



# **Translating Rhetoric into Reality: Implementing HIV policies in Swaziland and Zambia**

A synopsis of key findings prepared by



with support from





# Translating Rhetoric into Reality: Implementing HIV policies in Swaziland and Zambia

This report is a summary of a larger report entitled "Implementation of regional and international HIV prevention, treatment, care and support Conventions and Declarations in Swaziland and Zambia" which can also be requested from [SAfAIDSat reg@safajids.net](mailto:SAfAIDSatreg@safajids.net)



# Background and context of the study

The Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), with support from the Open Society Initiative for Southern Africa (OSISA) commissioned country assessments in Zambia and the Kingdom of Swaziland in 2008. The aim of the study was to examine the extent to which these countries were implementing HIV prevention, treatment, care and support (impact mitigation) strategies and services in line with major international commitments and declarations to which they are signatory. Similar studies had been conducted earlier in 2006 in Lesotho, Malawi and Mozambique.

This document summarises the findings of research by SAfAIDS on implementation of regional and international HIV prevention, treatment, care and support conventions and declarations in Swaziland and Zambia.

The goal of the assessment was “to assess the extent to which the Governments of Swaziland and Zambia have effectively implemented HIV and AIDS prevention, care, treatment and support strategies in line with the major international commitments and declarations to which they are signatories”.

## The specific objectives were:

1. To explore how legal and policy frameworks guarantee that HIV and AIDS interventions are in compliance with international human rights requirements to which the countries are signatories.
2. To analyse how processes and systems in place promote effective collection and analysis of HIV and AIDS information and knowledge required for planning, monitoring, evaluation and effective management of prevention, care and treatment programmes.
3. To explore the extent to which processes such as strategic planning and resource mobilisation for HIV and AIDS interventions are transparent and participatory.
4. To assess how accountable and integral systems for delivery of health service are.

The assessment, primarily based on qualitative approaches to obtain information on various HIV and AIDS services targeted for investigation, used literature review, consultative meetings, key informant interviews with key stakeholders and focus group discussions with clients of services and their representative organisations. SAfAIDS put together technical teams in both countries comprising of an independent researcher, SAfAIDS staff and an in-country partner organisation to conduct the assessment. This approach was similar for the two countries to allow for comparison.



## General findings

### **To what extent have the governments of Swaziland and Zambia implemented HIV prevention, treatment, care and support strategies and services in line with current international and regional conventions and declarations to which they are signatories?**

The provision of HIV prevention, care and support services in both countries is guided by a number of key international instruments, particularly UNGASS, the Millennium Development Goals (MDGs), the Abuja Declaration and the WHO HIV and AIDS Plan 2004-2005. UNGASS makes provisions for the development and implementation of multi-sectoral national strategies for combating HIV and AIDS which includes addressing risk, vulnerability, prevention, care, treatment and support for those affected by the HIV epidemic. The MDG goal number six seeks to combat HIV and AIDS and other diseases through increased use of condoms and behavioural change. The goal also sets a target for the universal access to treatment for HIV for all those who need it by 2010.

Generally, survey findings show that Swaziland and Zambia have to some extent demonstrated their commitment to be guided by interventional principles, by virtue of being signatory to the major international conventions that guide HIV and AIDS responses. Both governments have put in place policies and frameworks for domestication of these international conventions and protocols.



A number of key stakeholders from the UN, civil society and practitioners agree that there is high level political commitment to the fight against HIV in both Zambia and Swaziland. In line with this, findings of the study have shown that there are general improvements in coordination of the response, with coordinating authorities significantly resourced to fulfill their responsibilities. For instance, national level monitoring and evaluation information is more available, with some improvements in general reporting, through the UNGASS and DHS processes. Although this is the case, current figures do not show a rapid impact of responses. Prevalence rates, although indicating a possible decline, are still very high, and the full impact of the epidemic is yet to be realised.

Adoption of a multi-sectoral response in the two countries, to ensure that all sectors of society are actively involved in the design, implementation, review, monitoring and evaluation of the national response to HIV, is in line with UNGASS (2001), the Abuja Declaration (2001) and the Maseru Declaration (2003). Article 37 of UNGASS calls for governments to ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV and AIDS. The Abuja Declaration's article 26, calls for governments to "make available the necessary Declaration's resources for the improvement of the comprehensive multi-sectoral response" and article 1(a) and 3 (e) of the Maseru Declaration also exhort SADC countries to implement multi-sectoralism in their HIV and AIDS national responses.

The two countries have adopted the principle of 'Three Ones' (one strategy, one coordinating authority, and one monitoring and evaluation framework) evidenced by the countries' commitment to having one agreed upon National Strategic Plan (NSP), one national coordinating authority (National Emergency Response Council on HIV and AIDS (NERCHA) for Swaziland and NAC for Zambia) and one monitoring and evaluation framework (SHAPMoS for Swaziland and Nation AIDS Reporting Form (NARF) for Zambia).

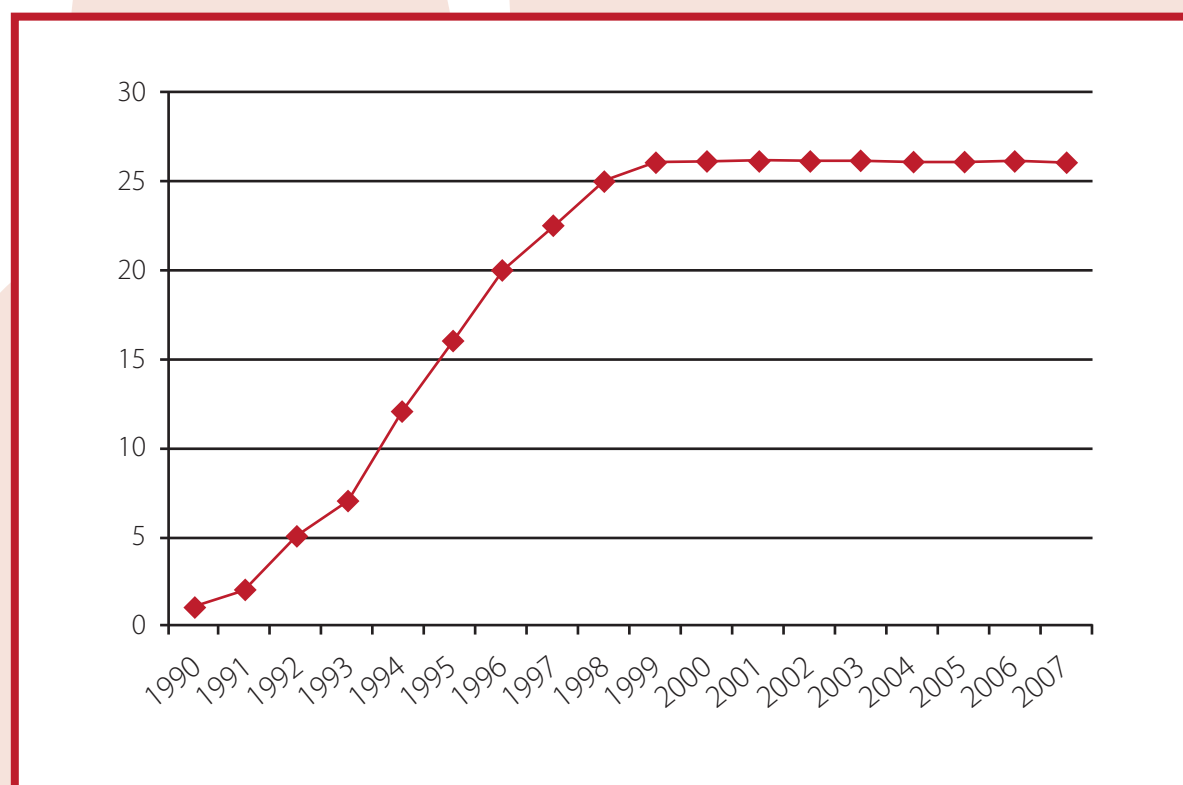
The survey findings have shown that the commitments by Swaziland and Zambia to implement regional and international declarations on HIV and AIDS, have yielded notable improvements in HIV prevention, treatment, care and support strategies and services.



## Swaziland

The HIV prevalence rate among Swazi people aged 15-49 years have stabilised, but at a high rate of about 26.1% from the year 2000 to date. The period of stabilisation coincides with the period in which Swaziland signed a number of declarations and conventions relating to HIV. One would therefore deduce that the conventions and declaration might have to some extent helped in stabilising the high prevalence rates in Swaziland.

### Swaziland: HIV prevalence rate among adults aged 15-49 years since 1999



Source: UNAIDS HIV update 2008

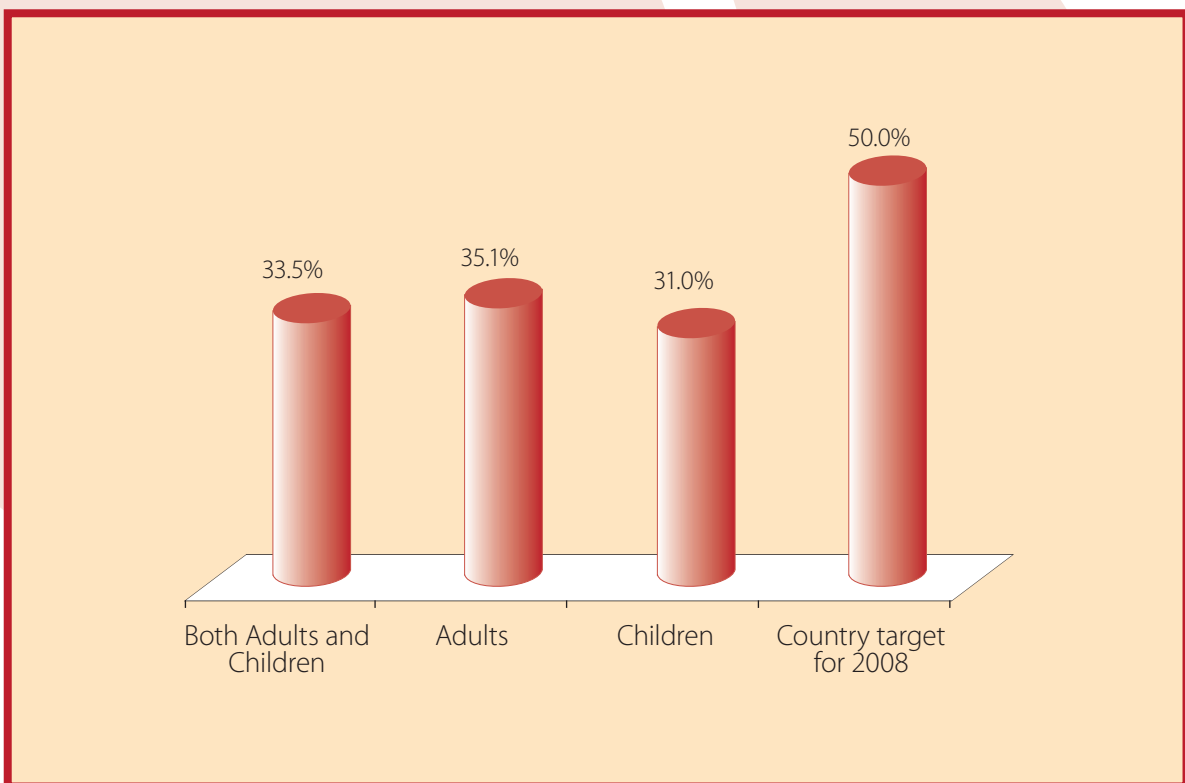
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Swaziland's UNGASS report (2008) shows that the country made considerable efforts in encouraging voluntary counseling and testing (VCT), condom promotion, information, education and communication (IEC), PMTCT and ensuring blood safety. Achievements under prevention include development of a national policy on blood safety in 2000, and adoption of national guidelines by 2001. The percentage of donated blood screened for HIV with an external quality assurance scheme is 100%.

Having developed its first PMTCT guidelines in 2002, HIV testing among pregnant women increased from 15% in 2004 to 66% in 2006. The percentage of HIV positive pregnant women accessing PMTCT programmes was 62% in 2006 and 64.8% in 2007. The country is thus on course to reach its target of reaching 80% by 2010 (Universal Roads Access to Prevention Treatment and Care and Support in Swaziland, November 2007).

In relation to care and support, the UNGASS report for 2008 states that the Government of Swaziland focused on treatment, care and support by highlighting the need for increased access and proper utilisation of ART; clinical management of opportunistic infections; diagnostic testing and counselling; institutional and home-based care; and palliative care. Achievements under care and support include rolling-out ART. Currently, 35% of adults and 31% of children with advanced HIV infection are receiving antiretroviral therapy. The country's target by the end of 2008 is 50%. Free anti-retroviral treatment was introduced in 2003 with 3,200 accessing it in 2004 and 25,000 in 2007. More healthcare workers have been trained since 2005 and there has been scaling up of voluntary testing and counselling, and supplying free Nevirapine for HIV positive pregnant women.

### Swaziland: Percentage distribution of people on ART by the year 2008



Source: Swaziland UNGASS report 2008 statistics



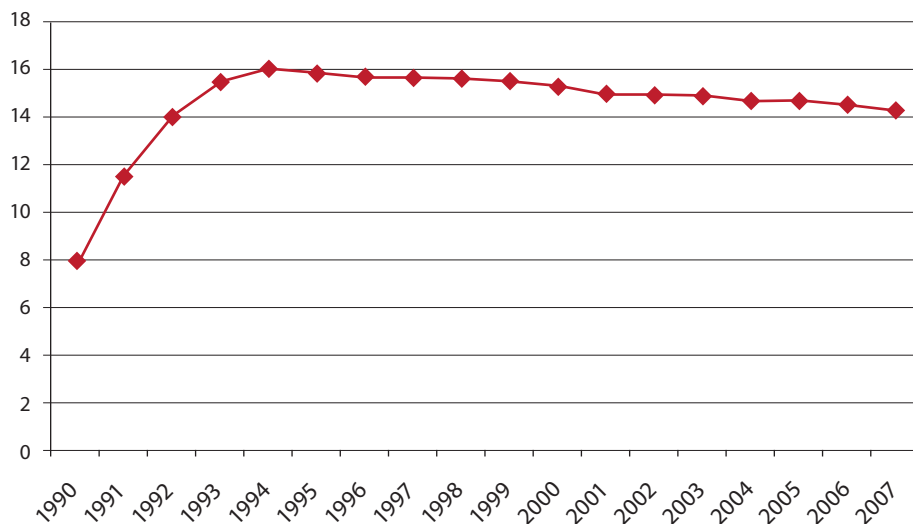
## Zambia

Zambia has scored positive results in implementing HIV prevention, treatment, care and support, in line with several regional and international declarations to which she is signatory.

Recent studies, including the latest Zambia Demographic Health Survey (ZDHS 2008) and UNAIDS update (2008) reveal that adult (15-49 years) prevalence rates have been declining from 1995. Current statistics indicate that the HIV prevalence rate among the adult population has declined from about 16% in 2005 to about 14.3% in 2007. This decline coincides with periods in which the Zambian Government has committed itself to various declarations and conventions, including the implementation of free ART for PLHIV.

The national HIV prevention, treatment and care strategy is focused on the prevention of HIV transmission, safe blood services, provision of ART services including prevention of mother-to-child transmission, voluntary counselling and testing and prevention of HIV transmission through health care and other care settings including support for children affected by HIV. Since the last reporting period and based on the core national programme indicators outlined in the 2008 UNGASS reporting guidelines, Zambia maintained 100% screening for HIV of all blood units collected in a quality assured manner for both 2006 and 2007, with the procedures and results endorsed by an external quality assurance team from the Royal College of Pathologists of Australia. This has been achieved despite increases in blood units collected from 61,584 in 2005 to 68,265 in 2007.

### Zambia: HIV prevalence rate among those aged 15 – 49 years



Source: Swaziland UNGASS report 2008 statistics

In Zambia the number of adults and children with advanced HIV infection receiving antiretroviral therapy increased from 39,351 in 2005 to 149,199 in 2007. In 2006, a total of 80,030 (32.9%) of all adults and children with advanced HIV infection were receiving ART, while the 149,199 accounted for 50.6% for 2007. The scaling-up of free ART continued in 2006, resulting in a significant increase in the number of centres providing both ARVs for PMTCT and ART nationwide, from 62 in 2005 to 146 in 2006, and 320 at the end of 2007.

## Zambia: Treatment indicators over time

| Indicators                | Years   |         |         |         |
|---------------------------|---------|---------|---------|---------|
|                           | 2004    | 2005    | 2006    | 2007    |
| # of sites providing ART  | -       | 62      | -       | 322     |
| # of people needing ART   | 290,000 | 300,000 | 310,000 | 330,000 |
| # of people Receiving ART | 20,000  | 49,000  | 82,000  | 151,000 |
| % of ART coverage         | 7       | 16      | 26      | 46      |

*WHO/UNAIDS/UNICEF Epidemiological Fact Sheet on HIV and AIDS Zambia update Report 2008*

On paper, Swaziland and Zambia's HIV and AIDS policies tend to comply with the various international and regional declarations on a number of issues such as elimination of stigma and discrimination against PLHIV, gender equality and elimination of all forms of discrimination against women, greater involvement of PLHIV, PMTCT, and prevention of HIV infection and respect for the human rights of PLHIV. HIV and AIDS responses in the two countries also seem to recognise the conventions and declarations that the countries are signatories to. However, a closer analysis of the two countries' implementation of declarations and commitments show that gaps exist in terms of specific objectives outlined in the sections that follow.



## Findings on specific objectives

### **1. To what extent do the legal and policy frameworks guarantee that HIV and AIDS interventions are in compliance with international human rights requirements to which the countries are signatories?**

Findings have revealed that there are some gaps in the extent to which the legal and policy frameworks in the two countries guarantee that HIV and AIDS interventions are in compliance with international human rights requirements. In Swaziland for instance, information dissemination is subdued, despite this being critical for a rights-based response. Stakeholders lamented inadequate dissemination of National Emergency Response Council on HIV and AIDS (NERCHA) reports, especially at community level. Although some reports are available on NERCHA's website in Swaziland and NAC's resource centre in Zambia, most stakeholders indicate a need for coordinating agencies to be proactive with information dissemination.

Zambia's HIV and AIDS policy has some gaps in terms of prevention. According to the mid-term review of the National HIV/AIDS/STI/TB Strategic Framework (NAC, 2008), the prevention aspect of the policy does not address the issue of men who have sex with men (MSM) and male circumcision. It is also justifiably argued that there has not been much attention paid by the policy to intravenous drug users - a relatively very small problem of the country. Further, the issue of MSM is a sensitive one in Zambia because of observed cultural values in Zambian society which does not recognise the practice of MSM. However MSM is a reality in the country. It is a complex issue which has not yet been considered in the policy.

The available legal frameworks in the two countries have not addressed existing negative practices which have impacted on HIV transmission in a negative way. Men dominate women in all aspects of life and culture. Women are not equals to men in society and therefore are not empowered to stand up for their rights. They were and still are socialised to be subservient to men, so much that even family law tends to work against them.

In Swaziland, women have limited property rights. They are the home-makers and caregivers to relatives who are living with HIV, thereby leaving them exposed and most at risk of accidental infection with HIV. Moreover, polygamy, inheritance and beliefs that having sex with a virgin cures HIV, make women, and young girls particularly vulnerable to infection. Swaziland is thus in a state of emergency, albeit, not recognised by many.



Both Swaziland and Zambia are not reporting on sexual minorities in their UNGASS reporting. This is blamed on the unavailability of data. Both governments could put in place systems that ensure that information on sexual minorities is deliberately captured in the national statistics. There is also a need to initiate HIV and AIDS interventions that specifically cater for sexual minorities.

Legislation on HIV and AIDS is either 'hidden' or implied in other statutes not directly related to HIV and AIDS, or does not exist. A researcher, Mr Kaumbu Mwendela, with the Public Health Watch in Zambia and a board member of the Zambia AIDS Law Research and Advocacy Network (ZARAN) stated that:

***"It is important to keep legislation as generic as possible to accommodate unforeseen eventualities but specific enough to avoid arbitrariness and abuse. If the law is so broad and sweeping then the enforcer is a law unto themselves. In this case the adage 'absolute power corrupts absolutely' applies."***

Zambia has not yet made a deliberate attempt to put in place a legal framework that specifically addresses the various protocols to which the country is signatory. The need for a rights-based approach is also identified as an essential missing element for Swaziland's current frameworks and policies.

## **2. How do processes and systems in place promote effective collection and analysis of HIV and AIDS information and knowledge required for planning, monitoring, evaluation and effective management of prevention, care and treatment programmes?**

In both countries, the HIV and AIDS coordinating bodies, NERCHA in Swaziland and NAC in Zambia, are mandated to effectively collect, analyse and disseminate information on all output indicators reflected within their HIV and AIDS strategic plans, and HIV and AIDS information and knowledge required for planning, monitoring, evaluation and effective management of prevention, care and treatment programmes. These coordinating bodies also publish annual reports on all indicators in the strategic plans. The monitoring and evaluation units within the coordinating bodies lead the mid-term and end-of-term review of the HIV and AIDS strategic plans. Such reviews consist not only of the analysis of indicator scores, but also other consultative processes, using qualitative research techniques to determine the challenges, implementation impediments and achievements. The two countries are signatory to the UNGASS and thus produce and present the biannual UNGASS report.

HIV and AIDS coordinating bodies in Swaziland and Zambia have strong Monitoring and Evaluation units backed by their central statistical offices, with the capacity to monitor HIV and AIDS national responses. However there are various challenges specific to each country that need strengthening to ensure that this capacity is realised.

In Swaziland, although NERCHA has a strong M&E unit, monitoring and evaluation systems of implementing agencies are not homogenous and in most cases they are weak. A recent assessment of M&E capacity of HIV and AIDS organisations in Swaziland identified M&E technical skills as a common gap. There was lack of experience in advanced areas of research methodology, design, data management and use of qualitative data analysis software. This translated to limited capacity for adequate management of M&E processes at organisational level.

Government agencies' capacity to monitor and evaluate were found to be generally weaker than those of NGOs'. Further, there was less support for M&E activities for departments not dealing with traditional health and welfare issues compared to those operating under MOHSW. Funding for monitoring and evaluation is generally low. However, a comprehensive picture has not been developed since NERCHA's financial system is only able to track projects that it funds directly and thus leaving out projects funded by or through other sources. Even though the plan does not specifically state the targeted annual funding resources for HIV and AIDS interventions that are to be earmarked for monitoring and evaluation, the realisation of the need to dedicate resources to the component is evidenced by its inclusion as one of the core indicators. Human resource capacity has also been a major challenge to the implementation, and monitoring and evaluation of the nation's responses to HIV and AIDS.

For Zambia, the capacity of the M&E unit at NAC has grown in recent years into a reasonably well-staffed unit with some levels of specialisation. The current establishment and staffing levels of the unit are outlined below:

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To a very large extent both countries have processes and systems in place to promote effective collection and analysis of HIV and AIDS information and knowledge required for planning, monitoring, evaluation and effective management of prevention, care and treatment programmes. Systematic data collection and reporting has also been enhanced by the need to routinely report against the Millennium Development Goals.

There are however a number of serious gaps in data collected. For example, data collected indicate a high level of HIV awareness of most-at-risk populations. Although this figure is high, new discussions based on evidence from southern Africa (SADC, 2006) indicate that the most-at-risk populations are young girls between 15 and 24 years, and these are not included in this collected statistic. Then there is the increasing number of orphans. It is certain that the actual numbers are not well known; let alone the current and future needs of the orphans. Planning processes are therefore continuing to be reactive, where proactive actions are required to establish the exact magnitude of the problem.

### **3. How transparent and participatory are processes such as strategic planning and resource mobilisation for HIV and AIDS interventions?**

It is evident from the survey that both countries have adopted a multi-sectoral approach in planning and resource mobilisation. Systems have been put in place to allow for the participation of beneficiaries and communities in the development of sectoral operational programmes that go through the government planning and budgeting procedures. Priorities related to HIV prevention, care and treatment are set based on needs analysis and rational policy choices. The priorities seek to address the needs of different segments of the population through clearly outlined strategies. This is critical, as it ensures community ownership of interventions which in turn not only improves the implementation of international conventions and declarations but also results in rational prioritisation of interventions, thereby allowing for efficiency and effectiveness in achieving set targets and goals in the national HIV response.

In Swaziland, the findings of the Joint Review of the first NSP were taken into consideration during the development of the second NSP. Lessons learnt from the previous interventions were instrumental in developing the current strategic plan. Before the development of the second National Multi-Sectoral Plan, Swaziland did not have a monitoring and evaluation plan for the national responses to HIV. Consequently, there was no systematic way for collecting output and outcomes data related to the national HIV responses. This had a negative impact on the generation of information implying that little information on challenges and successes was generated. Further, there was no systematic way of disseminating information generated from the national responses.

In the case of Zambia, joint planning plays a critical role in the development and reviews of the NASF. Since 2002, NAC has made it a policy matter to engage all key stakeholders in strategic planning and operational planning. The first strategic plan which was developed by NAC covered the period 2002-2005. This was in line with the medium-term expenditure framework (MTEF). Building on the strengths of the first NASF, the second NASF was developed to cover the period 2006-2010. The 2006-2010 NASF was developed through a multi-staged participatory bottom up approach. In June 2008, a nationwide exercise to conduct a mid-term evaluation of the NASF 2006-2010 was conducted. This exercise led to the production of the NASF supplement which has additional objectives and strategies, taking into consideration emerging issues including MSM and the development of resistant strains of both TB and HIV. NAC also takes advantage of the Joint Annual Programme Reviews (JAPR) to disseminate and get feedback on the NASF.

Despite a number of challenges, Zambia remains an enviable model in the region in the rapid roll out of the HIV and AIDS response from the centre to the periphery using a multi-sectoral approach. It is commendable that the HIV and AIDS Strategic Framework was formulated in a highly participatory manner, using a bottom-up approach.

The serious gap is related to wide distribution of information. In Swaziland, information dissemination is subdued, despite this being critical for a rights-based response. For example, stakeholders lamented inadequate dissemination of National Emergency Response Council on HIV and AIDS (NERCHA) reports, especially at levels lower than national. Although some reports are available on NERCHA's website in Swaziland and NAC's resource centre in Zambia, most stakeholders indicate a need for coordinating agencies to be proactive with information dissemination.

#### **4. How accountable and integral are systems for delivery of health services?**

While the countries have demonstrated their commitment to be guided by interventional principles and are signatory to major international conventions that guide HIV responses, budgetary allocations to key ministries, including health, do not match the work that needs to be done. The two countries budgets fall short of the agreed health sector budget allocation of 15% set under the Abuja Declaration (Swaziland-10%; Zambia-12%), indicating that more commitment is still required from the two governments.

Although there are credible efforts to enhance transparency and participation in processes for strategic planning and resource mobilisation for HIV interventions, the same cannot be said about the use of acquired resources. This survey highlights that for both countries covered, not all stakeholders are happy with the way resources, especially those from the state, are accounted for.

Both countries have shown their commitment to combat corruption in both the public and private sector by putting in place policies to establish anti-corruption agencies. However, despite the existence of the anti-corruption commissions (ACC) in both countries, corruption remains high, although some slight gains were reported in Swaziland by the Transparency International. This has been attributed to the introduction of anti-corruption measures. Swaziland is now ranked 72 down from 84 in the world according to the 2008 rankings by Transparency International Corruption Perception Index . According to the same ranking, Zambia is number 115 in the world.

The issue of autonomy of the ACC in the two countries affects their operations and hence their effectiveness. Currently, Swaziland does not have an Office of the Ombudsman through which public complaints can be investigated. The public can only have their complaints heard through Section 35 of the constitution that gives the High Court the jurisdiction to hear and determine claims against breach of any of the protective provisions of the constitution. Unlike Swaziland, Zambia has two principal instruments providing the public with avenues for redress when concerned about service standards, corruption or misconduct by public servants. These are the institution of the Ombudsperson (Commission for Investigations) established under Article 90(1) of the Constitution and the Anti-Corruption Legislation (see Section 9.6). The Ombudsperson is a public office that may be charged with representing the interests of the public by investigating complaints reported by citizens and addressing them, usually through mediating a settlement. The Office of the Ombudsman may initiate action on its own or respond to issues referred by others. Absence of an Ombudsman Office prejudices citizens of a formal complaint mechanism.

# Challenges faced in the implementation of conventions, declarations and protocols

Various factors have been noted as contributing to the failure by the countries to meet their obligations under the various conventions, declarations and protocols. Some of the factors include limited capacity; inadequate resources; poor translation of international commitments into local policies; and in some cases, dysfunctional governance systems.

Another key factor is the country-specific settings that make it impossible to identify peculiar requirements that are essential for the success of the initiative or implementation of the declarations. The socio-political, economic and cultural environments of each country are unique in their own way. As a result, a number of factors, unforeseen during the signing of declarations hinder the achievement of set goals and targets. Also, failure is attributed to failure by governments and other key players to facilitate implementation of actions required to realise the goals and targets of the declarations and other international instruments.

There is a strong realisation that HIV and AIDS are very much inter-linked with poverty, social and economic inequities between men and women, and long-standing cultural behaviours and beliefs. And that the epidemic seriously undermines the countries' commitment to achieving set targets.

Also, the two countries' budgets fall short of the agreed health sector budget allocation of 15% set in the Abuja Declaration (Swaziland-10%; Zambia-12%), indicating that more commitment is still required from the two governments. In southern Africa, Mozambique is currently the only country meeting this requirement (Guthrie, 2008). However Swaziland's 2008 national budget speech recognises the need to scale up allocation to the health sector to at least meet the 15% Abuja requirement.

The other factor could be failure, by the international conventions, declarations and other instruments on HIV and AIDS, to clearly define the means and ways that governments could achieve the desired goals. For example, The Millennium Declaration adopted in the fifth session of the UNGASS in 2000 lists targets with limited specific tactics and capacity for implementation, especially for developing countries (UNAIDS, 2000). Others, such as WHO's '3 by 5' initiative also achieved limited success. It is also worth noting that both Swaziland and Zambia are not reporting on sexual minorities in their UNGASS reporting.



# Specific recommendations

## Swaziland-specific recommendations

- a) Government should provide a platform for experts in the fields of poverty, HIV and AIDS, climatic and economic crises to establish the interrelatedness of the crises and thereafter ensure that stakeholders from these sectors fully understand the magnitude of the problems facing the country. Specifically, the triple threat of food insecurity, HIV and weakening government's capacity to respond to the needs to be debated at all levels. Resources within different sectors - including CSOs, private companies and international technical assistance organisations need to be managed prudently.
- b) The Swaziland National Network of People Living With HIV and AIDS (SWANNEPHA) should develop a profile of CSOs related to HIV and AIDS and the nature of their work. Such a profile could help quantify their input, relevance and resource base.

## Zambia-specific recommendations

- a) The Ministry of Health and the NAC should consider updating the HIV and AIDS policy framework to enable it to accommodate new challenges and opportunities, eg in pursuing circumcision.
- b) The Ministry of Health and the NAC should consider translating both the HIV and AIDS Policy and Strategic Framework into vernacular languages in order to make it more accessible to non-English speakers.
- c) The Government of Zambia through the Ministry of Health and NAC should step up the publicity accorded to any new HIV and AIDS policies or legal instruments. This is important for making people aware of their rights and obligations in the HIV and AIDS national response.
- d) The Government of Zambia should consider elevating the institutional positioning of NAC into an autonomous body with its chief executive who has powers of the controlling officer.
- e) Now that an adjunct to the National AIDS Strategic Framework (NASF) 2006-2010, which has taken into consideration emerging issues of men having sex with men (MSM), male circumcision, mainstreaming issues, has been developed, approved and launched, there is need to revisit the M&E plan with a view to including indicators for the new items.
- f) Given that there are more people appointed to deal with information and data management at NAC and the MOH and their decentralised structures, there is need to have a continuing education programme for key personnel.



# General recommendations

## Governments and National AIDS Coordinating bodies

- a) Create an enabling environment for rights-based approaches to service provision. Government should consider drafting and passing HIV and AIDS specific legislation to guarantee the rights of health service users in the national response.
- b) Consider a formal feedback mechanism from users of health services. Activation of the Office of the Ombudsman, or in the least case, suggestion boxes at health delivery centres is imperative.
- c) Continue to encourage integration of responses, especially those that are clinical and those based in the community.
- d) Provide the required leadership in meeting and reporting against commitments, including Abuja and Maseru declarations, the MPOA, CEDAW and the CRC, at least at the same level of commitment expressed within the UNGASS process.
- e) Strengthen monitoring and evaluation systems of key departments such as those addressing vulnerable children and abuse of women, including linking with stakeholders who are willing to share skills in these areas. There is need to consider placing M&E officers at lower levels.
- f) Proactively share information on successes and challenges with implementers at all levels. Establish a mailing list or e-forum where information can be shared regularly.
- g) Provide additional funding to National HIV and AIDS coordinating bodies and other players to ensure that monitoring and evaluation capacity is strengthened and rolled out at all levels.
- h) Provide frameworks for proactive national level discussions on AAA and the Paris Declaration.
- i) Honour budgetary obligations in the HIV and AIDS intervention processes. Meet the Abuja Declaration commitments regarding the 15% governments agreed to allocate to their health sectors, and specifically increase actual spending on HIV and AIDS.
- j) The government should create adequate frameworks for the protection of the rights of vulnerable groups. All relevant international instruments like CEDAW and the CRC should be translated into national laws and policies.
- k) Governments should encourage positive utilisation of the media so that it can be used as a vehicle for education and dissemination of information on HIV and AIDS. HIV and AIDS programmes should be aired during prime time.
- l) Governments need to come up with attractive remuneration packages that will be competitive enough so as to retain staff. In the long term it will be prudent for government to develop a career progression plan with each new essential health worker recruited to the public service.

## Civil society organisations

- a) Coordinating bodies of CSOs should work closely with coordinating partners to ensure that the organisations are using the agreed M&E framework for reporting.
- b) CSOs should develop the capacity of users of health services and their organisations so that they are better able to defend or demand their rights.
- c) As part of the AAA process, CSOs should seek to improve co-ordination and alignment of their efforts with government programmes. They should also work with government to create an enabling environment that maximises their contribution to development efforts.
- d) There is need to enlighten society about the importance of changing cultural beliefs and attitudes about sex. People need to change their sexual behaviour and avoid multiple casual sexual partners and use condoms consistently.
- e) There is need for media monitoring and training on reporting issues of gender and HIV and AIDS.

## Funding and technical partners

- a) Continue to provide technical capacity and other resources to ensure that the national response to HIV is informed by evidence, and observes people's rights. New research such as that surrounding male circumcision, transmission rates during window periods etc., should be adapted to local settings, and resources made available to test their applicability.
- b) It is clear that additional resources have to be solicited from external development partners. Notwithstanding the Paris Agenda, there is need to sum-up the number of emergencies countries are dealing with, and ensure that development assistance takes cognisance of these.
- c) There is need to improve implementation and the national coordinating entity's capacity to mobilise resources. While most implementing partners have finance and accounting departments, they do not have resource mobilisation components or units.
- d) Funding partners should consider funding a retention and capacity building strategy for professional health care personnel. The retention strategy should include competitive remuneration packages and availability of sufficient protective materials and equipment for health care personnel. The working and living conditions of all health workers, including those in rural areas should be improved and another deliberate measure should be to recruit health care professionals from abroad.
- e) It should be the responsibility of SADC or international bodies to find the means and ways to implement these agreements after being clearly articulated. It is not enough to talk, instead there is need to ensure that there is action on the ground that produces desired results. Implementing agencies should come up with realistic funding proposals and receive adequate funding. Drugs must be supplied constantly and always be in excess of the required quantities. Workshops should not be confined to urban areas but must reach the remotest areas. Food must be made available to all, despite geographical locations, as even some urbanites are economically disadvantaged.





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