision of the High Court.
Swaziland	None
Zimbabwe	None

Free download from www.hsrcpress.ac.za

©HSRC 2004



References and documents reviewed

Free download from www.hsrcpress.ac.za

Aisu T, Riviglione MC, Van Praag E, et al. (1995) *Preventive chemotherapy for HIV associated Tuberculosis in Uganda: an operational assessment at a voluntary counselling and testing center*, AIDS 9:267–273

American Dietetic Association and Dieticians of Canada (2000) Nutrition intervention in the care of persons with human immunodeficiency virus infection, *Journal of American Dieticians Association* 100: 708–717

Botswana Government, Gaborone, The Government Printer (1996) *Country profile 1995*

Bureau of Statistics, Kingdom of Lesotho (1996) *Population Census Analytical Report, Volume IIIA: Population Dynamics*

Compulsory HIV Testing of Persons arrested in Sexual Offence cases Fourth Interim Report on Aspects of Law relating to AIDS

Conselho de Ministros, Maputo (2000) Plano *Estratégico Nacional de Combate às DTS/HIV/SIDA 2000–2002*

Conselho de Ministros (2001) *Plano estratégico do sector Saúde, 2001–2005– (2010)*

Conselho de Ministros (2002) *Plano Estratégico Nacional de Combate às DTS/HIV/SIDA, 2000–2002*

Country Co-ordinating Mechanism of Lesotho, *Action Plans in Support of Lesotho's Co-ordinated Proposal for HIV/AIDS and TB to the Global Fund*

Department of Health, Lesotho (2000) *Policy Framework on HIV/AIDS Prevention, Control and Management*

Department of Health, Lesotho, *Draft Lesotho Public Service HIV/AIDS Policy*

Department of Health, Lesotho, *National AIDS Strategic Plan 2002/2003–2004/2005*

Department of Health, Pretoria (2000) *HIV Sentinel Surveillance Report* (Draft, 2000)

Department of Health, Pretoria (2001) *National HIV and syphilis sero-prevalence survey of women attending antenatal clinics in South Africa, 2000*

Department of Transport, Lesotho, *Draft Lesotho Transport Sector Policy on HIV/AIDS*

Dorrington R, Bourne D, Bradshaw D, Laubscher R, & Timæus I (2001) *The impact of HIV/AIDS on adult mortality in South Africa*, MRC Technical report, Burden of Disease Research Unit

Human Sciences Research Council/WK Kellogg Foundation (2002) *HIV/AIDS in Southern Africa. Report prepared for Kellogg Foundation*

ILO, Geneva, *An ILO Code of Conduct on HIV/AIDS and the World of Work*

©HSRC 2004

Kingdom of Lesotho, Ministry of Health and Social Welfare, Lesotho

Lesotho, *A Co-ordinated Country Proposal for Lesotho-Global Fund*
Lesotho Vulnerability Assessment Committee (2002) *Lesotho Emergency Food Security Assessment Report*

Lockerbie L, et al. (1992) *Health and Community Surveys: A practical manual for health and community workers*

Ministério da Saúde (2001) *Aconselhamento e testes Voluntários (ATV): Manual do Conselheiro e do Supervisor dos Gabinetes de ATV*

Ministério da Saúde (2001) *Guia para o tratamento antiretroviral do adulto*

Ministério da Saúde (2001) *Guia para prevenção de transmissão vertical do HIV*

Ministério da Saúde (2002) *Guia para o tratamento das infecções oportunistas no adulto infectado por HIV e profilaxia das infecções oportunistas*

Ministério da Saúde (2002) (Ronda de 2001) PNCS, *Relatório sobre a revisão dos dados de vigilância epidemiológica do HIV*

Ministry of Gender, Youth and Sports, *Gender and Development Policy*

Ministry of Health & Ministry of Planning and Finance (2002): *Health Sector Expenditure Review, Maputo*

Ministry of Health and Social Welfare, Maseru, *AIDS Epidemiology in Lesotho, 2000*

Ministry of Health and Social Welfare, Maseru, *Health and Welfare Sector Plan 1995/6–1999/2000*

Ministry of Health and Social Welfare, Maseru, *HIV/AIDS and STD Situation in Lesotho, 2000*

Ministry of Health and Social Welfare, Maseru, *Sexually Transmitted Infections Prevention and Control Programme, Annual Report, 2001*

Ministry of Health, et al. (2001) *Demography Impact of HIV/AIDS in Mozambique*

Ministry of Health, et al. (2002) *Demography Impact HIV/AIDS in Mozambique*

Ministry of Health, Gaborone: AIDS/STD Unit (1996) *Community home-based care for people with AIDS in Botswana.* Operational Guidelines NACP 30

Ministry of Health, Gaborone: AIDS/STD Unit (2000) *Eighth Sentinel Surveillance in Botswana, 1999*

Ministry of Health, Gaborone: AIDS/STD Unit (2000) *Programme to prevent mother-to-child transmission (MTCT) of HIV in Botswana*

Free download from www.hsrcpress.ac.za

©HSRC 2004

Ministry of Health, Gaborone: Family Health Division (2000) *Botswana MTCT pilot project January 2000 review*

Ministry of Health, NACP 38, Gaborone: AIDS/STD Unit (1997) *Botswana HIV/AIDS Second Medium-Term Plan (MTP II) 1997–2002*

Ministry of Labour, *Draft Code of Conduct on HIV/AIDS and Employment*

Ministry of Planning and Finance, Maputo (1999) *The State Budget*

Ministry of Planning and Finance, Maputo (2000) *The State Budget*

Ministry of Planning and Finance, Maputo (2001) *The State Budget*

Núcleo Provincial de Combate ao SIDA de MANICA. Plano de Acção de 2002

Pavignani E & Russo, Maputo (2001) *External Resources in the Health Sector* (Unpublished)

Population Services International (1998) *National AIDS Prevention Survey of Mozambican Sexual Behaviours and Condom Use: Final Report*

Population Services International (2002) *National AIDS Prevention Survey of Mozambican Sexual Behaviours and Condom Use: Final Report*

Republic of Mozambique, Maputo (2001): *Absolute Poverty Reduction Action Plan 2001–2005*

SADC, *SADC Code of Conduct on HIV/AIDS and Employment*

SAPES Trust, Lesotho (2001) *SADC Country Studies*

Scrimshaw NS & Gleason GR (1992) *Rapid Assessment Procedures: Qualitative Methodologies for planning and Evaluation of Health related Programmes*

Shisana O & Simbayi L (2002) *Nelson Mandela/HSRC Study of HIV/AIDS: South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002.* Cape Town: HSRC Publishers

Staugard F (1985) *Traditional medicine*. Gaborone: Ipelegeng Publishers

Swaziland National HIV/AIDS and STD Programme (2000) *Ministry of Health and Social Welfare*

Tlou SD (1997) *Indicators of Health In Botswana Society: The Poverty and Plenty Botswana Experience*. Gaborone: Macmillan

Tlou SD, et al. (2000) *Community responses to initiatives to prevent mother-to-child transmission of HIV in Botswana.* Washington DC: ICRW

UNAIDS & WHO, Geneva (1999b) *AIDS Epidemic Update: December 1999*

Free download from www.hsrcpress.ac.za

©HSRC 2004

UNAIDS & WHO (2002) *AIDS epidemic update*. UNAIDS/02.58E

UNAIDS, Geneva (2000) *Report on the Global HIV/AIDS Epidemic*

UNAIDS, Geneva (2000a) *Costing Guidelines for HIV prevention Strategies*

UNAIDS, Geneva (2000b) A Review of Household and Community Responses to the HIV/AIDS Epidemic in the Rural Areas of sub-Saharan Africa

UNAIDS, *Report on the Global HIV/AIDS Epidemic*

UNDP (1998) *Human Development Report, 1998.* New York: Oxford University Press

United Nations (1995) *Beijing Declaration and Platform of Action.* New York: UN

United Nations Development Programme, *Human Development Report*, 2002

United Nations General Assembly Special Session (2002) *Declaration of Commitment on HIV/AIDS: United Nations General Assembly Special Session on HIV/AIDS, 25-27 June 2002*

WHO (2002) *The Health Sector Response to HIV/AIDS: Coverage of selected services in 2001. Preliminary Assessment*

WHO, Geneva (1978) *Primary Health Care*

WHO/FRH/NUT/CHD (1998) *HIV and infant feeding guidelines for decision makers.* Geneva

Free download from www.hsrcpress.ac.za

©HSRC 2004

Web sites used:

AIDS Net <http://www.aidsnet.co.za/>
Department of Agriculture <http://www.agric.za/>
Department of Health <http://www.doh.gov.za>
Department of Welfare <http://www.welfare.gov.za/>
EBSCO Host <http://search.epnet.com/>
Health Systems Trust <http://www.hst.org.za/>
Health-e <http://www.health-e.org.za/>
Parliamentary Monitoring Group
<http://www.pmg.org.za/docs/2002/view minute.php?id=2154>
Policy Project <http://www.policyproject.com>
Polity.org <http://www.polity.org.za/pol/home/>
SA Health Info <http://www.sahealthinfo.org/>
Sabinet Online <http://thor.sabinet.co.za>
South African Police Services <http://www.saps.org.za/>
Stats SA <http://www.statssa.gov.za/default3.asp>
t'Hoen, Ellen. Globalisation and Equitable Access to Essential Drugs. *Third World Network Online* <http://www.twnside.org.sg/title/twr120c.htm>
UNAIDS (2003) AIDS epidemic update. 06/01/03 http://www.unaids.org
UNAIDS <http://www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf >
UNAIDS <http://www.unaids.org/>
UNAIDS <http://www.unaids.org, http://www.uaids.org/fact_sheets/ungass/index.html>
UNAIDS <http://www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf >
UNICEF: United Nations International Children's Emergency Fund
<http://www.unicef.org/aids/links.htm>
US Department of State <http://www.state.gov/g/drl/rls/hrrpt/2001/af/8404pf.htm>
Fairfield Faculty
<http://www.faculty.fairfield.edu/faculty/hodgson/Courses/so191/Project…AIDS_SA.htm>
WHO (2002) *Scaling up antiretroviral therapy in resource-limited settings: Guidelines for a Public Health approach*
<http://www.who.int/3by5/publications/documents/arv_guidelines/en/>
WHO (2002) *WHO 12th Essential Medicines Model list*, 2002
<www.who.int/medicines/organization/par/edl/trs/trs914intro.pdf>

Free download from www.hsrcpress.ac.za

©HSRC 2004