THE AFRICAN CAPACITY BUILDING FOUNDATION

HIV/AIDS AND PUBLIC SECTOR CAPACITY

IMPACT OF HIV/AIDS ON PUBLIC SECTOR CAPACITY IN SUB-SAHARAN AFRICA

TOWARDS A FRAMEWORK FOR THE PROTECTION OF PUBLIC SECTOR CAPACITY AND EFFECTIVE RESPONSE TO THE MOST AFFECTED COUNTRIES

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AN ACBF OPERATIONS-BASED STUDY BY

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ACRONYMS

ACBF	= African Capacity Building Foundation
AIDS	= Acquired Immune Deficiency Syndrome
ANC	= Antenatal Care.
ART	= Antiretrovial Therapy
ARV	= Antiretroviral drug.
BCAA	= Business Coalions Against Aids (Swaziland and Mozambique)
BESSIP	= Basic Education Sub-Sector Investment Programme (Zambia).
BCC	= Behavioural Change Communication.
CDC	= Centres for Disease Control and Prevention.
CETA	= Confederation of Private Companies (Mozambique)
CIDA	= Canadian International Development Agency
DANIDA	= Danish International Development Agency
DFID	= Department for International Development (UK).
DFID	= Danish Fund for International Development
DHRMD	= Department of Human Resources Management and Development (Malawi).
GDP	= Gross Domestic Product
GFATM	= Global Fund to Fight HIV/AIDS, Tubercloisis and Malaria.
GTZ	= Germain Agency for Technical Cooperation.
HAART	= Highly Active Antiretrovial Therapy
HIV	= Human Immunodefiency Virus.
IDU	= Intravenous Drug User (or IVDU)
ILO	= International Labour Organisation
IMF	= International Monetary Fund
IPAM	= Institute of Public Administration and Management (Lesotho).
JCVF	= Japan Counter Value Fund.
LAPCA	= Lesotho Aids Programme Coordinating Authority.
NAC	= National Aids Commission/Council
NERCHA	= National Emergency Response Council on HIV/AIDS (Swaziland).
NGO	= Non-Governmental Organisation.
NORAD	= Norwegian Agency for Development
NVP	= Nevivvapine
OPC	= Office of the President and Cabinet (Malawi).
PLWHA	= People Living with HIV and AIDS.
PRSP	= Poverty Reduction Strategy Paper.
PMTCT	= Prevention of mother-to-Child Transmission
PTCT	= Parent-to-Child Transmission
RTI	= Reproductive Tract Infection
SNAP	= Swaziland National AIDS/STDs Programme.
STD	= Sexually Transmitted Diseases
SRIC	= Swaziland Royal Insurance Corporation.
STI	= Sexually Transmitted Infections
TB	= Tuberculosis.
TOR	= Terms of Reference.
TRIPS	= Trade-Related Aspects of Intellectual Property Rights
VC	= Vulnerable Children
VCT	= Voluntary Counseling and Testing
UN	= United Nations.
UNAIDS	= Joint United Nations Programme on HIV/AIDS.

UNDCP = United Nations Drug Control Programme.
UNDP = United Nations Development Programme.
UNICEF = United Nations Children's Fund
UNIDO = United Nations Industrial Development Organisation.
USAID = United States Agency for International Programme.
UNGASS = United Nations General Assembly Special Session on AIDS.
UNCTAD = United Nations Conference on Trade and Development
WB = World Bank
WHO = World Health Organisation.
WTO = World Trade Organisation.

GLOSSARY

ACQUIRED
Not inherited from the gene from one's parent but from the environment

AIDS
Acquired Immune Deficiency Syndrome, which means the body loses the ability to fight infections because the immune system is weakened by HIV.

AIDS-Related Disease or HIV Related Disease
Symptoms caused by HIV infection that do not necessary indicate all AIDS; e.g. swollen lymphglands; long lasting diarrhoea, fever, tiredness. The term may also be used for full AIDS.

ANTIVETROVIVAL DRUGS (ARVS
Drugs that fight retroviruses such as HIV.

ARC (AIDS Related Complex)
A term for disease symptoms linked with AIDS but not yet life threatening.

AZT/ADV
Azidothymidine (zidovudine or retrovir) the first antiretroviral drug available to fight AIDS.

CLINICAL
Observable disease symptoms, medical

ENDEMIC
Normally occurring and widespread at a stable level

EPIDEMIC
An usual marked increase in cases in a fairly short period of time.

HIV Negative
Having no artibodies to HIV; this usually means no HIV is present.

HIV Positive
Having antibodies to HIV in the blood and therefore having HIV infections

IMMUNE SYSTEM
The body's defense mechanism to fight against infections and cancer; as well as complex cellular responses in the lymph and blood; HIV primarily affects all mediated immunity.

INCIDENCE
New cases of infection in a population within a fixed period (usually a year).

INCUBATION PERIOD
Time period between first infection by the disease agent and the appearance of disease symptoms with HIV this can be from months to years.

OPPORTUNISTIC INFECTION(OI)
Infection by an organism that only causes disease when the immune system is weak as in advanced HIV infection.

PANDIMIC
A global or very widespread epidemic

PREVALENCE
The level of existing infection in a population at a point in time; regardless of when the infection occurred.

RAPID TEST
HIV antibody test mostly performed by a drop o blood that gives a highly reliable results in a few minutes.

RETROVIRUS
Unusual, recently identified group of viruses, including HIV, which reproduces in a different way from most other viruses.

SCREENING FOR HIV
Analyzing for HIV the blood of whole population or groups with a population (for instance to measure incidence or prevalence; or to screen out HIV positive blood donors).

SENTINEL SURVEILLANCE
Screening of a key group in the population to gain an idea of the extent of an infection or other problem. E.g. Screening pregnant women, STI patients for HIV to find out HIV prevalence; repeat screening at regular intervals indicates trends in HIV transmission in the population group over time.

SEROPOSITIVE
Having antibodies to HIV; being HIV positive.

SEROPREVALENCE SURVEY
For HIV study of how widespread HIV infection is in a population by people's blood for HIV anti-bodies (seroprevalence is the prevalence of infection in blood serun).

TUBERCULOSIS (TB)
Serious, chronic bacterial disease of the lungs and sometimes-other organs; common with AIDS. TB is treatable with various antibiotics, although multi-drug resistant TB (MDRTB) is an increasing problem worldwide.

WINDOW PHASE
The time period between the initial infection with HIV and the production of antibodies – usually three months. During this time, an HIV anti-body test will be negative although the person does have the virus.

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EXECUTIVE SUMMARY

Never in history has there arisen such a widespread and fundamental threat to human development as the HIV/AIDS epidemic. As a result, one of the main challenges today for development management is how to address the massive loss of skills and experience from the public in Sub-Saharan Africa that has resulted from this pandemic, which has already reversed decades of hard-won socio-economic development progress in the African Continent. As part of the effort to be a better understanding and appreciation of the HIV/AIDS situation in the public sector, the African Capacity Building Foundation (ACBF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), jointly undertook to conduct a field study on "The Impact of HIV/AIDS on Public Sector Capacity in Sub-Saharan Africa: Towards a Framework for Protection of Public Sector Capacity and Effective Response to Most Affected Countries". To this end, a review of the impact of HIV/AIDS on public sector Capacity was conducted in a sample of six Sub-Saharan African countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe)

The main objective of the study was to enhance the knowledge of ACBF, UNAIDS and other development institutions of the state of public sector capacity in HIV/AIDS-affected countries and guide their interventions in the strengthening of public sector capacity in the face of the erroneous threat posed by the pandemic. The specific objectives were to: assess the extent to which policy analysis and management capacity were affected; identify the competencies, specific skills and experiences which were most affected; provide a gender-based analysis of the lost competencies, skills and experiences; review and assess the number, quality and adequacy of HIV/AID awareness, enducation, information sharing and learning programmes in the public sector especially in core policy-making institutions.

On the basis of the findings, the study was expected to recommend appropriate strategies, policies and programmes for protecting public sector capacity in the face of the pandemic, stepping up information sharing, education and learning programmes within and across public ministries and institutions, effective short-term and long-term response programmes by ACBF in capacity needs of the public sector; designing and implementation of a knowledge retention programme and mainstreaming HIV/AIDS into training and capacity building interventions in the public sector ministries and institutions of the six sample countries selected for the study.

In order to achieve the above objectives, the Consultants undertook a critical review of the studies and publications on the extent, magnitude and impact of HIV/AIDS on public sector capacity, prevention and management programmes in each of the six selected countries; developed a comprehensive set of questions which served as the basis of discussions and interview with the various stakeholders (national focal points, key public sector ministries and institutions, donor agencies, NGO's etc) in each country; review meetings were held by the consultants at the end of each working day to discuss the progress of the mission, adjusted the programme if and where necessary and mapped out the strategy for interview and consultations for the next day; and finally, held debriefing

meetings with ACBF in Harare to highlight the experiences of the mission before the Report was prepared.

It should, however, be pointed out even though the Consultants, developed a comprehensive set of institutional questionnaires which provided information on HIV/AIDS policy and management issues, cost implications and lost skills, competences and experiences and programmes in each public sector Ministry and institution, the envisaged collection, collation and analysis of the questionnaires which were distributed to the identified by public Sector ministries and institutions during the field mission in each country have not been carried out. This is because only one partially, completed questionnaire by one Ministry in Mozambique and three partially completed questionnaires by three Ministries in Zambia were received by the Consultants. Consequently, the findings, conclusions and recommendations which are presented in this Report, have been based solely on the analysis documents and publications which were received and the extensive interviews and discussions which were held with the various public sector ministries, institutions, donor agencies, focal point units, NGO's, etc in each of the six Countries.

Bearing in mind the foregoing context of the study, Section I is the situational analysis of the extent and magnitude of HIV/AIDS infections in some lay public sectors in Sub-Saharan Africa in general. Sections II, III, IV and V, briefly present the objectives, scope, expected output and methodology of the study, (sample and study design, methods of data collection, data analysis and study implementation process) respectively. Section VI undertakes an indepth analysis of the national profile and response to HIV/AIDS in the Six countries. Specifically, the general pattern of HIV/AIDS prevalence is examined with emphasis on the magnitude and dimension of HIV/AIDS prevalence rates, AIDS patients and deaths among adults, women and children, risk factors for HIV/AIDS, AIDS mortality and life expectancy. The other issues which are analysed in this section are national policies and strategies; HIV/AIDS institutions and programmes; pension and insurance funds, private sector initiatives and the role played by UNDP, UNAIDS and other donor agencies in the fight against HIV/AIDS in the six countries.

To the extent that the spread of HIV/AIDS has seriously eroded human capacity and adversely affected "capacity deepening", in many African countries, section VII is devoted to an analysis of the impact of the pandemic on public sector capacity and response in the six study Countries. Emphasis is placed on the nature of the socio-economic impact, pattern of infections, impact on the public sector capacity, and institutional costs of HIV/AIDS in some key public sector ministries and institutions, like health, education, finance and national planning, agriculture, women/gender and social affairs and police. The other critical issues which are examined in this section of the Report are public sector policies and programmes, funding of HIV/AIDS programmes, human resources planning and capacity building programmes, and some Best Practices of HIV/AIDS programmes which can be replicated within and outside each of the selected countries.

Finally, Section VIII is devoted to the conclusions and recommendations, which are intended to enhance ACBF's knowledge of the status of the public sector capacity in the six countries selected for the study. The objective is to guide the Foundation's interventions in the strengthening of public sector capacity in the face of the threat posed by the HIV/AIDS pandemic. To this end, recommendations have been made in respect of

the critical areas for training and capacity building, training and capacity bulding programmes for staff replenishment, mainstreaming HIV/AIDS into public sector management programmes, programmes for enhancing information sharing and learning, and best practices/successful programmes/policies and strategies of HIV/AIDS for replication.

IMPACT OF HIV/AIDS ON PUBLIC SECTOR CAPACITY IN SUB-SAHARAN AFRICA

1. BACKGROUND

The HIV/AIDS pandemic has infected 40 million people in the world and about 95% of them are in developing countries. The pandemic has already killed 28.5 million people since its emergence and 14 000 people become infected everyday. According to UNDP (2002), more than half of those newly infected with HIV/AIDS today are between the ages of 15 and 24. More than 11.8 million young people in this age bracket are living with HIV/AIDS and out of this number, 7.3 million are young women and 4.5 million are young men (UNDP, 2002). In 2001 alone, 5 million people became infected with HIV, out of which 3 million died.

Recent research reveals that of all adults living with HIV/AIDS, 50% or 18.5 million are women. Current estimates indicate that 3 million children are living with HIV/AIDS, 14 million children have been orphaned by the scourge and it is projected that the number will reach 40 million by 2010. There is currently no treatment for HIV/AIDS. More than 50% of the people who become infected with HIV/AIDS, (HIV1 or HIV2) develop AIDS within 8 and 15 years and most of these infected people die within 3 and 8 years, while another 40% or more will develop more clinical illnesses associated with HIV infection (Jackson, 2002).

There are twenty-nine countries in Sub-Saharan Africa that are most affected by HIV/AIDS, relative to only 3 in Asia and 2 in Latin America and the Caribbean. In 2001, it was reported that 68% of all new infections were in Sub-Saharan Africa (SSA) and 16% in South and South East Asia. Moreover, 70% of all adults living with HIV/AIDS are in Africa, indicating that Africa is the most affected region in the world, particularly South of the Sahara. It has been estimated that the continent has a total number of 28.5 million people living with HIV/AIDS, showing an increase of 30% over the past five years. More than 3.5 million Africans became newly infected with HIV in 2001 (Jackson, 2002).

As a result of HIV/AIDS, the average life expectancy for all Africans has fallen by 15 years over the past two decades. According to UNAIDS (2002), AIDS has caused 2.5 million deaths in 1998 and is now killing more people in Africa than malaria. Every minute, five youngsters between 15 and 24 years old get infected with HIV. Of all AIDS deaths since the beginning of the pandemic 20 years ago, 83 % have been in Africa. The disease is responsible for millions of funerals in Africa and the continent harbours 95% of all AIDS orphans. It has been estimated that HIV/AIDS has reduced the annual rate of growth of Africa's per capital GDP growth by approximately 0.8 percent, and no country in Africa has escaped this virus. Some countries are worse affected than others (UNAIDS, 2002).

According to UNAIDS (1999), HIV/AIDS prevalence rate among adults in sub-Saharan Africa (SSA), was estimated at 8% which was the highest in the world. In fact, this prevalence rate was 8 times the world's average. More than half of all new infections occur in the youth age bracket of 15-24 years and this has serious implications for the regions development. In 1999 alone, out of 5.6 million newly infected persons world-wide, 3 million were in SSA. The pandemic appears as the leading cause of death in SSA and the destruction of human capital which is crucially needed for Africa's socio-economic development is huge.

Within Sub-Sahara Africa, HIV infection is unevenly distributed across geographic areas and age groups (Ndongko, 1996). The percentage of the population that is infected with HIV ranges from less than 1% across most of the continent to more than 50% in certain sub-regions. The countries most affected are those around Lake Victoria which includes Rwanda, Uganda, Burundi, Tanzania, Kenya, Malawi, Zaire, Central African Republic and the Congo Democratic Republic. Estimates suggest that about 50% of the newly infected people are based in South Africa. In South Africa, 20.1% of adults are infected with HIV. With a total of 5 million infected people, South Africa has the largest number of people living with HIV/AIDS in the world.

Given the foregoing situation, the Southern Africa region appears to claim the majority of the HIV/AIDS affected countries in Africa. For example, in Malawi, Mozambique, Rwanda, and Zambia, between 1 out of 7 and 1 out of 9 adults live with HIV infection and 1 out of 5 people between the ages of 14 and 49 in Namibia, Swaziland and Zimbabwe. In the Central African Republic, at least 1 out of 10 adults are HIV infected, while in Kenya, the prevalence rate of adults has reached double digit figures and continues to rise with 15% of the adult population (15-49 years) living with HIV/AIDS. Thus given the scale of HIV/AIDS, the disease is a development crisis for SSA. (Ndongko, 1996).

The life expectancy in the 29 countries most affected by HIV/AIDS in SSA is presently estimated at 47 years, 7 years less than the situation without AIDS (Ndongko, 1996). Recent evidence suggests that most of the infection occur among the most economically active group of adults, especially those aged between 25 and 45 years; the age group of prime adult life. There is also a significant gender dimension to the pandemic. In SSA, two-thirds of those affected by HIV/AIDS infection are women in the prime age bracket (Ndongko, 1996). Women and girls are more susceptible to HIV/AIDS infection for both physiological and social reasons. They are therefore more vulnerable to the impacts of the disease since they largely care for others that are ill simultaneously thus have increasing the burden of sustaining a family. This suggests a need for mainstreaming gender into HIV/AIDS prevention and management programmes.

Many adults in their prime are helplessly falling to the scourge of HIV/AIDS as it is viciously decimating the work force, fracturing and impoverishing families, orphaning millions of African children and shredding the fabric of communities. As a result, family and community compositions are changing due to the deaths of young adults. Furthermore, HIV/AIDS affects all socio-economic groups and all sectors, ranging from the impoverished subsistence farmers, informal sector workers, domestic workers and unskilled factory workers to top managers, professionals, civil servants and politicians. The result is a steady decline in human resources with profound negative impacts on national

capacity as a whole and on certain sectors in particular, thus impeding economic and human capacity development in Sub-Sahara Africa (UNDP, Fact Sheet, 2002).

Recent studies focusing on 15-19 years old have revealed that teenagers with more education are now far more likely to use condoms than their peers with lower education. Furthermore, it has been observed that in countries with severe epidemics, the more educated teenagers are less likely to engage in casual sex. These recent findings reveal a reversal of the previous trend by which education tended to go hand in hand with more disposable income and higher mobility; both of which increased casual sex and the risk of contracting HIV (A VERT.ORG.2001). It becomes evident that as more information about HIV has become more widely available, education has switched over from being a liability for AIDS infection to being an asset for AIDS prevention.

The HIV/AIDS situation in SSA appears to be causing attrition rates in the countries and is also affecting core institutions in virtually every sector. The concentration of HIV/AIDS infection in a particular sector reveals the susceptibility of that sector to high HIV infection levels. The most susceptible sectors are generally those in which workers are frequently separated from their spouses and families, in which risk-taking is a norm and in which the bulk of the workforce consist of young and middle aged men. These criteria render the following socio-professional groups to be identified as high risk, in which the HIV/AIDS infection is highly concentrated: the military (including the police, gendarmerie and prison services), distant truckers, migrant mine workers, education and health services.

The military and other uniformed forces such as the police and gendarmerie have a particularly high concentration of HIV/AIDS infection. The high susceptibility of the military (and the allied forces) has been widely documented and is due to a number of factors. According to UNAIDS (1998), the single most important factor leading to high rate of HIV in the military is the practice of posting personnel far from their accustomed community and families for varying periods of time. This practice has the effect of freeing them from traditional social controls, remove them from contact with spouses and regular sexual partners and thereby encourages the growth of sex industries in the areas where they are posted.

Furthermore, since danger and risk-taking are part of the job of the military, they need and will seek release, including sexual release from the tension and stress of their work. Another significant fact is the fact that the military forces are disproportionately composed of young to middle-aged males in peak physical condition who are separated, frequently from their wives or families and home communities for long periods. Besides rape, soldiers often have access to sex workers, moreso as they are likely to have more ready cash than many other men in regions where they are deployed. Furthermore, peer pressure within the military is likely to reinforce casual sex and even the acceptance of STDs as signs of male prowess (Jackson, 2002).

The prison services also constitute a high concentration of HIV/AIDS infection. HIV/AIDS infection rates within prisons tend to be significantly higher than in the general public and this is due to a number of factors. In addition to rape and sodomy, high rate of same sex activity, including forced anal sex, occurs widely in prisons throughout the world. Although same-sex activity in the prisons does not imply that most prisoners are homosexuals, it is however practiced in the absence of their families and lack access to

formal partners; and this makes prisoners resort to sex with other men around them thus making HIV to be readily transmitted. More so, coerced sex and sex for favours between guards and prisoners have also been widely reported in many countries, including those in Sub-Saharan Africa. Furthermore, intravenous drug use with shared needles is a common problem in many prisons worldwide and it thus greatly contributes to HIV transmission (UNAIDS, 1998). However, needles exchange is more controversial in prison than in the general population because needles can be used as weapon.

Since most prisons in SSA are over crowded or filled to well over capacity, the number of people incarcerated and released into the community is undoubtedly substantial, and this has very important implication for HIV transmission in the population. In fact, even a short jail term for a relatively minor offence has great potential of exposing the prisoner to rape or sodomy and consequently to HIV and other serious infections (Serpa, 2001). Upon release, the prisoner will take those infections back home for onward transmission to their spouses and other sexual partners in the population. HIV prevention for prisoners is thus of particular concern and the need to protect prisoners is not only a human rights issue for them, but also for their families and communities where they will be released. Furthermore,, the general public and researchers have identified long distance truck drivers as playing a major role in the spread of HIV/AIDS (Tierney, 1990) in Africa as most drivers have sexual partners along transport routes with whom they often have unprotected sex.

With regards to the mining industry, the incidence of HIV/AIDS is generally reported to be high. This is due to the fact that the concentration of young men and their risks and hardships, encourage a thriving informal sector among women to supply vegetables, water, laundry, alcohol and sex (Schools, 1999). Mark Lurie of the Medical Research Council of South Africa has commented that if you want to spread a sexually transmitted disease, you would take thousands of young men away from their families, isolate them in single sex hostels and give them easy access to alcohol and commercial sex. Then to spread the disease around the country you would send them home every once in a while to their wives and girl friends. And that is basically the system we have with the mines". In addition, when the mines employ migrant labour from regions and neighbouring countries where AIDS epidemic has already flourished, there is assurance that many of the women servicing the miners become infected.

In education, it is arguable that teachers may be highly susceptible to HIV infection as their jobs take them to different parts of the country, away from their families. Moreso, male teachers may engage in sexual relationship with the students and this represents a pattern of HIV transmission to youths. Although this pattern of HIV/AIDS transmission is increasingly reported in many countries with high HIV prevalence, it should however be noted that this is not a universal finding in high prevalence countries as only few widely based analysis have been undertaken.

With regards to the health sector, the personnel in many countries have high rates of HIV infection and this leads to increased absenteeism and high staff turn over when they die. Medical personnel, however, with their long training are particularly costly and difficult to replace. Harvard and Haslegrave (2000) report that one-quarter of nurses in some hard-hit countries have HIV infection, even though hard data are often unavailable.

The informal sector has not been spared of the high concentration of HIV/AIDS infection. The informal sector has been identified by research results as the main area of expansion in depressed economies in developing countries that absorbs huge numbers of men and women to complement or substitute for the alternative, subsistence farming activities. The informal sector and small businesses or micro-enterprises are wide ranging and highly variable in both urban and rural areas. Some activities of the informal sector such as cross-border-trade in second-hand clothing and other goods primarily involves women who are at high risk of HIV infection.
These women are mobile, away from their families and at risk not only of supplementing income through selling sex, but are often coerced into sex in order to get through borders and pass police blocks since their tax evading trade is not formerly sanctioned. (Webb, 1997). Research results show that in Ghana, women migrating to Abidjan in Côte d'Ivoire to join the lucrative sex trade have returned home with high HIV infection level (Webb, 1997). Beer brewing and distilling is another widespread informal sector activity in many countries. Though it is illegal in most cases, the trade also creates a risk environment for HIV infection by attracting commercial and casual sex.

Sex work also contributes enormously in Sub-Saharan African and elsewhere to HIV transmission. Sex workers are usually women but by no means always women; they include men selling sex to men and/or to women, transgender people (having both part male and part female sexual characteristics) and transverates. Research results however show that in Sub-Saharan Africa, the great majority of sex workers are women selling sex to men. Many street children, boys and girls, also sell sex to men as part of their survival strategies. As Akin Aina (1989) has noted, male prostitutes can be found in virtually all large African cities and tourist centers, around the five star and other hotels catering mainly to an expatriate clientele and the local rich.

However, it could be noted that in many countries, at all levels of society from desperately poor widows and school girls or out-of-school youth to the high status girlfriends or mistress of wealthy businessmen and politicians, sex is traded for material benefits. In a minority of cases however, older women may also take on the role of "sugar mummies" purchasing sex through gifts or other means from young males. Nevertheless, evidence shows that such interactions are rare as compared with male purchase of sex from younger women.

Some of the reasons why SSA in general and Southern Africa in particular have been succumbed to the HIV/AIDS pandemic with such intensity include the existing cultural practices which regard any discussions on the disease as a 'taboo'; extrenched and uncontrolled sexual behaviour of the population at large despite the attempts being to sensitize and educate the people on the consequences of HIV/AIDS infections; and the fact that most of the preventive programmes do not reach most of the people who live in the rural often inaccessible areas of the countries most affected.

In view of the foregoing alarming situation of the HIV/AIDS in Sub-Saharan African countries and its long-term negative impact on the development of their economies, African governments and their development partners are making commendable efforts to slow down the rate of new infections and support the millions that are already infected. Most Sub-Saharan African countries have strategic plans and ongoing HIV/AIDS prevention programmes. However, while some countries, no doubt, have made progress in

reversing the spread of the pandemic most have not, despite having national HIV/AIDS programs.

Lack of progress has been due, in large measure, to inadequate financing, poor commitment and leadership by governments, tardy support by governments and the international community, especially in scaling up programmes that have proven effective, inadequate outreach to and resources for rural communities, and unduly narrow focus of HIV/AIDS programmes on the health sector.

For all sectors, at the organizational level, there are considerable costs associated with the pandemic. Such economic impacts are not usually felt until AIDS cases appear in significant numbers. When a staff member gets sick the organization has to cope with many indirect costs associated with increased absenteeism and costs associated with outpatient and laboratory cost; When the employee leaves the organization either through death, hospitalization or voluntary resignation, there are additional direct and indirect costs such as those related to hospital and drug costs retraining and employment of new staff. Even among staff who are not infected themselves, many will be affected through sickness and death amongst relatives, neighbors and friends. These situations are likely to strain considerably family resources thereby compromising the economic well-being of the family.

The Fact Sheet by the United Nations General Assembly Special Session on HIV/AIDS (2002) presents a crisp summary of the challenges posed by the pandemic for capacity building and development management. These consist of impact on economies and poverty, governance, the social sectors and women. The impact is differentiated and has short and long as well as direct and indirect dimensions. Such include impact on economies and poverty, capacity and governance, productive sectors, social sectors, and women. One of the main challenges today for development management is how to address the massive loss of skills and experience from the public sector in Sub-Saharan Africa that has resulted from the pandemic as HIV/AIDS has already reversed decades of hard-won progress on the African continent.

In view of the foregoing situation and in order for the continent to safeguard growth and development, the following among others, remain crucial: HIV/AIDS interventions will need to be integrated into overall development strategies and programs. Poverty reduction strategies must be improved and intensified and countries need to explore innovative ways of maintaining and rebuilding capacity in government.

The issue of poverty has been said to be related to HIV/AIDS. In most the SSA countries, the failure of home grown economic reform programmes geared towards restoring economic vibrancy and underlying macro-economic fundamentals had been reported. This eventually has put the people under pressure and a lot of stress leading them to resort to myriads of survival strategies among which include high mobility in search of sustenance within the countries and the region such as looking for high paying jobs (which makes married people to keep two homes), itinerant trade across the border, multib^le partners survival strategies and transactional sex. Such strategies have led to high mean rates of sexual partner change as well as high mixing of partners across geographical areas; thus facilitating high transmission of HIV.

As a result of the above situation poverty reduction strategies are becoming the main development programming instruments in many African countries; determining national priorities as well as external resource allocation. This is the primary reason for integrating HIV/AIDS into poverty reduction strategies; thus ensuring that adequate resources are allocated to programmes aimed at reversing the epidemic and managing its impacts. Essential public services such as education, health, security, justice and institutions of democratic governance must be maintained and each sector has to take account of HIV/AIDS in its own development plans and introduce measures to sustain public sector capacity and functions.

Such actions might include fast-tract training, as well as the recruitment of key civil servants and the reallocation of budgets towards the most essential services concerned with the impact of HIV/AIDS on public sector institutions in Africa. Others include designing and implementing effective HIV/AIDS prevention and management programs. Best practices in prevention and management need to be documented and applied through knowledge and information sharing communities and networks.

As part of the effort to a better understanding of the HIV/AIDS situation in the public sector, the African Capacity Building Foundation (ACBF) and UNAIDS undertook to conduct field study on the impact of HIV/AIDS on public sector capacity in Sub Saharan Africa: Towards a Framework for Protection of Public Sector Capacity and Effective Response to Most Affected Countries. The findings and recommendations of the study would enhance the Foundation and other development institutions' knowledge on public sector capacity in HIV/AIDS affected countries and guide their intervention in this area in the face of the treat posed by the pandemic. To this end, a review of the impact of HIV/AIDS on public sector capacity was conducted in a sample of six Sub Saharan African countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe). The results and recommendations are presented in this Report.

II. STUDY OBJECTIVES

In order to enhance the African Capacity Building Foundation (ACBF) and other development institutions knowledge of the state of public sector capacity in HIV/AIDS-affected countries and guide their interventions in the strengthening of public sector capacity in the face of the enormous threat posed by the pandemic, ACBF, in collaboration with UNAIDS decided to conduct this study based on a sample of six Sub-Saharan African countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) with the objective of reviewing the impact of HIV/AIDS on public sector capacity.

The specific objectives were to :

- Assess the extent to which policy analysis and management capacity were affected in the public sectors in these countries and project a potential long-term impact of the pandemic on the sectors.
- Identify the competencies, specific skills and experiences which were most affected by the pandemic in the public sector.
- Provide a gender-based analysis of the lost competencies, skills and experiences in the public sector, and

- Review and assess the number, quality and adequacy of HIV/AIDS awareness, education, information sharing and learning programs in the public sector, especially in core policy institutions such as ministries of finance, planning, agriculture, health, education and central/reserve bank with a view to identifying and documenting best practices and replicable programmes as well as future strategies.

On the basis of the findings, the study was expected to recommend appropriate strategies, policies and programmes for:

- Protecting public sector capacity in the face of the pandemic;
- Stepping up information sharing and learning programmes within and across public sector ministries and agencies, including programmes for information exchange and sharing of experience, best practices and strategies;
- Effective short-term response programme by ACBF to most affected countries as well as medium to long-term strategic interventions in capacity needs of the public sector of such countries;
- Design and implementation of a knowledge retention programme for ministries and agencies in the public sector to minimize impact of lost skills and competencies, and
- Mainstreaming HIV/AIDS into training capacity building interventions.

III. SCOPE OF THE STUDY

The study reviewed the relevant country experiences and took a hard look at the following, among others:

- The timing and pattern of skills loss by the public sector ministries and institutions.
- The gender profile of lost competencies, skills and experiences.
- The capacity dimensions of workplace effect of the pandemic, especially morale, motivation and team spirit; staff health policy; and long-term human resource planning.
- The availability, adequacy and effectiveness of prevention, management, learning and information sharing programmes in the public sector ministries and institutions.
- Effective safety nets for public sector capacity and implementation strategies.

IV. EXPECTED OUTPUT

The study was expected to produce a Report on the basis of its assessments, observations and findings, and to draw conclusions and recommendations which were to provide insight into the impact of HIV/AIDS on public sector capacity and very importantly offer a constructive guide to the most effective framework and strategies for protecting public sector capacity in Sub-Saharan Africa in the face of the pandemic.

Specifically, it was to provide key recommendations on strategies and instruments for:

- Short medium and long-term responses to the impact of the pandemic on public sector capacity of most affected countries;
- Accelerated response to the capacity needs of countries that are worst affected;
- Enhanced programmes for workplace prevention, education and experience sharing;
- Systematic documentation of capacity loss, database development on lost competencies, skills and experiences; and
- Mainstreaming HIV/AIDS into training capacity building interventions.

V. METHODOLOGY

This comprised of an extensive review of studies so far conducted on the impact of HIV/AIDS on public sector capacity and prevention and management programmes that are being supported by the countries and the donor community, especially by donor agencies such as the World Bank, UNAIDS, DFID, WHO, UNICEF, ILO, among others. The study also involved field surveys; interviews and an analytical framework for data collection and impact analysis.

5.1 Sample and Study Design:

This is an evaluation study, designed to diagnose the impact of HIV/AIDS in public sector institutions in a sample of six Sub Saharan countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) selected by ACBF and UNAIDS. The study analysed the impact of HIV/AIDS on public sector capacity through the assessment of issues related to policy, management institutional costs as well as information, education and other types of HIV/AIDS programmes that have been implemented in relevant institutions. Three principles governed the sample design. First, the assessment of core public sector institutions across the countries was used to ensure homogeneity.

Secondly, the selected institutions were meant to show country variations in the ways that HIV/AIDS affect public sector institutions. Thirdly, the collected data on the impact of AIDS on public sector institutions was to add value as this aspect had received little attention in the past. All core public sector institutions in each of the countries were to be studied but many of them could not be reached due to time constraint and unwillingness to release data or grant interviews to the Consultants. The public sector ministries and institutions met by the mission are indicated in Table 1. The fieldwork was carried out between 2 and 28 August, 2003.

5.2 Methods of Data Collection

This study was to utilize quantitative methods of data collection. Quantitative and qualitative approaches were preferred in this study to enable the complementality of data that could provide better insight to the understanding and appreciation of the phenomenon under study, including the outcome of the various programmes that have been put in place in each of the countries. Four survey instruments of primary data and secondary data were to be used. These were:

- Institutional Questionnaire which profile information on HIV/AIDS policy and management issues, cost implications and lost skills, competencies and experiences and programs in each public sector institution;
- Document review/Interview Guide that assessed programme design, implementation process and sustainability;
- Group Discussion Guide that explored the staff and managers' perceptions of HIV/AIDS intervention programmes; and
- Questionnaires for the HIV/AIDS National Focal Points, NGO and Donor Institutions/Agencies which assessed their perception of HIV/AIDS programmes implementation by periodic pubic sector institutions with particular focus on the impact on public sector capacity and development.

5.3 Data Analysis

Themes and concepts were generated from Group Discussions. Completed questionnaires were to be sorted, coded and entered into the computer using the EPI-INFO statistical package 6.2 software. Appropriate data analysis was to be made and findings were to be summarized and presented in the form of tables, graphs and charts. However, apart from generating themes from Group Discussions, the collection, collation and analysis of completed Questionnaire have not been undertaken. At the time of revising the First Draft Report, the administered Questionnaires had not been received from ACBF; except for Mozambique and Zambia where only partially completed questionnaires were collected from one and three institutions, respectively.

5.4 Study Implementation Process

In order to achieve the objectives of the study, the Team proceeded as follows:

- Undertook a critical review of the studies and publications on the impact of HIV/AIDS on public sector capacity, prevention and management programmes, which were being supported in each of the six selected countries and by the international donor agencies.
- Developed a comprehensive set of questions, which served as the basis of discussions and interview with the various stakeholders (national focal points, key public sector ministries and institutions, donor agencies etc.) in each country with a view to addressing the specific objectives and the scope of the study spelt out in Section V of TOR. (see Table 1 for a summary of the various institutions with which the study team held interviews and meetings in each of the six countries).
- Conducted the study using the designed instruments which are indicated in Section 5.2
- Review meetings were held by the Study Team at the end of each working day to discuss the progress of the mission, adjusted the Programme if and where necessary; and mapped out the strategy for interviews and consultations for the next day.
- Held debriefing meetings with ACBF on the return of the Study Team to Harare to highlight the experiences of the Mission before the First Draft Report was prepared.

TABLE 1: Public Sector Ministries and Institutions Met by the Mission Team

COUNTRY	PUBLIC SECTOR INSTITUTIONS	UNITED NATIONS AGENCIES	OTHER INSTITUTION
LESOTHO	Ministries of Finance and Development Planning; and Lesotho Aids Programme Coordinating Authority (LAPCA)	United Nations Development Programme (UNDP)	Maloti Hospital
MALAWI	Ministries of Economic Planning and Development; Agriculture; Education; Health, Gender; and Ministry Responsible for HIV/AIDS Programmes; Resources Management; Office of 1st Vice-President; and National Aids Commission	United Nations – AIDS; and United Nations Development Programme (UNDP)	Centre for Disease Control
MOZAMBIQUE	Ministries of Education, Health, Planning and Finance, National Aids Commission	United Nations AIDS, UNDP (Economic and Policy Analysis Unit; and Poverty and HIV/AIDS Unit)	CETA (Confederation of Private Companies)
SWAZILAND	Ministries of Health and Social Welfare; Education; Public Service (Public Sector Management Programme), and National Emergency Response Council on HIV/AIDS (NERCHA)	United Nations Children's Fund (UNICEF)	Swaziland Royal Insurance Corporation (SRIC), Public Service Pension Fund, Federation of Swaziland Coalition Business Enterprises; Swaziland National Association of Teachers
ZAMBIA	Ministries of Health; Education, and Finance and National Planning	United Nations Development Programme (UNDP) - HIV/AIDS Adviser	NONE
ZIMBABWE	Ministries of Finance; Health; Industry and International Trade; Public Service Commission and Reserve Bank of Zimbabwe	United Nations AIDS; World Health Organisation (WHO) and United Nations Development Programme (UNDP)	African Capacity Building Foundation (ACBF); Zimbabwe AIDS Network

Source: Compiled by the Consultants from the Mission Programmes prepared by the Focal Point Persons in each of the six Countries.

5.5 Study Limitations

This Report is based exclusively on the information we obtained from the interviews/discussions that the team mission carried out during field work and the various the review of publications/documents collected from the six countries during the mission. This is because the comprehensive set of Institutional Questionnaires developed and distributed to the various public, sector ministries and institutions in the countries visited have not been completed and returned to the team for collation and analysis despite the promises to do so. Since the questionnaire required some time to complete as respondents needed to check and collate information from various records in their ministries the team mission had to leave them behind because only a few days was approved for the fieldwork in each country.

As at the time of writing this Report, the team mission received only one partially completed questionnaire from the Ministry of Gender and Social Coordination in Mozambique and three partially completed questionnaires from the Ministries of Education, Finance and National Planning; and the National AIDS Coordinating Committee in Zambia which are insufficient for content analysis. Furthermore, because of constraints of time, tit was not possible to interview staff from all the envisaged ministries and institutions in each country. However, information about a few ministries was occasionally obtained from other sources such as UNDP, WHO, or UNDAIDS offices.

VI. NATIONAL PROFILE AND RESPONSE

6.1 General Pattern of HIV/AIDS Prevalence

The magnitude and dimension of HIV/AIDS prevalence rates, AIDS patients and deaths among the adults, women and children in the six countries are presented in Tables 2, 3, 4 and 5. Data from Sentinel Surveillance and interview responses reveal that the six countries are in the epi-centre of the HIV/AIDS epidemic. From the review of the documents as of year 2000, three of the countries are the worst affected by HIV/AIDS with Zimbabwe topping the list with a national adult prevalence rate of 33.7% followed by Swaziland with 33.4% and Lesotho 31.0% during the same period (UNDP, 2000). These three countries have crossed the red line (30%) of HIV epidemic, implying that approximately one third of the adults (those aged between 15 and 49 years) are infected with the virus. These countries are followed by those in the very high category (>5to <30) with Zambia reporting 21.5%, prevalence, 15.0% in Malawi, and 13.0% in Mozambique, during the same period (see Table 2).

Table 2: Countries with more than 4% HIV Adult Prevalence Rates

COUNTRY	ADULT RATE (%)	ADULTS AND CHILDREN	ADULTS (15-49)	ORPHANS CULMULATIVE
LESOTHO	31.0	360,000	330,000	73,000
MALAWI	15.0	850,000	780,000	470,000
MOZAMBIQUE	13.0	1,100,000	1,000,000	420,000
SWAZILAND	33.4	170,000	150,000	35,000
ZAMBIA	21.5	1,200,000	1,000,000	570,000
ZIMBABWE	33.7	2,300,000	2,000,000	780,000

Source : UNDP, HIV/AIDS Statistical Fact Sheet, 2000

Interview responses however show slight variation in reported National prevalence compared with those reported by UNDP in year 2002. In Zimbabwe, the officials reported a 24.6% prevalence in year 2002, 36.8% in Swaziland, and 31% in Lesotho, 8.4% in Malawi, 14% in Mozambique and 20.2% in Malawi during the same period. Furthermore, in three countries, reported antenatal prevalence results of the sentinel survey in year 2002 was 38.6% in Malawi, 30.0% in Zimbabwe in year 2000 and 21.1% in Lesotho in year 2003.

Overall, the data obtained from interviews show a quantum leap in prevalence rates from the year when AIDS case was first reported by the government. National prevalence in Lesotho increased from 5.5% in 1991 to 25% in 1999 and 31% in 2002 while that of Swaziland jumped from 3.9% in 1992 to 16.1% in 1994 to 31.6% in 1999 and 36.8% in 2002. Similar trajectory jumps were recorded in Zambia from the first AID case report in 1994 to 19.95% in 1999. Furthermore, prevalence rates were higher in urban areas than in the rural. In Lesotho, urban areas had higher prevalence of 31% compared with 27.6% in the rural with about 330,000 adults living with HIV/AIDS in 2002. Similar, results were reported in 1994 in Zambia with peak 30% in the urban and 15% in the rural.

Further data from UNAIDS shows a strong positive relationship between HIV prevalence and poverty. In year 2002, Zimbabwe with a 33.7% adult (15-49 years) HIV prevalence has 40% of its population living below the national poverty line with a number two world HIV ranking. Furthermore, Lesotho with 31% prevalence has a stunning 86% of her population living below the poverty line with 40 Human poverty index value. Similar observations are noted in other countries (see Table 3).

Table 3 : HIV Prevalence and Poverty

World HIV Rank	Country	Adults (15-49) living with HIV/AIDS (%)	Adults and children living with HIV/AIDS	Women (15-49) living with HIV/AIDS	Human poverty index (HP1-1) value	Population below national poverty line (%)	PRSP country
4	LESOTHO	31.0	360 000	180 000	25.7	49.2	√
9	MALAWI	15.0	850 000	440 000	42.5	54	√
10	MOZAMBIQUE	13.0	1 100 000	630 000	47 9		√
3	SWAZILAND	33.4	170 000	89 000	25.7	49.2	√
6	ZAMBIA	21.5	1 200 000	590 000	40	86	√
2	ZIMBABWE	33.7	2 300 000	1 200 000		40	X

Source : UNAIDS (2002), UNDP Human Development Report 2002 ; World Bank Website.

The pattern of HIV/AIDS infection as provided by interviewees in Mozambique, Malawi and Zimbabwe is not different. The Mozambique data show 13% prevalence in the capital Maputo, and 6.9 in the rural north, while 2001 estimates by National AIDS Commission (NAC) indicate a national adult prevalence rate of 25% in urban areas and 13% in the rural, 13% were recorded in Malawi. In Zimbabwe, the urban prevalence is 2.5 times higher than that of rural areas. These estimates from the officials seem to agree with the figures provided by UNAIDS in 2002.

The number of people living with HIV/AIDS in each of the six countries is staggering and continues to rise. Data from the review of documents showed that as of 2002, Zimbabwe topped the list with 2,000,000 adults aged 15-49 infected representing 33.7% of the adult population. This was followed by Swaziland with 150,000 representing 33.4% of adults in the same age group. Zambia takes the third position with 1,000,000 indicating a 2.5% adult infection rate followed by Lesotho with 18.0% (330,000) (see Table 4). In all countries, HIV/AIDS infection rates reported by those interviewed to be highest among the 15-24 year old compared to other age groups. For example, Lesotho officials reported a staggering prevalence rate of 54.0%; followed by 24.6% in Zimbabwe, 16% in Mozambique and 16% in Malawi. Zambia and Swaziland did not provide any figures.

A striking gender difference is noted in all the countries with significant proportion of women infected with nearly 20% more infections. In Lesotho 180,000 of women aged 15-19 were infected compared with 150,000 men. In Mozambique the number of adult women infected (630,000) nearly doubles that of men (370,000) while in Zimbabwe adult women living with HIV/AIDS (1 200 000) was much higher than men of the same category (800,000).

TABLE 4: Estimated Adults Living with HIV/AIDS

Country	Men (aged 15-49)	Women (aged 15-49)	Total Adults (aged 15-49)	Percentage of total Adult population	Children (aged 0-14)	Total Adults and Children
LESOTHO	150 000	180 000	330 000	18.0	27 000	375 000
MALAWI	340 000	440 000	780 000	15.0	65 000	845 000
MOZAMBIQUE	370 000	630 000	4 000 000	13.0	80 000	1 080 000
SWAZILAND	61 000	89 000	150 000	33.4	14 000	164 000
ZAMBIA	410 000	590 000	1 000 000	21.5	150 000	1 150 000
ZIMBABWE	800 000	1 200 000	2 000 000	33.7	240 000	2 240 000
TOTAL	2 131 000	3 129 000	5 260 000		576 000	598 000
TOTAL ARFICA	**11 000 000**	**15 000 000**	**26 000 000**	**9.0**	**2 600 000**	**285 000**

Source : Avert Org. HIV/AIDS Statistics in Africa, 2002

Furthermore, similar gender differences are recorded among the youth in Malawi, infection among women between ages 15-24 range from 12 – 18% compared with 5-8% for men of the same age group. Similarly, in Zambia, a peak prevalence rate of 50% was estimated among women aged 20-29 years compared to 42% among urban men, while young men in 15-29 years age group had a much lower prevalence than of the same age (Fylkesnes, 1997). In Mozambique, nearly 57.0% Mozambican adults (15-24 years) living with HIV/AIDS are women; and with women aged 20-24 years out numbering men by four to one (IHE/MOH, 2001).

Similarly, 60% of all HIV infections in Zimbabwe are said to be women while females aged 15-19 years are five times more than males of the same age group who are HIV positive. All the above data show that women are disproportionately affected by HIV/AIDS. Further evidence from data indicate that HIV/AIDS prevalence is high among people affected by STIs, migrants and children in all the six countries. For example, HIV prevalence is reported to be 4% higher among female with Sexually Transmitted Infections (STI) compared to males, and 13% among female Tuberculosis patients in Swaziland.

(i) **Life Expectancy**

AIDS has a direct and immediate impact on life expectancies in the countries studied. Few available data sets suggest that life expectancy is falling in all these countries. According to the Lesotho Demographic Survey, life expectancy for men decreased to 48.7 years from 58.6 years in 1999 and for women 56.3 years from 60.2 years. In 1996, the proportion of children aged 0 to 14 years with both parents decreased by 0.7% but increased to 2% in 2001.

In Swaziland life expectancy at birth dropped from 58.8 years to 45.8 for males and 46.8 for females (Government of Swaziland 1999). Modeled projections indicate that life expectancy will decline to 31 years in 2006, compared to the expected of 63.2 years in 2006 (World Bank). Similarly in Mozambique, life expectancy rate is projected to decline from 43.5 in 1999 to 36.5 in 2010 when the prevalence rate would have reached 16.3%.

According to UNDP Reports, life expectancy has dropped in Zimbabwe from 53.4 in 1993 to 44.1 in 1999 and 43.5 in 1998. Similarly, the life expectancy of 48.6 in 1993 to 40.1 in 1997 and 40.5 in 1998 were reported in Zambia (UNDP 1996, 1999 and 2000 Reports). This decrease in life expectancies and its worsening situation in the future is significant especially for national development in these countries. Giving these findings, it is clear that HIV/AIDS has undermined development in all the six countries through erosion of the human resources base at a time when they are most needed.

(ii) Risk Factors for HIV/AIDS

A major risk for HIV/AIDS is unprotected sexual intercourse. This mode of transmissions is estimated to be responsible for more than 80% of all reported cases and the risk of seropositivity increases with the number of sexual partners. There was almost universal agreement among those interviewed that between 80-90% of HIV/AIDS infection in their countries was due to unprotected sex with multiple partners. This risk factor was reported to be exarbated by poverty which drove people to exchange sex for money, breakdown of family structure as a result of migration to urban areas in search of cash and services.

In respect to the public sector, majority of those interviewed pointed out that the major cause of HIV infection among public sector Ministry staff was the unprotected sexual intercourse. This was further buttressed by the study carried out by the Institute of Development Studies, University of Zimbabwe in 2002, which reported that nursing staff admitted that sexual activities were quite common in the medical fraternity; majority of which did not result in marriage. Cases of doctors having a "syndicate of nurse partners" were said to be common. This pattern of HIV/AIDS risk factor was reported to be common in all the countries among health workers.

Secondly, prostitution was also reported to be a major factor. Casualised sex is reported to be on the increase as a result of poverty and long absence of spouses (one or two) from home. Interview reports in all the countries studied also affirmed that nurses, teachers, doctors, army officers, agricultural officers are often deployed to locations without their spouses. This was sighted as one of the risk predisposing factors to HIV/AIDS. Moreover, epidemiologists, drivers and front line officers who go to the field on monitoring or for short time outside their official duty stations are said to have a cache of women and men friends with which they have sexual intercourse; majority of which are unprotected.

Thirdly, sexual network along the transport sector between females cross border and local traders and commercial truck drivers are said to be common in major most boarders and transportation nodes across most the countries. Thus most commercial truck drivers and local traders have sex with multiple partners from varying geographical locations.

The fourth factor is related to cultural beliefs that promoted fidelity for women but not for men. Of import are cultural beliefs that negate condom use in favour of natural non-protective vaginal sex. These are reported as facilitating the spread of HIV/AIDS.

Finally, interview responses from the ministry of health staff also implicated work place injuries among health staff who work in the clinics and hospitals as a factor. Such staff usually fail to put into practice the universal precautions to prevent the spread of HIV/AIDS in the work place, is also a contributing factor. Occupational exposure such as

percutaneous injury, contact of mucous membrane or skin with blood or other body fluids from infected persons who are being cared for are reported to be on the rise in the absence of protective materials.

(iii) AIDS Mortality

Unusual levels of deaths from HIV/AIDS alter population dynamics and the most direct demographic consequences of AIDS is increased mortality AIDS statistics (Table 5) shows the annual estimated deaths of adults and children in the six countries. Of importance is the death rates in thinly populated countries like Lesotho with 25,000 and Swaziland with 12,000 in a single year (see Table 5). Furthermore, there is also strong evidence that AIDS mortality has galloped in all the six countries. From the data provided by those interviewed, Lesotho data showed an astronomical increase of 16,000 AIDS deaths in 1999 to 25,000 in year 2001. As of 2003, annual deaths among those aged 15-19 years was 330,000 with an average of 70 deaths per day being reported. According to HIV/AIDS Care and Support (2001), in year 2000, 50% of the patients and 1 out of 4 outpatients had HIV/AIDS related conditions and the number of AIDS related deaths in that year increased from 16,000 to 25,000.

A stunning increase of 60,000 AIDS deaths in 2001 rose to 400,000 in 2003 in Mozambique and is projected to rise to 1.6 million in year 2010. Similarly, a 1999 cumulative total of 110,000 AIDS deaths in Zimbabwe rose to 200,000 in 2001. Furthermore, 70,000 AIDS deaths were recorded in Malawi in 1999, which jumped to 80,000 in 2001. A similar pattern of mortality of 7,100 in Swaziland in 1999 increased to 12,000 in 2001.

In Zambia, an overview of mortality in an Agricultural study revealed that staff mortality in six provinces and headquarters increased by more than 100% between 1990 and 1998, and was highest in 1995 (132%), 1993 (126%) and (22%) in 1992. This and other estimated annual AIDS-related deaths remain alarmingly high in these countries and indicate the very serious consequences of HIV/AIDS infections.

TABLE 5: Estimated AIDS Deaths Among Adults and Children

COUNTRY	ADULTS AND CHILDREN DEATHS (2001)
LESOTHO	25 000
MALAWI	80 000
MOZAMBIQUE	60 000
SWAZILAND	12 000
ZAMBIA	120 000
ZIMBABWE	200 000
TOTAL DEATHS	497 000

Source : AIDS Statistics : Deaths of Adults and Children in Africa, 2002

6.2 National Policies and Strategies

Political response is a determinant of the effectiveness of other responses to HIV/AIDS as they can exert great influence on resource allocation to HIV/AIDS Programmes. On the other hand, political attitudes influence socio-cultural response and are potent in influencing how societies react to threatening situations such as HIV/AIDS. It is apparent that the government in each country has recognized HIV/AIDS pandemic as a major national health problem and has responded through the formulation of national policies, strategies and programmes.

There is evidence of a high level of political commitment to HIV/AIDS in Swaziland, Mozambique and Malawi. According to the National Director of NERCHA, King Mswati III of Swaziland declared HIV/AIDS a national disaster in 1999. Similarly, in Lesotho in November 2001, His Majesty the King declared HIV/AIDS as a disease of national proportion deserving national priority status. In addition, the Prime Minister was reported to have insisted that a multi-sectoral effort is needed more than ever to fight the disease.

According to the UNAIDS Country Coordinator, Mozambique on the other hand endorsed the Declaration of Commitment on HIV/AIDS both at the national level and at the UN General Special Session on AIDS (UNGASS). In addition, there has been consistent reference by political leaders in Mozambique to HIV/AIDS threat. The President called the epidemic a national disaster in 1999.

In Malawi, the Executive Director of the National AIDS Commission and Deputy Director responsible for HIV/AIDS reported that, the Office of the President and Cabinet (OPC) was designated as the highest office for oversight of the national HIV/AIDS response. In April 2003, a new portfolio of a Minister of State in Charge of HIV/AIDS was created within the OPC.

During 1998/1999 period in Zimbabwe, there was noticeable improvement in political commitment as HIV/AIDS pandemic was acknowledged as a burgeoning socio-economic problem that has the potential of truncating the nations development. A number of high ranking political leaders have supported this initiative.

6.3 National Institutions and Programmes

The different types of national responses to HIV/AIDS including their mission and activities in the six countries as reported by those interviewed are indicated in Table 6. In an effort to respond to the epidemic, three countries Lesotho, Malawi and Zimbabwe (1999) have established National HIV/AIDS policies. In Lesotho, the government has given clear policy commitment to strengthening of all HIV/AIDS activities and sector – specific response strategies. Similarly in Zimbabwe, the government has instituted a legislation establishing the National AIDS Council. Moreover, the AIDS levy policy, the school health policy and guidelines on infant feeding as it relates to HIV have been legislated. In Malawi, HIV/AIDS policy documents exist that recognises the need to address HIV/AIDS as a cross cutting development issue. It is of importance that Malawi is the only country out of the six that has approved national gender policy, which provides guidelines on the fight against HIV/AIDS from the AIDS epidemic.

Some of the countries have put into place National Strategic frameworks. For example, it was reported that Lesotho, Mozambique and Zimbabwe have adopted multi-sectoral approaches through the establishment of relevant structures for a broad based participation including private, public, CBOs, religious institutions, media and international partners (see Table 6). Lesotho, Malawi and Swaziland set up in 2001 National AIDS/STDs Strategic Plan. The Lesotho AIDS Programme Coordinating Authority (LAPCA) in 2001, Swaziland National AIDS/STD Programme (SNAP) 1986, National AIDS Commission (Malawi); and the National AIDS Council (NAC) in Zimbabwe have been set up and charged with the responsibility of coordinating HIV/AIDS projects.

Furthermore, Zimbabwe has developed medium and short-term (1987-1988) and two medium term plans (1988-1993 and 1994-1998). One major legislative policy on discrimination against PLWHA in the workplace was operationalised into law in Mozambique. However, in Swaziland, a policy mandating all financial sectors to have an HIV/AIDS policy is yet to be launched. A substantial number of sectoral policies and guidelines have been formulated in support of national strategic plan but this vary from country to country.

TABLE 6: National HIV/AIDS Institutions/Programmes

Country	Name Of Institution/Programme	Year Of Establishment	Mission And Activities
LESOTHO	▪ Lesotho AIDS Programme Coordinating Authority (LAPCA) ▪ National AIDS Committee comprising of seven Ministers of Principal Ministries	March 2001 2001	▪ Coordinate and monitor HIV/AIDS Programmes. ▪ Mobilize Resources for the Programmes. ▪ Creation of Ten District AIDS Coordination Centres. ▪ Supervises the activities of the Lesotho AIDS Programme Coordinating Authority (LAPCA). ▪ Creation of HIV/AIDS Focal Points in Public Sector Ministries and Institutions.
MALAWI	▪ National AIDS Commission (NAC) ▪ Ministry Responsible for HIV/AIDS Programme	July 2001 2002	▪ Coordinate the National Response to HIV/AIDS epidemic ▪ Ensure mainstreaming of HIV/AIDS into all sectoral programmes ▪ Monitor the National Response to HIV/AIDS ▪ Assist in Capacity Building of Public Institutions ▪ Supervise the activities of the National AIDS Commission
MOZAMBIQUE	▪ National AIDS Council ▪ HIV/AIDS Focal Points in 22 Public Sectoral Plans in each Ministry ▪ Provincial HIV/AIDS Focal Points	2002 2002	▪ Coordinate and monitor the implementation of the National AIDS Control Programme ▪ Coordinate the National Response to HIV/AIDS involving all sectors ▪ Mobilizing of resources which are channeled to needy area in the Public Sector ▪ Promote the sensitization of HIV/AIDS among staff, the Ministries and Provinces
SWAZILAND	▪ National Emergency Response Council on HIV/AIDS (NERCHA) ▪ National Strategy Plan for HIV/AIDS	2002	▪ Coordinate and monitor the complementation of the National Strategic Plan for HIV/AIDS ▪ Provides support for prevention and counseling ▪ Created Technical Committee of Stakeholders
ZAMBIA	▪ National AIDS Council ▪ Ministerial Committees on HIV/AIDS		▪ Monitor and coordinate the HIV/AIDS Programme in each Public Sector Ministry ▪ Examine how to reduce the impact of HIV/AIDS in the work place
ZIMBABWE	▪ National AIDS Council/Commission ▪ Focal Points in Public Sector Ministries		▪ Coordinates and monitors the National Multi-Sectoral Response to HIV/AIDS ▪ Monitor the evolution of the HIV/AIDS situation in each Ministry.

6.4 National HIV/AIDS Programmes

In summary, the analysis of interview responses show the national bedrock strategy of the national response are in the areas of advocacy (Malawi), awareness raising to educate the public on dangers of HIV/AIDS and the need to protect self and other people through IEC (Malawi, Lesotho, Zimbabwe, Mozambique) and Condom Promotion (Malawi, Mozambique). Furthermore, the following national programmes were reported: Pursuit of Safe Blood Supply (Zimbabwe, Malawi), Voluntary Counselling and Treatment (Malawi, Mozambique, Zimbabwe), Prevention of Mother-to-Child Transmission, (Malawi), Universal Screening of Blood for HIV before transfusion (Zimbabwe, Malawi, Zambia), Care Initiatives for PLWHA (Zimbabwe, Mozambique).

Others examples of national response to HIV/AIDS include the introduction of ARV treatment (Zimbabwe, Lesotho), Epidemiological Surveillance (Zimbabwe, Malawi), Home Based Care (Mozambique) and Treatment of STIs (Mozambique). The Government of Lesotho has also implemented intervention programmes targeted at in and out of school youths, women in the workplace and people living with HIV/AIDS. One major finding is that it is only Mozambique that has established a web-based information system to track HIV/AIDS intervention. It is obvious from above findings that Malawi and Zimbabwe have implemented the majority of sector wide and preventive programmes compared to other countries.

Furthermore, despite the limited resources in most countries, it was reported that churches and women's groups were also making efforts to curb HIV/AIDS by providing assistance to the needy. This assistance was being provided through the following programmes :

- Behaviour Change Programme : The purpose of this programmes is to create a universal awareness through voluntary counseling and testing. It was reported that although studies show that 98% of the population is aware of HIV/AIDS, however, increased awareness has not led to significant behaviour change in these countries.

- Children and Youth Programme : This is a programme initiated to identify sustainable, replicable community programmes to assist orphans and children affected by AIDS, and to increase economic opportunities for youths affected by AIDS.

- Condom Promotion Programme : This programme is to broaden the role of community-based distributors of condoms. Distribute, sell and encourage the use of condom and build a sustainable supply of condoms.

An example of a well organized faith based programme is the "Treasuring the Gift" established in Zambia in 1998, which brought together various religious denominations with the aim of developing learning materials for education in reproduction health, sexuality, HIV/AIDS and other sexually transmitted diseases. The project's strengths lie in its focus on the youth of all denominations, using peer education and participatory learning and action techniques. The outcome is a 142 – page book entitled "Treasuring the Gift: How to handle God's Gift of Sex" that contains 18 participatory learning and well illustrated activities, easy to use for replication by youth groups. The participatory approach increases the confidence and experience of those using the book and the activities

are designed to encourage honest discussion about the realities of sexual behaviour among young people. It allows the youths to practice the skills they need to avoid emotional hurt, unplanned pregnancy or infection with HIV/AIDS or STDs. Furthermore, it was observed in Swaziland and Lesotho that a sizable number of staff offered collective team prayers in the morning although; this opportunity has not been maximized for public staff HIV/AIDS programmes.

Furthermore, interview responses revealed the existence of National Pension and Insurance Funds in only Swaziland and Zimbabwe. It was found that the Swaziland Insurance Corporation provides retirement benefits for all government employees through the Pension Scheme of the Corporation which has a defined benefit plan. All employees contribute 7% of their pensionable emoluments with the balance of the required contribution rate (as advised by an actuary), contributed by the Corporation. However, interview responses indicate that civil servants pay 5% of the premium of from their salaries 15% is borne by the government. The Pension Scheme is funded and is actuarially valued every three years using the project unit credit method The pension funds provides defined benefits to members but is currently under funded as it is only able to cover 42% of its current liabilities (SRIC, Annual Report, 2000).

In Zimbabwe, it was reported that the National Pension and Insurance Funds also provide savings for people which are put together to provide for those in need such as those affected by HIV/AIDS. Interview responses indicated that the national fund is running into financial glut. It was reported that the basis for the insurance and pension provision in Zimbabwe is under strain because of the high mortality of those staff affected by HIV/AIDS and that this mortality is strongest in an age group (18-45 years) that was expected to continue making contributions to the pension fund without making claims in order to maintain reasonable level of surplus funds which could be invested.

The AIDS situation in Swaziland seems to excercabate this situation as more withdrawals from the Scheme have been recorded. For example, while the sum of 9,736.69 Lithange for one(1) death tuberculosis (an HIV opportunistic condition) wasreportedly paid for in the third quarter of 1999, payments for the same disease increased to two(2) in the following quarter of 1999, seven(7) in the first quarter of 2000, and nineteen(19) in the third quarter of 2001. Similarly, payments for unknown causes of death which may be related to HIV increased from five(5) in the third quarter of 1999 to twelve(12) in the third quarter of year 2001 and to thirty-one in the second quarter of year 2003.

Furthermore, interview responses in Swaziland also confirmed that more and more young people (those aged 20 to 30 years) being infected by HIV/AIDS are leaving government service thereby depleting the pension funds. Such people usually leave young orphans who draw on the pension fund until they are 21 years. In light of heavy payments from the Pension Funds to those who die from HIV/AIDS, it was proposed that a two to four percent increase in contributions from the civil servants be added to absorb the impact of the epidemic on the fund and as a way of shifting the burden of the fund's current problems of HIV/AIDS away from the government. Overall, evidences from these two countries underscore the problems that the National Pension and Insurance Funds are going through as a result of the increasing HIV/AIDS mortality.

6.5 Public Sector HIV/AIDS Policies and Programmes

Faced with the disaster being caused by the high HIV/AIDS prevalence rate, the challenges facing the public sector ministries and institutions in the six countries is how to reverse the bias against capacity cheeping. In other words, what kind of response could decrease pressure on the diminishing supply of highly skilled and experienced staff and professionals (Cohen, 2003). In the case of the six study countries, the nature of the public sector policies and programmes is summarised in Tables 7, 8, 9 and 10.

Table 7: Public Sector HIV/AIDS Policies and Programmes

COUNTRY	MINISTRY/ INSTITUTION	TYPES OF POLICIES/PROGRAMMES
LESOTHO	• Health • Education	• VCT – Voluntary counseling and testing were undertaken in the Lesotho Hospital for public sector ministries. - HIV/AIDS activities are mainstreamed. - HIV/AIDS Focal Point Unit has been established in the Ministry. • HIV/AIDS had been incorporated into the curricula by the Ministry - Workshops were conducted to educate teachers. - Life skills were used and young girls trained to say not to premarital sex.
MALAWI	• Education • Agriculture • Police Service	• No formal policy on HIV/AIDS but schools had Anti-Aids club supported by UNICEF-UNAIDS. - Had a comprehensive HIV/AIDS programme initiated with the support of UNAIDS-MALAWI. - Programme had tow components. • Rural AIDS project and HIV/AIDS work place intervention. - Task force on HIV/AIDS chaired by the principal secretary responsible for Administration and Finance. • Ongoing HIV/AIDS programme with objectives to : - Raise awareness among police officers, their spouses and children on HIV/AIDS. - Break the silence related to HIV/AIDS so that people could share experiences, ideas and knowledge on HIV/AIDS . - Bring behavioural change sexuality in the police community and in schools
MOZAMBIQUE	• Planning and Finance • Education • Gender and Coordination of Social Action	• HIV/AIDS committee had been created. - Establishment of Focal Point of HIV/AIDS at provincial levels. - Sectoral policies have been initiated. • Developed and were implementing programs to equip young people in and out of school with information and life skills to protect themselves and facilitate their access to youth friendly health services. • Finalised strategies for the care and protection of children made vulnerable by HIV/AIDS and implementation was under way in collaboration with NGO's and grass root organisation.
SWAZILAND	• NERCHA • Education	• Focal Point persons from public sector ministries were working closely with NERCHA - Consultants were being recruited to develop HIV/AIDS policies to each public sector Ministry. • Education Sector had no real programme on HIV/AIDS

	• Agriculture, Food and Fisheries (MAFF)	but education sector committee on HIV/AIDS had been created in the Ministry to tackle the problem at the level of students and teachers. - Schools have Anti-Aids clubs supported by UNICEF AND UNAIDS. • No Government conceived and managed programme on HIV/AIDS in the Ministry. - UNDP supported SFSDP (Small Holder Farm Systems Diversification). - World Bank.
ZAMBIA	• Education • Finance and National Planning (MFNP)	• The Ministry of Education elaborated an HIV/AIDS strategic plan (2001-2005) with a clear vision, goals and objectives, as well as programmes to respond to the AIDS pandemic. - The Basic Education Sub-Sector Investment Programme (BESSIP) was initiated in 1999 and has elaborated an HIV/AIDS Education Programme covering the period 2001-2006. - Introduction of Free Education Policy. - School Health and Nutrition Programme. Workplace Programme : Health and Social Welfare Technical Committee. o The Ministry of Finance and National Planning, Health and Social Welfare Technical Committee (HSWTC) has the following specific objectives : • to keep MOFNP staff healthy by way of minimizing the spread and consequences of preventable diseases such as HIV/AIDS and related illnesses; and • to provide moral, spiritual and material support to ailing employees without segregation.
ZIMBABWE	• National AIDS Council • USAID, WHO, UNICEF	• Introduction of AIDS levy policy to finance - Behaviour change programmes - Children and youth programmes - Condom programmes. - • Provision of financial and material support to - voluntary council testing services programme - policy and advocacy programme.

Governments have reacted differently in respect to policies on HIV/AIDS for public sector institutions. Only three countries, Mozambique, Zambia and Malawi have specific public sector policies on HIV/AIDS in place. These polices cover all the ministries in Zambia and Malawi but in Mozambique the Ministries of Higher Education, Health and Fishery have separate AIDS policies put in place. In Lesotho, public sector policy is still in a draft form, while no such policies were found in Zimbabwe and Swaziland.

In Zambia, the government reacted to the ravaging incidence of the HIV/AIDS pandemic by setting up the National AIDS Committee. Other Public Sector Institutions such as the Ministries of Education and Finance and National Planning, have initiated policies and set up cross-cutting programmes which provide horizontal and vertical linkages across all their Departments to raise awareness, and provide moral and material support to their ailing staff

member. The Ministry of Agriculture, Food and Fisheries needs to budget and organise its HIV/AIDS programmes.

The Government of Zimbabwe has increased its efforts to reduce spread of HIV/AIDS, as demonstrated by Policy and Advocacy Programme in which the country is working to strengthen the development and implementation of positive HIV/AIDS related policies in the public sector.

In respect to public sector programmes put in place or being initiated in the six countries, it can be observed from Table 7 that these range from Voluntarily Counselling and Testing (VCT), to mainstreaming HIV/AIDS into public sector development programmes, creation of HIV/AIDS Focal Units, peer education, life-skills, work place programmes to organisation of workshops to educate staff, raise awareness, among policy-makers, share information and break silence related to AIDS in order to change the behaviour of staff.

Table 7 also shows that ministries have reacted differently to planning and implementation of HIV/AIDS programmes for their staff where HIV/AIDS public policies are in existence. In Mozambique, Lesotho and Zambia, each Ministry has an HIV/AIDS focal person who is charged with the responsibility of coordinating the AIDS programme for the staff in their ministries while the National HIV/AIDS Commissions/Committees provide resources to support their activities.

In Mozambique and Malawi, the Ministry of Education was found to be the most active in mutting in place HIV/AIDS programmes. In both countries, the Ministry has developed training packages for school children, on positive living which are being incorporated into the educational curriculum. Both countries have also initiated the process of implementing Behavioural Change Communication (BCC) for all teachers and the management staff. In both countries, the ministries of education have conducted training workshops for the teachers on HIV/AIDS. In the absence of any public sector policy, the Ministry of Education in Swaziland has managed to conduct life skills education for students. Of strong note, is that the Swaziland Association of Teachers has conducted TOT for 33 teachers from different schools covering 15 branches and 4 regions.

In Zambia it was apparent that the Ministry of Finance and National Planning is pro active in implementing HIV/AIDS prevention programmes. For example, the Ministry has placed Television (TV) Monitors at strategic corners, corridors and rooms which help many staff to gain access to HIV/AIDS information at every time during the work period. Furthermore, the opportunity exists for staff members to borrow HIV/AIDS videotapes, through members of the Technical Committee on HIV/AIDS, for viewing at home. In addition, condoms are placed in all toilets while T-shirts with key HIV/AIDS messages have been developed. The Ministry has also established a Health and Social Welfare Technical Committee to monitor the incidence and prevalence of HIV/AIDS/STDs among its staff. However, the Ministry of Finance in Swaziland has only been able to conduct studies on HIV/AIDS impact in 1999.

It was also evident from the information provided from all the countries studied that the Ministry of Health is spearheading the implementation of programmes in biomedical interventions including VCT, clinical care surveillance, prevention of mother to child transmission have based care and other initiatives.

However, the Ministry of Health has not done much for its staff in three countries (Mozambique, Zambia and Malawi) in respect to HIV/AIDS programme implementation. It appears that the efforts of the Ministry are largely directed to the coordination/implementation of national level programmes. Interview responses show that there is hardly any HIV/AIDS workplace programme targeted to the staff except one or two 1-day seminar. Yet it is evident that the Ministry of Health in all the six countries are losing substantial members of their staff to HIV/AIDS. Of note is that the police service (Ministry of Defense) had implemented an HIV/AIDS awareness programme with support from UNAIDS.

Furthermore, it was observed that many and varied training and capacity building programmes were either already in place or were being initiated to replace those members who had died from HIV/AIDS in the countries studied. The nature of these programmes reported to the mission is presented in Table 8.

The mission further observed that although ther were a variety of public sector HIV/AIDS programmes, it can be observed from Table 9 that there was no deliberate attempt to mainstream them into public sector development programmes, except in the case of Lesotho where HIV/AIDS has been incorporated into the Curriculum of the Ministry of Education and Zambia where the HIV/AIDS Education programme is a component of the Basic Education Sub-Sector Investment Programme.

Table 8: Training and Capacity Building Programmes for Staff Replenishment

Country	Capacity Building Programmes
LESOTHO	• Capacity building is undertaken in the Lesotho Institute of Public Administration and Management (LIPAM) which is under the Ministry of Public Services.
MALAWI	• Crash programme have been initiated by the key ministries; Agriculture, Education and Health to meet the gap created by the staff who have died due to HIV/AIDS or have resigned due to HIV/AIDS related illness. - Proposals had been developed to put in place a capacity building fund to assist the Government to train staff in those areas where there are critical shortages. - Short-term measures to use the United Nations Volunteers (UNV) to train the staff who can fill the gap created by dead or sick staff.
MOZAMBIQUE	• Formal training programmes for nurses, teachers have been initiated and the new curricula has a component to HIV/AIDS. - Open discussion of HIV/AIDS problem among staff. - Condom distribution among staff in public sector ministries. - Manuals of HIV/AIDS have been introduced at the primary school level e.g A booklet called "positive living". - Capacity needed to plan and integrate HIV/AIDS into sectoral development programmes. - Need for technical personnel (Economic Analyst, Policy analyst, Budget Analyst).
SWAZILAND	No Programmes in place.
ZAMBIA	- Teacher Developments, Deployment and Compensation, Component of Basic Education Sub-Sector Investment Programme (BESSIP) - National 10 – Year Human Resource Plan for the Public Health Sector (1st Edition) (National Human Resource Plan for Health).
ZIMBABWE	No Programmes in place.

Source : Compiled from the Field Interview and HIV/AIDS Policy Documents

Table 9: Mainstreaming HIV/AIDS into Public Sector Development Programmes

Country	Ministry/Institution	Public Sector HIV/AIDS Programmes
LESOTHO	• Finance Planning and Development • Education	• 2% of the budget of each Ministry is allocated to support HIV/AIDS programmes. - HIV/AIDS units had been established in each ministry. • HIV/AIDS incorporated into the curricula by the Ministry of Education. - Workshops conducted to educate teachers and students on HIV/AIDS.
MALAWI	• Agriculture	- Creation of an HIV/AIDS Association at the work place to mobilise resources to support staff living with HIV/AIDS. - Human resource units in the ministry are being encouraged to provide welfare services and support to the staff affected by HIV/AIDS. - The possibility of providing Anti-Retroviral of Drugs (ARV) to workers should be explored by the government. - Each sector should develop an HIV/AIDS work place policy which is specific to its work environment and operations.
MOZAMBIQUE	• Finance, Education, Health, Women and Social Coordination	- Sectoral plans for HIV/AIDS is established in each ministry for promoting the sensitisation of the pandemic within the staff of the public sector ministries. - In the educational sector, teachers and students are trained to be aware of AIDS and it is now part of the school curriculum. - VCT is being emphasised by ministries e.g Ministry of Planning and Finance. - Health Ministry is building capacity to ensure security in blood safety.
SWAZILAND	• Defence • Institute of Management for Public Administration	- Condom distribution programme has been initiated for all public sector ministries. - Ministries of Defence and Correctional Services have put in place HIV/AIDS programme - Programme development on training of trainers by the Institute of Management for Pubic Administration.
ZAMBIA	• Ministry of Education (MOE) • Ministry of Finance and National Planning (MFNP)	- The HIV/AIDS Education Programme is a component of the Basic Education Sub-Sector Investment Programme (BESSIP). - The activities of the HIV/AIDS Education Programme have been integrated into the other components of BESSIP, (as cross-cutting linkages) such as in the production of Education materials, Curriculum Development, Teacher Development, Deployment and Compensation, School Health, and Nutrition and Equity and Genders as well as Monitoring. - Integrating HIV/AIDS education in the school curriculum . - Appointment of HIV/AIDS focal persons throughout the system. - Staff attrition, mostly due to HIV/AIDS is considered in the National 10 – year Human Resource Plan for the Public Health Sector.
ZIMBABWE	• Ministries of Finance, Health, Industry and International Trade, Reserve Bank.	- No HIV/AIDS Progammes have been initiated as yet by these institutions.

In respect to qualify and adequacy of HIV/AIDS awareness, education and information sharing and e-learning programmes, overall, the number, quality and adequacy of HIV/AIDS awareness, education, information sharing and learning programmes the public sector ministries and institutions in all the six countries is extremely poor.

It can be observed from Table 10 that only very few programmes for enhancing information sharing, education, awareness and learning have been initiated by a number of key public sector ministries and institutions in all the six study countries. While some of these programmes are well targeted, it was revealed to the mission that they are not gender sensitive and most have not had positive impact on the behaviour of the population particularly in countries like Mozambique, Lesotho, and Malawi where the HIV/AIDS epidemic remain relatively high. It was also clear to the mission that none of the ministries in all countries have e-learning programmes on HIV/AIDS for their staff.

This can be explained by the absence of skills in conducting behavioural and antecedent studies on HIV/AIDS among public sector staff and using the information derived to plan and implement strategic information sharing, education, awareness and learning programmes.

Table 10: Programmes for Enhancing Information Sharing and Learning

Country	Ministry/Institution	Type of Programmes
LESOTHO	- Education	- Workshops to be conducted to educate teachers and students. - Free education to be provided to all children due to the high level of poverty which has promoted prostitution and crime. - Peer Education. Youth be initiated to educate themselves on the pandemic. - Awareness Creation to Use of local language to create Awareness through the Media.
MALAWI	- Health, Education, Planning/Development - Department of Human Resources Management and Development	- Door to door counselling on HIV/AIDS b intensities. - Mainstreaming of HIV/AIDS into the curriculum be started. - HIV/AIDS should be at the centre of management. - There is need to have an HIV/AIDS focal point in each ministry for integrating HIV/AIDS into their programme. - There's need to assess the performance of executives on how well they integrate HIV/AIDS into programmes. - Computerised formation management system should be introduced throughout the public service.
MOZAMBIQUE	• Education • Health	• Internal organisation in the Ministry of Education be carried out to improve communication strategy to enhance the transmission of message on HIV/AIDS should be teachers and students. - Information on HIV/AIDS is now part of the school curricula available to students. - Development of extra curricula activities using different sensitisation methods to create awareness among teachers and students be intensified. • Creation of focal points in the public sector ministries to continue. - Sectoral plans for HIV/AIDS be established in each public sector ministry for promotion of the sensitisation of HIV/AIDS within the staff of public ministry.
SWAZILAND	• Health	• Awareness campaign launched in the entire country – "AIDS is everybody's problem in Swaziland", be continued.

	• Education	• Rehabilitation – of medical bases in the entire country. • Critical activities like socialisation of children programmes, food intervention and economic power be intensified through education and training.
ZAMBIA	- Ministry of Finance and Economic Development (MFED)	- Work Place Programme run by the Health and Social Welfare Technical Committee (HSWTC), be enhanced. - Basic Education Sub-Sector Investment Programme (BESSIP) with its component (HIV/AIDS Education) (HIV/AIDS Programme) be intensified. - HIV/AIDS Educational Programmes be initiated. - Social, Health and Nutrition (SHN) Programme expanded be intensified
ZIMBABWE	Finance, Health, Industry and International Trade.	- Exchange visits programmes - Grassroot recommendations should be taken into consideration when drawing up national policies and programmes for HIV/AIDS. - Communication/drama skills programmes to be developed and enhanced.

With respect to capacity and training building programmes, it can be observed from Table 11, that considerable effort had been made in most of the six study countries to put in place some kind of short-term programmes. These range from the regular capacity and training programme undertaken by the Lesotho Institute of Public Administration and Management, to crash training programmes initiated by the Ministries of Agriculture, Education, Health and Gender in Malawi; and the training of teachers, students, medical doctors and production of training Manuals on HIV/AIDS Programmes in Mozambique.

In Zambia, the public sector ministries and institutions are reacting by elaborating plans to replenish their human resources and provide capacity building programmes. For example, the Basic Education Sub-Sector Investment Programme (BESSIP) of the Ministry of Education has a component on HIV/AIDS Education that has cross-cutting linkages with the other components of the programme. In the same vein, the Ministry of Health has elaborated a human resource development plan for 10 years that considers attrition rates due to HIV/AIDS pandemic.

In Zimbabwe, HIV/AIDS presents a serious threat especially as the public sector institutions still lack internal capacity building programmes to replace the middle and junior level staff who are dying. Information from the Ministries of Health and Education revealed that there is also inadequate human resources capacity to respond to the AIDS crisis due to the brain drain. The Ministry of Finance has created a focal Unit to identify the skill deficits but no programmes have been developed to mobilize the required human resources needed to replenish the lost skills.

Table 11 : Human Resource Planning and Capacity Building Programmes

COUNTRY	MINISTRIES/ INSTITUTION	TYPE OF HUMAN RESOURCE PLANNING	TYPE OF CAPACITY BUILDING AND TRAINING PROGRAMME
LESOTHO	- Development and Planning - Education	- Not yet in place	- Capacity building is undertaken by the Lesotho Institute of Public Administration and Management (I.PAM)
MALAWI	• Department of Human Resource Management and Development (DHRMD) - Gender and Social Welfare	- The existence of a Department of Human Resources Management and Development (DHRMD) - It coordinates public sector response to the HIV/AIDS epidemic - Ensured that HIV/AIDS issues are mainstrained in all human resource management	- Crash programmes had been indicated by the key ministries, Agriculture, Education, Health to meet the gap created by staff who have died or have resigned due to HIV/AIDS - Proposals has been developed to put in place a capacity building fund - Courses provided for 18 months to go to the field to mount education and information sharing programmes
MOZAMBIQUE	• Education • Health • Women and Social Affairs	• Not yet in place • Not yet in place • Issue not really addressed but process is on board to fund the long term planning of resource needs	- Teachers and students trained to be aware of HIV/AIDS called "positive living" - Building capacity to insure security in blood safety - Training of medical doctors
SWAZILAND	• Health • Education	• No programme for Human resource planning • Not yet in place	• None existent but there is need to put in place training programmes for much skilling • Education sector committee on HIV/AIDS created in the Ministry to tackle problems at the level of teachers and students
ZAMBIA	• Ministry of Education (MOE) • Ministry of Health	• Basic Education Sub-Sector Investment Programme (BESSIP) that has a strong component on HIV/AIDS • The Ministry of Health has elaborated a human resources plan for the Health Sector that takes into consideration the incidence of HIV/AIDS on	• HIV/AIDS Education • Teacher Development, Deployment and Compensation Capacity Building and Decentralisation.

		the personnel of that sector, and is entitled the NATIONAL TENYEAR HUMAN RESOURCE PLAN FOR THE PUBLIC HEALTH SECTOR (1st Ed; January 2001).	
ZIMBABWE	• Finance • Health industry and International Trade PSC and Reserve Bank	• Created a Unit to identify skill deficits but no programmes have been developed • Lack of internal capacity Building • Inadequate Human resources	• NONE • NONE

Source : Compiled from the Field Interviews and Policy Documents on HIV/AIDS

While acknowledging the myriads of national and public HIV/AIDS interventions programmes in each of the countries studied which are important for HIV/AIDS control, a number of weaknesses were observed in respect to planning framework and coordination.

First, it was apparent that although the National AIDS Commissions/Committees in different countries have been coordinating HIV/AIDS preventive control and control efforts over the years, however, their efforts are proving inadequate at the maturation stage of the AIDS epidemic in these countries thereby calling for a strong and sustainable multi-sectoral response and co-ordination. Second, it was noted that the HIV/AIDS programmes is not core-streamed into the ministries plans and programmes in most countries. Third, most intervention programmes have not mainstreamed gender into its planning and implementation framework. It was noted by the team that the HIV/AIDS programmes actively implemented in a few ministries such as the Ministry of Education in Mozambique and Malawi, and the Ministry of Finance and National Planning in Zambia are not gender-sensitive.

A fourth observation is that there seems to be lack of effective coordination of these programmes in all the countries as different stakeholders are vertically planning or implementing HIV/AIDS programmes. Finally, it was also evident that faith-based organizations have not been well entrenched in the HIV/AIDS programmes as true partners in progress except in Zambia. For example, it was observed in Swaziland and Lesotho that a sizable number of ministry staff offered collective team prayers in the morning. This opportunity has not been maximized for staff HIV/AIDS programmes in the ministries.

6.6 National Funding of HIV/AIDS Programmes

The funding of HIV/AIDS programmes in all the six study countries has come from local and external donors. It can be observed from Table 12 that, some of the countries have been making some effort to support the HIV/AIDS Programmes by allocating 2% of their Annual Budget, like in Lesotho and Malawi or providing funds to the key public sector ministries like Ministry of Health in Mozambique and the National Emergency Response Council on HIV/AIDS in Swaziland.

Furthermore, it can be observed from Table 12 that the financing of HIV/AIDS programmes in Zambia is mostly carried out by external donors, notably the United Nations Development Programme (UNDP), the United States Agency for International Development (USAID), UNICEF, Japan Counterpart Value Fund (JCVF), and Finland, the World Bank, Global Fund, CIDA, etc. The Government of Zambia has marginally been implicated in the financing programmes and its contribution was budgeted for the fiscal year 2002-2004 for the Work Place Programme of the Ministry of Finance and National Planning.

Funding for national HIV/AIDS programme involved budgetary allocations by the government and funds from donor institutions. Responses from interviews showed that it is only in Mozambique, Lesotho and Zimbabwe that the government provides large amount money for HIV/AIDS programmes. In Mozambique, an increase in resources committed by the government was put at $15,000,000 for HIV/AIDS Programmes over three years. This fund is managed by the AIDS Fund which is an institution with administrative, financial and patrimonial authority and supervised by the Ministry of Planning and Finance.

Furthermore, the Zimbabwe government has instituted the AIDS Levy in which 3% of taxable income is pooled. This has led to a collection Z$793,903,645.55 in 2000, Z$1,249,420, Z$280.09 in 2001, Z$2,835,887,308.72 in year 2002 and Z$3,235,143,417.93 in 2003 totaling ZM$8,114,354,652.31 in a period of four years. In Lesotho, government was able to ensure budgetary allocation of 2% to all HIV/AIDS Programmes.

The dominance of donor funds clearly characterize the national response to HIV/AIDS especially in the areas of prevention and mitigation. For example, in 2003, Malawi signed an agreement with the Global Fund for the allocation of US$196 million for HIV/AIDS over the next 5 years to address key areas of VCT, PMTCT, CHBC, ARV therapy and management and strengthening of institutional support. The country is also in the final stages of obtaining US$35 million over the next four years through the World Bank Multi-country AIDS Programme.

Similarly, Malawi has signed an agreement with the Global Fund for the allocation of US$196 million over the next five years to address key areas of VCT, PMTCT, CHBC, ARV therepy and institutional support. Moreover, the country is also at final stages of discussion with the World Bank for approval of an allocation of US$ 35 million over the next four years through the Banks multi-country programme.

In Zimbabwe, most of the national HIV/AIDS programme activities that were spearheaded and co-ordinated by NACP and those of various NGOs have relied heavily on multilateral and bilateral donors, like the UNAIDS, WHO and World Bank. Furthermore, in Mozambique UNDP has pledged the sum of US$3,490,000 for the national implementation of HIV/AIDS programme from 200262006. Similar reports were obtained in Swaziland but limited funding assistance was noticed in Lesotho, except for the considerable technical support being provided by UNDP and UNAIDS.

Table12: National Funding of HIV/AIDS Programmes

COUNTRY	MINISTRY/INSTITUTION	LOCAL FINDING	EXTERNAL FINANCING	OTHR SOURCES OF FINDINGS
LESOTHO	- Finance, Planning and Development	- Each ministry allocated 2% of its budget for HIV/AIDS programmes.	- USAID - Ireland AID - UNFPA - CTZ	NONE
MALAWI	- Education, Health, Agriculture, Planning and Development	- 2% of the Budget of each ministry was allocated for HIV/AIDS programmes. - Government provides 5% of the total budget for NAC.	- World bank, CIDA Global Fund, NORADDFID - $10 million USD made available each year to the National Aids Commission.	NONE
MOZAMBIQUE	Health	- Government Aid, - $8000 to S of 11 provinces - $20 000 to Central Health Services	- External and internal fundings amount to 20 million US Dollars.	NONE
SWAZILAND	National Emergency Response Council to HIV/AIDS (NERCHA)	- NERCHA is funded by the Government and by grants to HIV/AIDS emergency fund by multi-lateral donors.	- Global Fund - European Union and Italy.	NONE
ZAMBIA	Ministry of Agriculture, Food and Fisheries (MAFF)	NONE	- UNDP Programme on HIV/AIDS (1998-2001) ($250 000) - World Bank (2 000) ($100 000)	NONE
	Ministry of Education (MOE) (Through the HIV/AIDS Education Programme – Budget)	NONE	- Finland through Education Sector Support Programme (ESSP) (378 000 USD) (2000 budget) - Japan Counterpart Value Fund (JCVF) (1 343 300 USD) - UNICEF (1 000 000 USD) - USAID (145 000 USD) (TOTAL 4 744 900	NONE

			USD)	
	Ministry of Finance and National Planning (HIV/AIDS Work Place Programme 2002-2004)	- Government of Zambia (million Kwacha) 2002 : 162.9 2003 : 109.2 2004 : 109.2	- The World Bank (million Kwacha) 2002 : 583.1 2003 : 76.3 2004 : 136.3	NONE
ZIMBABWE	Government of Zimbabwe UNAID, WHO, UNICEF	. Aids levy of 3% of taxable income of individuals.	. UNAIDS, WHO and UNICEF offer financial and material support.	NONE

Source : Compiled from Field Interviews and Policy Documentation on HIV/AIDS

In the past years, HIV/AIDS programmes in Zimbabwe have been funded from both internal and external sources of finance. Internal funding has been through the creation of National AIDS Council (NAC) and the introduction of an AIDS Levy. About 30% of the budget for HIV/AIDS programmes for 2000 came from the AIDS Trust Fund based on 3% of taxable income of individual. NAC recently provided Z$2 billion (US $600 000) from the AIDS Levy Fund to the Ministry of Health "with an instruction that this should cascade to village level".

UNAIDS 2003 update, has also revealed that more than $5 billion have been mobilized to fund HIV/AIDS programmes. The Government of Zimbabwe has also decided to fund HIV/AIDS programmes by reducing the price of Anti-retroviral drugs. The private sector has not been left out for it has provided funding for HIV/AIDS programmes implemented by the Ministry of Health.

Apart from the internal sources of finance, there are also external sources of funding through donor organizations such as USAID, UNICEF, WHO, Royal Netherlands Government. For example in 2001, USAID allocated $6.4 million to support programmes such as Voluntary Counselling and Testing, Youth Programmes, Behaviour Change Programme etc. WHO has not also been left out for it provided extra budget such as CDC, Global Fund and VCT. (see www.usaid.gov/pophealth/aids).

However, it should be pointed out that the amount provided by the individual study countries to support the HIV/AIDS programmes is grossly inadequate considering the dimension and magnitude of the epidemic. To the extent, that most funding for HIV/AIDS have come from external bilateral and multilateral sources, the question arises as to how the current HIV/AIDS programmes and those being initiated shall be sustained in the future, if external resources dry up. There has been no clear-cut answer to this question.

6.7 Private Sector Initiatives

Previous evidence of impacts of HIV/AIDS in companies exists. Out into in 2000 attributed death rates of 941 per 1000, in RSSC sugar industry in Swaziland, 5.0/1000 in Hippo Valley Sugar Estate in Zimbabwe and 6.75/1000 in Makambala Sugar Estate in Zambia. There was evidence of strong private sector response and initiative on HIV/AIDS in Mozambique and Swaziland to mitigate the negative impact of the epidemic on the performance of the private sector.

The private sector response in Mozambique, which employs an estimated 150,000 workers, was reportedly driven by a survey financed by DfID and the World Bank in 50 big and small companies involving the interview of 120 owners/managers and 1,500 workers. The survey showed that 62% of the respondents perceived HIV/AIDS to be a problem. Furthermore, 23% indicated HIV/AIDS as a number one risk to their business but 74% of these did not have an HIV/AIDS activity in their company. Furthermore, 90% of the companies did not have any laid down policy on HIV/AIDS.

In Swaziland and Mozambique, Business Coalitions Against AIDS (BCAA) have been created. According to the Swaziland Director of Private Sector Companies, the Empresarios contra o Sida was created in Mozambique in 2000 while the HIV/AIDS Coordinator of Swaziland Business Coalition reported that the Federation of Swaziland Employers formed the Business Coalition Against AIDS (BCAA) in 2001. The aims of these business coalitions are to facilitate local business responses to HIV/AIDS and to share information and experience between different business sectors. Membership of these coalitions were drawn from various organizations, business associations, non-governmental organizations and employer federations. It was also found that the Malawi Chamber of Commerce and the Employers Association have just combined forces to establish a new business coalition but which has not been officially formalized.

According to the interviewer, both business coalitions of Swaziland and Mozambique have an HIV/AIDS policy. The HIV/AIDS policy was put in place in Mozambique at the end of year 2000 while that of Swaziland was initiated in 2002. Swaziland BCAA also has a policy on Antiretroviral Drug.

Furthermore it was reported that both coalitions have implemented a number of HIV/AIDS programmes. For example, aggressive awareness campaign for top managers as well as among private sector workers were reported to have been implemented. The purpose of targeting managers was to make them not only aware of the problem that HIV/AIDS poses to their companies but also to make them change agents. It was also ascertain that, the two coalitions have also implemented condom supply programmes to reduce the spread of HIV/AIDS among their workers.

In Swaziland, a total of 561 businesses have signed a declaration to identify focal point persons for HIV/AIDS within their companies. Apart from the mobilization programme, the coalition has also put together a manual on HIV/AIDS prevention and control and developed posters on equal rights and treatment, provision of condoms at workplace, peer education and VCT for the HIV/AIDS awareness campaign. In addition, volunteers from the Family Life Association trained private business workers in their business centers (BCAA, 2003).

In Mozambique, however, apart from the awareness campaign, the coalition was reported to have conducted anonymous prevalence survey of HIV/AIDS among 293 workers using a saliva test method which shows an overall HIV/AIDS prevalence of 20.1%, with the Head Officers being least affected with a rate of 11.5%. The result of this survey led the coalition to estimate that $2,500 a year would be required to treat an HIV positive private sector employees which is believed to be unsustainable for many companies (Rodrigues, 2003).

It was also reported that most of these activities in both countries were donor-driven. For example, UNIDO and UNAIDS were said to have provided technical assistance to one of the programmes in Mozambique while the World Bank granted US$2 million towards HIV/AIDS workplace programmes within the private sector. Furthermore, UNDP Mozambique has taken a major initiative to launch the global compact and corporate social responsibility principles into the Mozambique corporate sectors.

As robust as these programmes are in Mozambique and Swaziland, no attempt has been made to evaluate their impact on prevention and behaviour change. Furthermore, it was also noted from the interview responses that only limited measures have been put in place to mitigate the impact of excess morbidity and mortality due to HIV/AIDS on business and the employees. Moreover, one particular problem that was echoed from those in bounded is that in the two countries, the issue of ensuring sustainable ARV treatment for company workers. Suggestions to overcome these problems by those interviewed include: the need to strengthen their advocacy for government to provide them with tax benefits for HIV/AIDS costs incurred in the workplace and strong partnership with international donors and NGOs.

6.8 The Role of UNDP, UNAIDS and Other Donor Agencies

(i) *Technical Support*

The UN and other donor agencies have played significant roles in the fight against HIV/AIDS in all the six countries. In Mozambique, it was reported that the UN agencies notably the UNDP and UNAIDS have provided contributions in respect to strengthening technical capacities of all workers to respond to the crisis; condom promotion, STD treatment and reproductive health. In Mozambique and Malawi, UNICEF has provided assistance in respect to prevention of mother to child transmission, care of infected children and their parents, the protection and care of orphans, and provision of training and drugs for opportunistic infection. Ministry officials confirmed that the WHO provided assistance in strengthening the health system including improvement of biosafety in health care service in Zambia, Zimbabwe and Mozambique. The Centers for Disease Control and Prevention (CDC) also support improved HIV/AIDS surveillance and data analysis

(ii) ***Leadership and Policy***

A strong and sustained advocacy by UN system has also led to a better appreciation of the seriousness of HIV/AIDS epidemic within the government and the civil society in the six countries. In this regard, information obtained from interviews revealed that UN supported the instrumental development of national strategy plans to combat STD/HIV/AIDS as reported in Lesotho, Zimbabwe and Mozambique. The UNDP, World Bank, UNICEF and UNAIDS were reported to have also provided institutional supports for the various national AIDS committees/councils at the national and district levels in the same country. The UN group under the overall coordination of UNAIDS in Malawi and Mozambique provided technical assistance for the development of sector operational plans, development of a framework for monitoring the national strategic plan, establishment of HIV/AIDS data bases and resource mobilization and the formulation of Global Fund and World Bank proposals.

(iii) ***Partnership for Expanded Reforms***

Furthermore, the UN system has generally provided financial and technical support to civil society organizations and their networks in the six countries while the UNDP in Mozambique, Lesotho, Malawi and the World Bank provided assistance to national AIDS committees to scale up technical and institutional support. For example, in Mozambique, the World Bank has allocated US$5,000,000 to develop capacities of community based organizations and US$25 million to support their initiatives. In addition, CIDA (Canada) is also supporting free education programmes in Zambia and Malawi. Overall, the provision of financial and technical assistance were more noticeable in Mozambique, Lesotho, Malawi, Zambia and Swaziland. However, the supportive roles of these agencies are currently marginal in Zimbabwe.

VII. IMPACT ON PUBLIC SECTOR AND RESPONSE

7.1 Introduction:

In many African countries, the spread of HIV/AIDS has seriously eroded human capacity and adversely affected "capacity deepening", which has been defined as building upon existing skills in order to increase productivity. This has particularly been true of the public sector ministries and institutions, where skilled personnel have been lost, valuable labour time consumed, work schedules disrupted and when institutions replace staff and managers who have been continuously ill or have died from HIV/AIDS (Cohen, 2003).

With current treatment protocols, the majority of individuals in the public sector who are HIV positive face dramatically shortened life-spans. This has raised the opportunity cost of additional training, because few of the costs incurred will be recouped in higher subsequent earnings. To the extent that they are forbidden from discriminating, public sector ministries and institutions have to assume that the average productive life span of any staff they train will decline, and this would directly reduce the incentive to support or put in place long-term training and capacity building programmes.

This is because with the public sector and the rest of the society bear the direct and indirect costs of HIV/AIDS and considerable resources are being diverted from socio-economic development projects and programmes to HIV/AIDS treatment and preventive programmes However, on the other hand, without public sector ministries and institutions with qualified and experienced staff of various categories who are capable of effectively administering and managing the national development programmes, the long-term impact of the epidemic on African countries will be considerable (Cohen, 1999).

In view of the foregoing considerations, the purpose of this section of the Report is to analyse the impact of HIV/AIDS on the public sector ministries and institutions and the various ways in which the public sector has responded to the health and development challenge posed by the epidemic in the six study countries. To this extent, particular attention shall be paid on such issues as the general socio-economic impact, pattern of HIV/AIDS infections, impact on public sector capacity, institutional costs, policies and programmes, financing, human resource programming and capacity building programmes and best practices which were observed during the fields mission. In order to facilitate the analysis, highlight the similarities and differences, each of these areas has been presented in a tabular form covering all the six study counties at the same time.

7.2 General Socio-Economic Impact

Although, it was generally stated by most people interviewed that the general socio-economic impact of HIV/AIDS is difficult to measure, (since other problems impinge on the economy of each country). However, the available data and information gathered during the field mission and a review of the documents made available to the study team revealed that the general social and economic impact of HIV/AIDS on the public sector ministries and institutions in the six countries is similar. It can be observed from Table 13 that the social impact ranges from increased mortality, reduced life expectancy, increased number of orphans, increased child labour, drop in the quality of health care, reduced demand and supply of education to over burdening of health care systems. On the other

hand, the economic effects consists of declining revenues in the public sector, reduced household income, decline in agricultural production, declining savings and investment, a decrease in GDP of 8% - 10% in Mozambique and a projected reduction of 34% in GDP over the period 1991-2012 in Swaziland (Cohen, 2000).

It should be noted that most of the staff interviewed presented information bout what they felt were the major impacts of HIV/AIDS infection in their countries but could not quantify the impact. Moreover, majority could not provide the team with data during the discussion. This constraint notwithstanding, increased mortality and increased orphanage were the two most common social effects reported in Malawi and Mozambique, Swaziland and Zambia while reduced productivity is a major economic effect were similarly reported in the same countries.

The epidemic has not spared any public sector institution or socio-professional group in the six countries. For example, the education sector in Zambia is suffering a heavy toll. There is a rising number of orphans and school drop outs and this poses serious problems to the education system. The number of school aged orphans in 1996 was estimated at 400 000 and this number had doubled to 800 000 by 1998. According to the Staff in the Zambian Central Board of Health, this number is expected to rise to 1.2 million by the year 2010 (MFED, 2002).

The result of this trend is a low participation in education for many of the school-aged children, especially orphans due to inability to pay school fees and prolonged stay at home to care for sick parents and guardians as the death of parents result in the loss of household income, children leave school pre-mature by and engage in income generating activities. There are consequently adverse implications for the enrolment, retention and achievement level of children in school in all the six country. Furthermore, decreased fertility rates have affected demand for education negatively due to early female deaths and increased under-five mortality because of AIDS (Webbs, 1996).

It was generally stated that the socio-economic situations in each of the countries was better before the advent of HIV/AIDS but there is systematic decline of social and economic life with increasing HIV/AIDS prevalence over the years.

On the supply side, estimated 40% HIV prevalence rate among teachers as early as 1993 (Fylkesnes, K, et al, 1994) result in a 6.8% annual death rate rising over time including management and particularly young and often better-trained teachers. The latest statistics provided indicate that 1 400 teachers died in 2000 alone, more than double the 1997 figure of 624; while about 2001 teachers died in 2001, although obviously not all of these deaths are directly attributable to HIV/AIDS. As a consequence, the sector continues to experience low productivity and efficiency problems due to teacher absenteeism, more staff shortages and more education cost (MFNP, 2002).

The Ministry of Finance and National Planning in Zambia (according to the Assistant Director) has recognised the threat posed by HIV/AIDS as the staff is affected by increased morbidity and mortality rates mostly due to the pandemic. While acknowledging pancity of data on mortality fefore 1998, the Central Statistics Office recorded 99 deaths for the period 1999/2000, while the headquarters of the Ministry recorded 38 deaths for the period

1999/2001. It was also reported that an increasing number of staff (which was not quantified) is going on leave and there is rising absenteeism (MFNP, 2002).

Furthermore, it was observed that funeral attendance is on the rise due to deaths among the staff though not always caused by HIV/AIDS and the frequent deaths of colleagues is causing discussion of concentration among other colleagues. As a result, it was reported that the overall productivity of the workforce in Zambia is declining and there is a reduction in returns on training investments at especially professional levels since the Ministry of Finance and National Planning also coordinates data from other Ministries information was also provided about the situation in other Ministries. It was further reported that in the Ministry of Agriculture, Food and Fisheries, there is also rising morbidity and mortality among extension workers, which has reduced contact time between extension workers and farmers (Kanwanga, J, et al. 2003).

Table 13: Nature of Socio-Economic Impact of HIV/AIDS

COUNTRY	SOCIAL EFFECTS	ECONOMIC EFFECTS	OTHER EFFECTS
LESOTHO	- Increase mortality and absenteeism - Eroded public sector ability to meet increasing demands for basic social services.	- Undermined the productive sectors of the economy - Declining revenues in the public sector.	- Threatens population growth rate
MALAWI	- Increase number of orphans - Increase child labour - Child headed household phenomenon - Psychological trauma - Increased mortality rates - Reduced life expectancy - Reduced on demand and supply for education - Drop in quality of health care	- Brooded the work force - Decline in Agricultural production - Reduced Household income	- Impoverishment, stigma, discrimination and inequality NONE
MOZAMBIQUE	- Increase in the number of orphans - Reduced life expectancy - Affects demand and supply of education	- GDP 8% - 10 lower - Compromises development efforts by attacking presented future producers (15-49 yrs)	NONE
SWAZILAND	- Reduced life expectancy from 55.1% in 1991 to 49.2 in 2006 - Reduced demand and supply of education - Increased mortality - Overstretched health care systems - Over burdened the social welfare department.	- Loss of skilled labour - Reduced productivity - Declining savings and investments - 34% reduction in GDP over the period 1991 – 2015 (World Bank 1998).	- Decrease in population growth rate - Increased medical and funeral cost due to increased morbidity and mortality.

ZAMBIA	- Illness and death of family members, relatives, friends and workmates often quite young - Illness and death of husbands, wives and infants - Anxiety and trauma – stigma - Exploding number of a number of orphans due to aids - More families become poor as breadwinners die - Creates immense psychological stress through repeated death and bereavement - Elderly and disabled people are left without family support as breadwinners die - Creates unbearable strains on extended families, thus ; -Provokes increased demand on welfare relief and counselling - Draws funding away from development work - Increase dependency rates.	- Increasing overall reduction in the experience, skill institutional memory and disruption of productivity due to increased staff turnover - Increasing cost of pre-employment training, in-service training to bring new employees up to the level of the old ones - Increasing loss of skilled labour, time and reduced supply of raw materials - Drastic reduction of public sector capacity due to high increasing morbidity and mortality - Diversion of productive labour time of healthy family members to caring for sick household members - Diversion of resources to medical expenses - Diversion of food resources to funeral ceremonies and cash for coffins and bereavements - Withdrawal of children from school to reduce expenditure - Changing patterns of consumption and production by households receiving orphans from other households - Reduction of economic performance as a result of ailing human resource variable - Reduction of investments - Slow growth in GDP and less growth in employment and this threatens system failure (collapsing social and economic infrastructure capacities).	- Illness disrupts learning and teaching - Extra load for strong and healthy teachers when sick teachers are absent - Pupils and students who fall ill lag behind in their studies - Additional burden to teachers and learner whose family members get ill or die - Schools suffer disruption when teachers and learners die; alongside loss and sorrow - Loss of human capital limit opportunities for economic growth and subsequently negatively affects government revenues - Reduction of sector capacity as a result of reduction of resources to finance productive activities
ZIMBABWE	- Social exclusion - Increased number of orphans - Increased incidence of child labour - Increased number of street children and crime wave - Gender inequality	- Increased cost of production - Reduction in revenue - Reduction in productivity and production - Decrease in food security - Poor living standards - Poverty has been aggravated - Development has been hindered	

Source : Compiled from Field Interviews and Policy Documents on HIV/AIDS

Today, Zimbabwe is among the top leading countries in Sub-Saharan Africa with highly infected HIV/AIDS persons. Estimates shows that at the end of 2001, 2 million adults were living with HIV/AIDS and with women comprising 60% of the cases (see www.UNAIDS.gov./pop.health/aids). As a result, Zimbabwean life expectancy has been projected to 35 years by 2010, compared with 66 years in 1997. The crude death rate will

be more than 200% higher in 2005 than it was in 1990 if something is not done to check the rate of HIV/AIDS infection rate. The question raised by one of those interviewed was that "If we bury our educators, those who build our roads, worked on farms, mothers and fathers of our children etc. then the consequences are great and are examined under social and economic effects".

The social effects start immediately when person suffers from the HIV/AIDS related illnesses. This is because parts of the incomes are diverted to medical care and feeding habits are affected negatively. Members of the family missed school especially the girl child in order to care for the sick-which led to an increased gap of gender discrimination; there is also an increase in the number of orphans which has led to a fall in the moral standards of the society as the number of street children are increasing on daily basis. There is also a pressure on the Government to provide facilities for orphans who do not have relatives who can take care. There is also child-labour abuse.

The economic impact has been heavy on the household, farms and Government. Responses from interviews indicate that HIV/AIDS has resulted a fall in household savings which are either used up for medical care or funeral celebrations. The using up of these savings for the above unproductive services is causing a lot of poverty due to low consumption and high mortality rate, which is the order of the day. On the part of firms, HIV/AIDS has increased the expenditure of firms and reduced firms' revenue. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training.

The greatest number of HIV/AIDS cases is found in the ages of 20-39 years in the six countries. The loss of people in this productive year has caused a problem in terms of quality and quantity of labour force in the agricultural sector. This has resulted in a fall in performance of this sector leading to a fall in food production and food security. According to United Nations AIDS Programme (UNAIDS 2002 Update, Zimbabwe), 3 800 Zimbabweans die each week from AIDS related infections. This constitutes a great loss to the Government of Zimbabwe in terms of human capital. The loss of human capital makes development planning difficult and the Government is spending a lot of money to implement a comprehensive prevention of mother-to-child transmission programme.

Overall, the HIV/AIDS pandemic has become a major health crisis and development challenge in all the six countries. For example, in virtually all the countries the average life expectancy has been reduced by nearly ten years due to increased morbidity. Most disturbing is the fact that the increase mortality and absenteeism is rapidly eroding the ability of the public sector ministries and institutions, to meet the increasing demand for basic social and economic services.

7.3 Pattern of HIV/AIDS Infections in Public Sector Ministries

Overall, the pattern of HIV/AIDS infection in public sector ministries and institutions was reported to mirror that of national prevalence. Generally in these ministries, many interview respondents were unable to give precise information as to the number of staff that were affected by HIV/AIDS because most staff or those who died as a result of AIDS did not officially report them. Even in the absence of precise data, interview respondents were almost certain that the deaths of many staff in the ministries were due to HIV/AIDS given the symptoms exhibited before finally resigning or getting hospitalized. For example, the response from the ministry of Women and Coordination of Social Welfare in Mozambique on the number of staff affected by HIV/AIDS was said to be "unknown", although it was acknowledged that the some of the Ministry staff died from acute Diarrhoea and Tuberculosis.

Generally the pattern of HIV/AIDS infection in public sector ministries and institutions is generally reported to be rising among all staff categories and all types of skills. To this extent, it can be observed in (Table 14) that all the ministries whose staff were interviewed reported that their staff have been affected by HIV/AIDS.

Table 14: Pattern of HIV/AIDS Infections in Public Sector Ministries and Institutions

COUNTRY	MINISTRY/INSTITUTION	CATEGORY OF STAFF	KINDS OF SKILL AFFECTED
LESOTHO	• Ministry of Development Planning • Education, Youth and Gender, Health and Social Welfare	- No HIV/AIDS deaths recorded but deaths have occurred from opportunistic infections - Competence had been lost mainly at the top level of management of the public sectors as compared to middle and lower levels	- Staff from the bureau of statistics had a high prevalence of opportunistic infections - Teachers - Medical Doctors - Students at the tertiary level who have scholarships
MALAWI	• Education (MOEST) • Health (MOHP) • Police Service (MPS)	• Secondary school teachers experienced more deaths than primary school teachers. • Professional skills, or senior staff and middle level staff were more affected than junior level staff. • Junior police officers were more affected	- The Department of Animal Health and Industry (DAHI) professionals weremost affected with SMR of 457, Research scientist (21), agriculture officers (39), Technical officers (68) and Technical assistants (707), were also affected. - Higher than average SMR values were found for Laboratory technicians (9), Clinical officers (35), medical assistant (44), Registered nurses (79), Health service assistant (115), and Environmental

			health officers were less affected. - Sergeants (67), Inspectors (12), Constables (211), Commissioners (0) and Second Sergeant.
MOZAMBIQUE	• Women and Social Affairs • Planning and Finance • Education • Health	- Affected senior and middle level staff e.g Master degrees in social sector and also lower level staff - Difficult to know how many staff who had died in the Ministry except in the customs department because HIV started 5 years ago. - Middle and Junior staff level.. - Junior level staff were more affected than middle and senior staff.	- Technical skills, senior level management and junior level staff. - Assessment study on the situation of HIV/AIDS in the education sector made in 2000 revealed that by 2010 the education sector will loose 17% of teachers and administrative staff and 13% students. - Male and female nurses were most affected especially in the rural areas .
SWAZILAND	• Health • Education • Agriculture and Cooperatives	- Junior level staff such as nurses were most affected than senior level staff like medical doctors. - Middle and junior staff.	- Nurses were the most vulnerable - Teachers and students (10% - 15% attrition rate) were most affected and more female teachers were affected. - Agriculture extension workers.
ZAMBIA	• Ministry of Agriculture, Food and Fisheries • Ministry of Education (MOE) • Ministry of Finance and National Planning	• Aagricultural Extension Workers. • Teachers well-trained - - Experienced teachers • Economists, Planners, Accountants, Auditors, Statisticians, Demographers, Administrators, Information Technology Specialists, Systems Development Specialists; and Support Staff.	- Extension skills. - Teachers - Managers - Support staff Professionals and Non Professionals alike. - Doctors, nurses, midwives.

	• Ministry of Health	• Midwives in Lusaka (1991-92) prevalence rate was 39% - Nurses in Lusaka (1991-92) prevalence was 44%.	
ZIMBABWE	• Ministry of Health • Public Srvice • Ministry of Education	• All categories • All categories • All categories	• Doctors, Nurses, Technicians etc. • Psychologists, Sociologists, Economists and legal officers • Teachers, students, pupils, administrators. - All farmers.

Source: Compiled from Field Interviews and Policy Documents on HIV/AIDS

In most countries, the staff of the ministries of education either reported that their staff were the most affected compared with other ministries. Similar information were obtained from staff from other ministries and UN and WHO agencies about the ministry of education as being most affected even when the ministry was not visited by the team. The data from the planning unit, Ministry of Health and Population Malawi (Table 15) specifically showed that the Ministry of Education is most affected by HIV/AIDS compared with the Ministry of agriculture and the Ministry of Health and Population.

Table 15: Estimated HIV/AIDS Related Deaths Among Professions in Malawi

YEAR	MOEST	MOAI	MOHP	TOTAL
1995	261	107	152	520
1996	246	98	137	481
1997	302	165	150	617
1998	472	304	198	974
1999	831	236	270	1337
2000	453	294	200	947
TOTAL	**2 565**	**1 204**	**1 107**	**4 876**

Sources: Planning Unit, Ministry of Health and Population

In Lesotho, interview responses indicate that about 70 people in the ministry of Education die every month and 27% of teachers are said to be affected based on sentinel surveillance results. Furthermore, available report estimates put HIV/AIDS among teachers in Zimbabwe at 30%, which translates to 30,181 teachers. If the 4% HIV/AIDS mortality among teachers in 2001 is taken as a proxy, using these conservative figures implies that an estimate of 3,219 teachers might have died of HIV/AIDS related sicknesses in 2001.

Overall, the pattern of skills most affected from the ministries of Education in each of the six countries showed that teachers were most affected. It was projected that over the period of 2001-2010 the AIDS epidemic in the Education sector in Mozambique will claim 17% of its personnel and that some 9,200 teachers will die. It was reported in Swaziland that the skills most lost are those in the areas of mathematics and science.

Apart from teaching skills, which seem to be most lost in all the countries, other significant losses of skills were reported in some key ministries. In the ministry of health, the skills of physicians in Lesotho, Zambia and Zimbabwe as compared with nursing skills in Malawi and Swaziland were the most lost. In Malawi, 79 registered nurses were reported to have died while in Zambia 41% of those affected by HIV/AIDS were psychiatric nurses and 22% of Public Health Nurses.

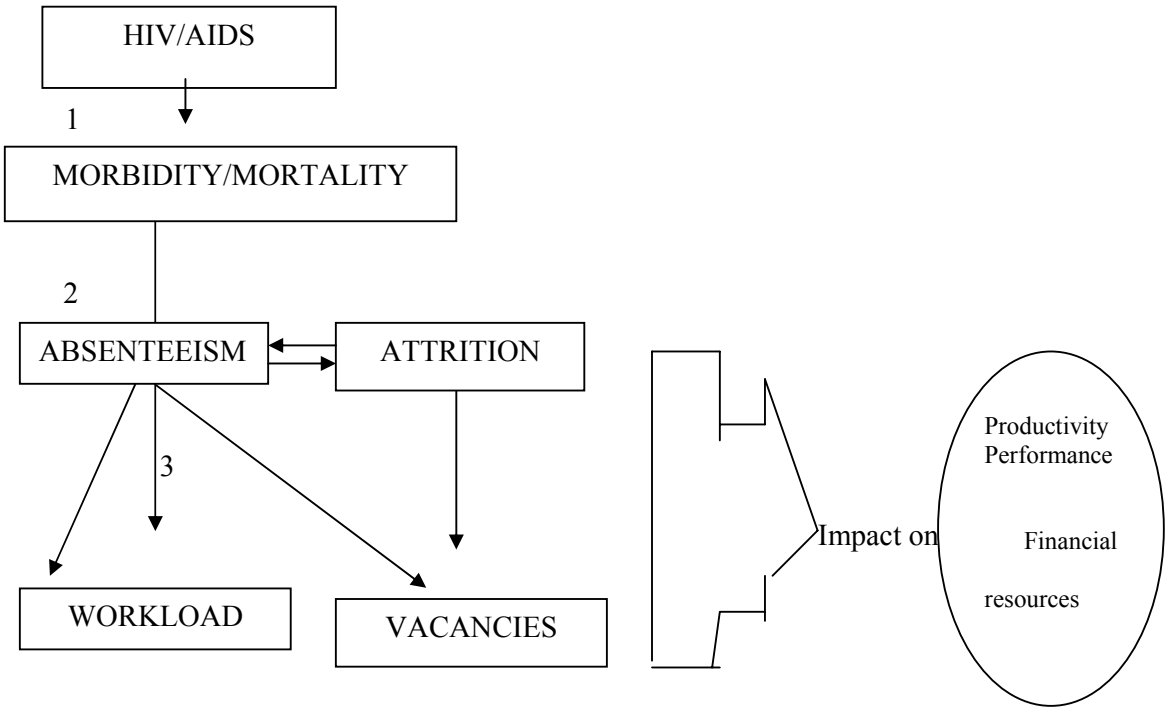
In the Ministry of Agriculture in Swaziland and Zambia where the staff were interviewed, agricultural extension workers were reported to be most affected. The result of a study in Zambia corroborated this finding as it was ascertained that 80% of the 6113 in the non-professional category died nation wide in the agricultural sector.

7.4 Impact on the Public Sector Capacity

The HIV/AIDS pandemic is having a great negative impact on public sector capacity in all the six countries through rising morbidity and mortality of the human resources of all categories. There is a drastic reduction in the performance and efficiency of the public sector to deliver essential goods and services and this implies negative consequences on the growth of the economy with attendant ramifications on rising unemployment and poverty. With the rising incidence of HIV/AIDS victims in the public sector, there is increasing tendency to shift resources from investment to the provision of social welfare and health services which are already stretched to their limits (Cohen, 2003).

As indicated earlier, HIV/AIDS has been rapidly eroding the capacity of the public sector Capacity in the ministries and institutions in the six countries. In order to adequately respond to their socio-economic challenges and needs, the nature of the impact of HIV/AIDS is presented in Figure 1. It can be observed from Figure 1 that HIV/AIDS results in increased morbidity and mortality, which have direct impact on human resource capacity.

FIGURE 1 : Impact of HIV/AIDS on the Public Sector Capacity



Attrition leads to organisational loss of labour and vacancies, which can disrupt production activities and thus have adverse effects on the overall output. Increased morbidity leads to increased absenteeism and vacancies, which results in a greater workload to other staff members. Qualified and often experienced staff is also lost. These four impacts collectively impact negatively; on productivity, performance, financial resources and service provision (Cohen, 2000).

The erosion of human resource capacity will negatively impact on the productivity and performance of individual, employees and the organisation as a whole. It also has significant financial implications related to recruitment and training, medical benefits, funeral costs and death benefits. The erosion of human resource capacity will negatively affect the core business of the organisation and impede service provision.

Overall, it can be observed from Table 16 which highlights the impact of HIV/AIDS on public sector capacity in the six countries, that the technical skills lost through the epidemic have been experienced by all levels of staff-senior, middle and low level. To the

extent that HIV/AIDS leads to illness and subsequent death of staff, this has had a negative impact on productivity and output. The replacement of the lost staff with less qualified and inexperienced staff has resulted in weak policy analysis and impacted negatively on the management capacity of the public sector ministries and institutions. This has been particularly true inthe case of experienced accountants, medical doctors, economists and teachers, who are lost through HIV/AIDS.

Table 16: Impact of HIV/AIDS on Public Sector Capacity

COUNTRY	MINISTRY/ INSTITUTION	NATURE OF IMPACT
LESOTHO	Ministry of Finance Ministry of Planning and Development	- Competences and skills were lost mainly at the top level of management of the public sector e.g. medical doctors, teachers and students who were on scholarship. - Policy analysis and capacity were negatively affected in that HIV/AIDS leads to the death of its skilled and experience manpower e.g. Economist and Accountants and this experienced trained skills are difficult to replace.
MALAWI	• Ministries of Education, Health, Agriculture, Gender and Social Welfare	- Eroded the capacity of the public sector to respond to challenges encountered. - HIV/AIDS resulted in increased morbidity, and mortality which had particularly impacted on human resource capacity. - Attrition due to HIV/AIDS mounted to organisational loss of labour and vacancies which had adverse effects on the overall performance of an organisation. - Qualified and experience staff were lost.
MOZAMBIQUE	• Ministries of Finance, Education, Health • Women and Social Affairs	- HIV/AIDS led to illness and death of staff and this had negative impact on productivity and output. - Management capacity and policy analysis were affected. - Loss of technical skills. - resulted in the use of less experienced and less skilled lower staff – replace dead skilled staff thereby affecting output.
SWAZILAND	• Public sector management department • Education • Health	- Resulted in weak policy analysis and management capacity. - Resulted in the loss of skilled and experienced workers which led to productivity loss, declining savings and investment. - Loss of institutional memory.
ZAMBIA	• Ministry of Agriculture, Food and Fisheries. • Ministry of Education	- Extension staff : rising morbidity and mortality among extension (staff) workers has reduced contact time between extension workers and farmers. - Rising costs in terms of medical allowances for staff and immediate family, funeral and bereavement allowances poses rising constraints on budgetary resources. • **Supply Side :** 40% of HIV prevalence among teachers - 1 200 teachers dying annually particularly among managers and young teachers; - Four teacher – hours lost (on average per week per school (in 1995) in urban areas due to teacher illness and funeral attendance. - Increased classroom stress related to longer teaching hours, combined with both teacher and pupil illness lowers the quality of education. Teachers are more frequently absent, increased likelihood of anxiety about health, depression, poorer attitudes to work and reduced ability to perform to standard. - 624 teachers died in (1997). - 2001 teachers died in (2001). - 1 400 teachers died in (2002).

	• Ministry of Health	• **Demand Side :** - 400 000 school aged orphans (1996) - 800 000 school aged orphans (1998) - 1 2 million projected school aged orphans in 2010. - Low levels of enrolment, retention and achievements in school. • **Quality of Education :** School management are struggling to cope with irregular teacher attendance, poor quality of teaching and learning and the depletion of trained experienced pool of teachers**.** • **Deaths :** - 99 deaths were recorded by the Central Statistics Office - 38 deaths at Headquarters of MFNP (1999/2001). - Increasing morbidity and mortality rates arising mostly from HIV/AIDS pandemic. - Increase of staff going on leave, increase in sick leave and other absenteeism. - Decrease in productivity of workforce, increase in labour. - Increasing death of service provides (Doctors, nurses). - Fatalistic attitudes of Doctors, Nurses and Midwives. - Movement out of high prevalence zones by medico.
ZIMBABWE	• Ministry of Education • Ministry of Health • Ministry of Agriculture	- A fall in the demand and supply of education services. - Congested hospitals because of increased number of admissions and loss of medical staff. - Fall in production and falling food security.

The impact of HIV/AIDS on the education sector in Zimbabwe has been revealed by a fall in the demand and supply of education services. The data available suggests that primary school enrolment have been declining since 1998 (Zimbabwe Human Development Report 2002/3 : HIV/AIDS and Human Development : HIV/AIDS and Zimbabwe Education Sector). The decline can be associated to a decline in fertility caused by HIV/AIDS epidemic whose infection rate is high among the reproductive age group (15 to 49 years).

The supply of education services is equally on a decline due to infection rate among teachers. The latest figures put the teacher population in the primary and secondary school sectors alone at 10 0603 (Zimbabwe Human Development Report 2002/2003 : HIV/AIDS and Zimbabwe Education Sector, p. 19). Available estimates put HIV/AIDS infection rates among teachers at about 30%, and this translates to 30 181 teachers. In 2001, 4% of teachers died, the majority of them due to HIV/AIDS - related illnesses.

According to Zimbabwe Human Development Report (2002/2003), the impact of HIV/AIDS on the health sector can be summarized as follows:

- Poor human resources base as a result of resignation, deaths, discharges and absenteeism.
- Congested hospitals because of increased number of admissions.
- Acute shortage of essential drug due to increased demand at a time that drug supply is erratic because of foreign currency shortage.

- Compromised safety of both patients and health personnel due to shortage of basic hospital requirements.
- Service costs have drastically increased but the budget allocated to the health sector has in real terms declined.

It is accepted that HIV/AIDS creates a negative synergy that worsens the challenges facing Zimbabwe's agricultural sector (UNDP Human Development Report: The Impact of HIV/AIDS on Agriculture: 2002/2003). This Report summarises the HIV/AIDS Impact on Zimbabwe Agriculture as follows:

- skill and experience labour lost to AIDS.
- Investment funding decline due to a shift in resources to care for infected persons instead of production.
- Planning becomes difficult due to the fact that planner are faced with the dilemma of choosing between development and mitigating HIV/AIDS.
- Decrease in the availability of skilled labour and essential agricultural knowledge for orphan-headed households. There is also loss of gender – specific agricultural knowledge.

7.5 Institutional Costs

Institutional costs stem from the fact that quality of services declined as the affected staff is unable to work as before. They are always on sick leave; their productivity decline due to poor health, there is sometimes a strain in social relationship, as other workers have to do extra work due to absenteeism of HIV/AIDS victims. There is also a loss of skilled and experienced staff, which lead to extra-costs of training new staff and productivity decline during the interim period. The lost of human life entitles extra-costs for funerals. Other institutional costs include: discrimination in employment; social exclusion of people living with HIV/AIDS. Aggravating the impact of gender inequality, increasing number of AIDS orphans; increasing incidence of child labour and depleted human capital (Cohen, 1999; Bell et al (2003).

Discussion/interview responses indicate that the HIV/AIDS pandemic is outstretching the resources of public institutions in the study countries as they increasingly incur financial and human costs. Their human resource capacity is being weakened and fragmented by rising death tolls, increasing incidence of illnesses, sick leaves, funerals, absenteeism with serious implication on the productivity and capacity.

The escalating costs in medical allowances, for staff and immediate family, funeral grants, coffin allowances, transport and fuel costs as well as outstation allowance are increasing labour costs, stretching the budget limits and diverting resources from investments as well as experiencing declining revenues because the major contributions to economic activity, particularly in the private sector, have fallen by the wayside due to the epidemic (Bell, et al, 2003).

Overall, it can be observed from Table 17 that in the six study Countries the institutional costs of HIV/AIDS have broadly taken the following form :

- increase in replacement and recruitment costs.
- Reduction in output and productivity due to increased absenteeism.
- Increase in recycling and training costs.
- Loss of experience and institutional memory.
- Extra work load for other staff.
- Increase funeral costs and expenses.
- Increased deaths gratuities.
- Loss of experienced and skilled staff.
- Loss of productive time.
- Increase in medical care, health and insurance benefits.
- Cost of sick and compassion leave.

Table 17: Nature of Institutional Costs of HIV/AIDS

Country	Ministry/ Institution	Financial Cost		Human Cost		
		Direct	Indirect	Direct	Indirect	Others
LESOTHO		- Increase in replacement and recruitment costs	/	- Loss of major economic contribution	- Increased mortality and absenteeism. - Reduction in output and productivity	
MALAWI	- Education • Agriculture - Health - Police - Education	-Increased training and recruitment cost or replacement cost • increased training and replacement cost - Increased training and replacement costs - Increase recycling and training cost (187 billion mehcais)	- Increased transport cost to sick officers - Cost of employees to visit sick colleagues • Funeral cost or expenses (MK 5000 for transportation and MK 6 000 on coffin) - Increase in death gratuities (MK 58 423 000 by 2001) - Funeral expenses - Funeral cost or expenses - Medical care and health benefits	- Loss skills and experienced workers - Loss of skill and experienced staff - Loss of personnel and staff - Loss of skills and personnel - Loss of teachers and students - Reduced efficiency of education better (US$ 110.5 million)	- Loss of productive time -Absenteeism - Increased funeral costs (MK 12 000 to MK 30 000 per funeral) - Loss of productive time - Increase work load for other workers -Absenteeism - Extra work load for other staff.	
SWAZILAND	- Health Education	- Increased recruitment and replacement cost		- System wide loss of experience and professionalism.	- Illness and death effects. - Staff morale. - Increased absenteeism. - Loss of productivity	
ZAMBIA	- Ministry of Agriculture, Food and Fisheries) (MAFF)	- Medical allowance for staff and immediate families - Outstanding allowances to accompany a deceased	- Related funeral costs	-Rising death toll of extension staff. **Mortality of Extension Staff** - 132 (1995) - 126 (1996) - 122 (1992)	- Rising illnesses and bereavements in the community - Attending funerals of colleagues and	-Foregone training cost -Additional retraining expenses - Rising absenteeism due to illness and

		member - Funeral grants - Coffin allowance - Transport and fuel costs for burial - Escalating cost of medical and funeral bills. - A 25% increase in public expenditure (1995) required to maintain, recruitment and staffing levels. - Return on investment in Education and training decline - Increase in Labour Costs - Claim for death and pension benefits - Funeral expenses for employees		- 2001 teachers died (2001) - 1 400 teachers died (2000) - 624 teachers died (1997) - 38 deaths at 49 and 99 at Central Statistic Office - Low performance as new recruitment undergo induction	relatives - Attend funerals and bereavements of colleagues and relatives - Irregular teacher attendance - Poor quality of teaching - Depletion of experienced pool of teachers - Other employees are absent to attend funerals of colleagues - Increase in overtime for non-infected employees	funeral attendance - Disruption of concentration of other employees due to frequent deaths of colleagues - Co-workers are demoralised - Loss of institutional memory
ZIMBABWE	- Ministry of Education - Ministry of Health	- Burial fees = " =	- Low producing - School drop outs -Absenteeism = " =	- Loss of teachers - Extra-training cost = " =		- Employment discrimination - Social exclusion - Gender inequality = " =

In order to have a better appreciation of the magnitude of some of the institutional costs resulting from HIV/AIDS, we shall examine the cases of the Ministries of Education, Science and Technology (MOEST); Agriculture and Irrigation (MOAI); Health and Population (MOHP); in Malawi. Specifically, we shall examine the costs of training and

replacing the dead teachers in MOEST, and professional staff in MOAI and MOHP. In addition, we will also present the data on the loss of productive time due to funeral attendance (1990-2000) and payment of death gratuities (1997 – 2001) by MOAI. The nature and magnitude of the cost of training and replacing of the lost staff in the three ministries are presented in Tables 18, 19, 20 and 21.

Table 18: Training Costs of the Replacement of Dead Teachers in the MOEST

Occupation	Duration	Number of replacements	Unit cost of training	Total Cost of Training	Total Cost in $US
Primary School	2 years	158	MK 300 000	MK 47 400 000	697 059
Secondary School	4 years	1 739	MK 720 000	MK 1 252 000 000	18 412 941
TOTAL		**1 897**		**MK 1 299 400 000**	**19 110 000**

Source : Planning Unit, Ministry of Education, Science and Technology, Lilongwe

Table 19: Training Costs of Staff in MOAI

Level of Training	Duration	Cost of Training	Salary Paid During Training	TOTAL
Phd (UK)	3 years	US $45 000	US $ 4 035	US $49 035
MSc (UK)	2 years	US $ 26 483	US $ 2 690	US $ 29 173
MSc (UK)	1 year	US $ 13 241	US $ 1 345	US $ 14 586
BVM (Zambia)	6 years	US $ 31 289	US $ 8 071	US $ 39 360
Short Courses (A)	5 weeks	US $ 10 071	US $ 92	US $ 10 173
Short Course (out of Africa)	8 weeks	US $ 23 734	US $ 495	US $ 24 229

Source; Planning Unit, Ministry of Agriculture and Irrigation, Lilongwe

Table 20 reveals that between 1991 and 2000 MOAI lost 1 367 years of productivity of professionals with first degrees and above, amounting to a total replacement cost of US $ 9 014 998.

Table 20: Replacement Costs of Dead Professional Officers in MOAI 1991-2000

Level of Training	Number of Officer	Total N° of Years	Total Replacement
Ph.D	18	187	US $ 833 595
MSc	25	271	US $ 7 905 833 (2yrs)
Bachelor's	71	844	Cost not available
Bachelor's of Veterinary Medicine	7	65	US $ 275 570
TOTAL	121	1 367	US $ 9 014 998

Source : Planning Unit, Ministry of Agriculture and Irrigation, Lilongwe

Between 1990 and 2000, a total of 290 paramedical deaths were recorded. Paramedical training is planned for three years and to replace them would cost a total of MK 13 050 000 (basic training). As workers die , other staff members are expected to attend the funeral of their colleagues. This practice has resulted in considerable loss of productive time as can be observed in Table 22 in which the estimates on MOAI are presented.

Table 21: Annual Training Costs for Recruitment of MOHP Personnel

	Basic Training (per person per anum)			Post-Basic Training (per person per anum)		
	Tuition	Boarding	Total	Tuition	Boarding	Total
Amount	Mk 9 000	Mk 6 000	Mk 15 000	MK 66 500	MK 40 000	MK 106 500

Source : Planning Unit, Ministry of Health and Population

It is assumed that 20 officers would have attended each funeral and they would have been absent from work for 3 days . Generally, HIV/AIDS has resulted to the payment of death gratuities which had not been budgeted for between 1997 and 2001. It can be observed from table 23 that MOAI, paid a total amount of MK 58 405 633 in death gratuities to the families of the deceased staff of the ministry.

Table 22 : Loss of Productive Time due to Funeral Attendance in MOAI 1990-2000

Number of Deaths		Total Funeral Attendants	Total Number of Days Lost	Total Number of Months Lost	Average Salary per Funeral Attendance	Total Salary Lost
TOTAL	1 613	32 260	64 820	2 933	MK 3 000	MK 8 799 000
HIV/AIDS RELATED	158	3 160	6 320	257	MK 3 000	MK 861 000

Source: Planning Unit, Ministry of Agriculture and Irrigation, Lilongzwe

Table 23: Death Gratuities Paid by MOAI 1997-2001

Year	1997	1998	1999	2000	2001
Total Gratuities	MK 6,720,581.27	MK 11,586,641.66	MK 12,176,230.42	MK 15,325,018.15	MK 12,507,191.15
HIV/AIDS Related	MK 658,617	MK 135,491	MK 1,193,271	MK 1,501,852	MK 1,225,705

Source : Planning Unit, Ministry of Agriculture and Irrigation, Lilongwe

To the extent to which HIV/AIDS has led to increased morbidity, mortality and absenteeism among staff and workers of the public sector ministries and institutions, their ability to meet the increasing demand for basic social services has been undermined. This

has been compounded by the fact that the public sector institutions are increasing by facing considerable financial and human costs associated with HIV/AIDS.

7.6 Best Practices

Identifying practices in Africa that work in responding to the HIV/AIDS epidemic and examining how and why they work is a tremendous challenge to national governments and development partners, particularly regarding the effective promotion of sharing of these practices, including such means as documentation and widespread distribution of the lessons learned. Broadly, Best Practice, means accumulating and applying knowledge about what is working and not working in different situations and context. In order words, it is both the lessons learned and the continuing process of learning, feedback, reflection and analysis (what works, how and why and so forth)(UNAIDS, 2002).

Within the context of HIV/AIDS, the lessons learned must be widely shared and adapted to local condition in order to enable an effective response to the epidemic. To this extent, the objectives of Best Practice are: (a) to strengthen the capacity to identify, document, exchange, promote, use and adapt Best Practice as Lessons learned within a country and between countries as a means to expand the National response to HIV/ADIS; (b) to promote the application of the Best Practice process for policy and strategy defunction and formulation; and (c) to collect, produce, disseminate and promote Best Practice (UNAIDS, 2002).

Within the context of the above guidelines, it can be observed from Table 24 that in the six study countries, there are a considerable number of Best Practices of HIV/AIDS Programmes. They include, House Care Programmes, Peer Education, Women in AIDS Awareness Creation (Lesotho), creation of HIV/AIDS Associations, mainstreaming HIV/AIDS into the educational curriculum, participation of HIV/AIDS patients in training programmes (Malawi); use of Drama to sensitize the community, Mobile groups against HIV/AIDS (Mozambique); HIV/AIDS Work Place Programmes (Zambia) and Training of Peer Trainers and Youth and Children Pogrammes (Zimbabwe).

It should be pointed out that the identification of the Best Practices has been based on a simple description of the practices and achievements. From this point of view, some of the Best Practices undertaken in Table 24 have either worked in full or in part and have been useful in providing lessons learntt to other institutions within the same country and elsewhere.

Table 24: Best Practices of HIV/AIDS Programmes

COUNTRY	MINISTRY/ INSTITUTION	NATURE OF BEST PRACTICE
LESOTHO	• Lesotho AIDS Programme Coordinating Authority (LAPCA)	- House care programme : which are responsible for treating AIDS patients - Family care : an example of two best practice in Lesotho - Peer Education : youths sit down and educate themselves on the totality of the pandemic and they are joined in this activities by the Ministry of Youth and Gender and Social Welfare. - Women in AIDS : They engage in income generally activities. For example, they get together and plough the fields for children who have been affected by HIV/AIDS. - Awareness creation : the local language called Sosotho is used to create awareness of the disease through the media.
MALAWI	• National AIDS Council (NAC) • Agriculture • Education • Health	• increasing discussion on HIV/AIDS infections - Heavy release on the clinical diagnosis for AIDS . - Door to door discussion of HIV/AIDS • Voluntary counseling and testing which has increased over the years. - Support of top management and commitment - Formation of HIV/AIDS Associations - Participation of HIV/AIDS patients in training programmes • Mainstreaming HIV/AIDS in the Curriculum • AIDS awareness campaign by staff of the Ministry of Health to talk to students and staff
MOZAMBIQUE	- National AIDS Council, Education, Health, Finance and Planning	- Use of drama to sensitize the community on the dangers of HIV/AIDS - Creation of focal points in the public sector ministries - Programmes for care and treatment for all infected patients - Mobile groups against HIV/AIDS go round to sing with HIV/AIDS positive persons in different communities. - Use of HIV/AIDS as an opportunity to improve services
SWAZILAND		- Non existing because people have been slow in grasping the magnitude of HIV/AIDS and doing something about it in terms of policies and strategies
ZAMBIA	- Inter-Religious - Ministry of Finance and National Planning (MFNP)	**Treasuring the Gift :** Is a project that brought together various religious denomination with the operational objective of developing sexual health learning materials aimed at dissemination information on sexuality, reproduction and HIV/AIDS and other STDs. The strengths of the project lies in its focus on the youths, uses peer education and participatory learning and action technique as well as interfaith approach to sensitive topics. The outcome of the project is a 142 – page book entitled " Treasuring the Gift : How to handle God's gift of sex" that is easy for use for HIV/AIDS education. **HIV/AIDS Work Place Programme :** is coordinated by the Health and Social Welfare and Technical Committee of the Ministry of Finance and National Planning. The programme is distinguished by the fact that in addition to raising awareness and providing advocacy and sensitization, it provides moral, spiritual and material support to ailing employees without segregation.

ZIMBABWE	• Ministry of Health	• Training of peer trainers who are middle managers in all fields - Peer education given to women and men who are role models and knowledgeable. - Orphans and children affected by HIV/AIDS receive, visits from community members - Voluntary counseling and testing centers which were created since 1999. More than 50 000 clients were counseled and tested in 2001 and by the end of that year actual demand had exceed projections by 42% and 10 VCT clinics were opened a strategic locations in the country.

Source : Compiled from Field Interviews and Policy Documents on HIV/AIDS

Overall, and in terms of replication by other countries and institutions, five best practices emerge from our findings. Three are related to improving funding availability for HIV/AIDS programmes while the remaining two relate to programme management. The first is the policy in Lesotho and Malawi which stipulates that 2% of each public sector ministry budget should be allocated to HIV/AIDS programme. The second is the AIDS Levy in Zimbabwe in which 3% tax is paid on taxable income and which has cumulated into billions of Zimbabwe dollars each year. The third best practice is the levy for HIV/AIDS risk behaviours where such items as cigarette and alcohol are taxed.

The fourth is the provision of HIV/AIDS information corners in the Ministry of Finance and National Planning with inter-active TV monitors put in places where staff congregate and in key offices. This example from Zambia has enabled many staff to have access to HIV/AIDS information. Finally, is the policy in Zambia which states that each ministry should have an HIV/AIDS Technical Committee with members drawn from all the departments of the ministry. These types of practices can be replicated in other countries to increase availability of funds for HIV/AIDS, programmes, particularly from external sources, and to effectively monitor and contain the spread of the epidemic.

VIII CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

Overall, the study has demonstrated beyond doubt that HIV/AIDS represents a multi-faceted complex set of problems that has crossed all social and economic boundaries in the six countries. The scope and gravity of this pandemic on the public sector Ministries and institutions have been overwhelming. To this extent, the message of this study is not that the situation is hopeless but that unless it is treated with sufficient urgency and on an adequate scale, the socio-economic impact, particularly on the public sector Capacity, in the six selected countries, and other countries in Sub-Saharan Africa, may become devasting and irreversible.

Consequently, in order to enable the countries to effectively address the challenge of arresting the spread of HIV/AIDS and managing the socio-economic impact, not only ACBF and UNAIDS, but also all sectors and other development partners and African governments need to embrace the full enormity of HIV/AIDS within the training and capacity building programmes to ensure an adequate response in the public sector ministries and institutions in the six countries.

However, the inadequate attention given to HIV/AIDS in the New Partnership for Africa's Development (NEPAD) is symptomatic of the inability to come to grips with the wider socio-economic development implications for Africa of the worst epidemic in modern times

The overall conclusions recommendations have been based on the analysis in the preceding sections to enhance ACBF's knowledge of the status of the public sector capacity in the six countries studied with a view to guiding the Foundation's interventions in the strengthening of public sector capacity in the face of the threat posed by the HIV/AIDS epidemic. To this end, this section has highlighted the following areas for the intervention of the Foundation and other development institutions :

- Critical Areas for Training and Capacity Building.
- Training and Capacity Building Programmes for Staff Replenishment.
- Mainstreaming HIV/AIDS into Public Sector Management Programmes.
- Programmes for Enhancing Information Sharing and Learning.
- Best Practices/Successful Programmes/Policies and Strategies for Replication.

8.2 Identified Critical Areas for Training and Capacity Building

On the basis of its observations, assessments and findings during the field mission, the study team identified critical areas which could guide the Foundation's comprehensive training and capacity building programmes in each of the six study countries. These areas and recommended programmes in some cases are presented in Table 25.

Table 25 : Critical Areas for Training and Capacity Building

Country	Ministry/Institution	Identified Critical Areas for Training and Capacity Building
LESOTHO	• Development Planning	- Training of Statisticians, Economists, Human Resource Management Specialists and Policy Analysts need to be reinforced.
MALAWI	• Department of Human Resource Management and Development (DHRMD)	•The DNRMD should put in place a mechanism to facilitate fast tracking the recruitment system in order to improve government operations; a comprehensive incentive package should be developed to cater for the skills that are difficult to replace. - Government should explore the possibilities of using UN Us (United Nations Volunteers) as a short term measure to replace critical capacities-lost. - Government should institute performance management or result-oriented appraisal system, that consideration should be made to increase the Malawi Government Scholarship Fund (MGSF) to cater for the development of critical skills.
	• Health and Population	• Training of laboratory technicians need to be funded. - Training of personnel for HIV/AIDS testing in the national laboratories. - Provide support to Malawi Colleges of Health Services which train auxiliary staff such as midwives etc.
MOZAMBIQUE	• Finance	• Critical areas for capacity building are in policy analysis and planning.
	• Education	• Educational planning to take into account the implication of HIV/AIDS for both demand and supply sides. - Training of teachers in Education to be aware of AIDS. - There is need to formulate a comprehensive and particular national human resource development strategy .involving both the public and private sector.
	• Health	• Capacity building programmes could be funded in the following areas : - Strategic planning for replacement of staff who have been lost. - Skilled staff who are very conscious of the HIV/AIDS problem. - Research programme on how HIV/AIDS is affecting women and then identify what type of intervention projects can be put in place.
SWAZILAND	• Public Sector Management Department	• There is need for public sector ministries to establishe a research unit to collect, analyses data and prepare policy papers. • There is need to strengthen policy analysis and management. - It is important for public sector ministries to spend funds on training and multi-skilling.
	• Health	• There is no public health capacity especially laboratory technologist, doctors, midwives etc thus there is need for training in this areas.
ZAMBIA	• Ministry of Health (MOH)	•Medical Doctors, Clinical Officers, Registered Nurses, Registered Midwives, Environmental Health Technicians, Laboratory Technicians, Radiographers, Zambian enrolled midwives, Zambian enrolled nurses, Physiotherapists

	• Education • Finance and Planning	•Teachers for Grades 1 – 7 level and Grades 8 and 9 level •Economists and planners.
ZIMBABWE	• Health • Industry and International Trade • Public Service Commission	•Training of both senior and junior psychologists and sociologists who can counsel HIV/AIDS patients - Training of peer educators - Training in community-based skills • Training of economists with specialization in international trade issues to deal with WTO, UNCTAD, etc. - Training of economists for designing, implementation, monitoring and evaluation of programmes. • Training of legal officers, administrators, engineers, computer experts, medical doctors and nurses.

The critical areas for training and capacity building vary across countries. However, there exist a need to ensure the existing of AIDS Focal Persons are properly trained in each public sector ministry, especially in Malawi, Lesotho, Zimbabwe. Re-training of existing Focal Persons in other countries is essential as some of them seem to lack adequate skills in performing their jobs.

It was evident that training institutions that produce physicians, pharmacists, nurses, laboratory scientists are in short supply of qualified staff to train these categories of professionals. It is therefore recommended that efforts should be geared towards assisting the countries in identifying and training a set of core staff in these various fields through a special training grant that allows them to attend training institutions for 2-3 years abroad with scholarships. A complementary effort is to recruit, on a short term basis, foreign experts, who can teach in those institutions and mentor the existing staff.

Voluntary Counseling and Testing (VCT) is a major area that needs to be scaled up while psycho-social support training are essential for key staff in each ministry to ensure that people infected or affected with HIV/AIDS can adequately cope with anger, hopelessness and bereavement. The institutionalization of Anti-Retroviral Drugs for public health workers is extremely crucial if VCT is to be effective. Moreover, there is need to train the staff of public sector ministries on how to mainstream gender into their HIV/AIDS programmes since gender issues are hardly mainstreamed into any of the programmes that are being implemented.

Considering the fact that most of the critical areas cut-across the six countries and in order to ensure effective coordination, and efficient implementation, it is recommended that the Foundation should put in place a broad framework which would enable the regrouping of the identified areas in terms of their common characteristics and importance for all the six countries.

8.3 Training and Capacity Building Programmes for Staff Replenishment

In view of the fact that virtually all the training and capacity building programmes were facing considerable financial difficulties and inadequate experienced skilled staff to implement them, it is recommended that rather than mounting new training programmes, the ACBF should provide financial and technical support to facilitate the smooth

implementation of the ongoing programmes specified in Table 8 in each country. By so doing, ACBF would be helping the countries to fill the skill gaps which existed before HIV/AIDS and which have worsened since the advent of the epidemic.

It is clearly evident from all the countries that there is lack of technical skills that can be effectively used to core-stream HIV/AIDS with development plans and programmes combined. In this regard, there is need to strengthen public sector institutional capacity to coordinate, plan and implement multi-sector strategies and programmes so as to limit the spread of HIV/AIDS. Based on this observation, the following recommendations are made:

- Design a training programme for senior civil servants to facilitate the transformation of how the ministries deal with HIV/AIDS in these countries.
- Introduce in-service training on HIV/AIDS for all public sector staff.
- Set up mechanisms for collating HIV/AIDS and "opportunistic infections", morbidity and mortality data in the sector and disseminate this to all key players in the sector on a quarterly basis.

8.4 Mainstreaming HIV/AIDS into Public Sector Development Programmes

In order to effectively address the health and development challenges posed by the pandemic in the study countries, it is absolutely necessary that HIV/AIDS be integrated into the development programmes of the public sector ministries. To the extent that all the public sector ministries and institutions have limited implementation capacity and financial resources, the ACBF could reinforce the newly HIV/AIDS Focal Point Units by sending the staff for relevant training on mainstreaming HIV/AIDS into development programmes with a view to enhancing their ability to effectively carry out this exercise in their respective countries.

Currently, the majority of ministries do not have specific policies on HIV/AIDS. It is crucial that countries should be assisted to plan and draw up HIV/AIDS policies and programmes. Such policies must aim at providing concrete and realistic framework that will guide action by all the players in each ministry. In addition, the policy must also ensure that each ministry has a budgetary component to fight HIV/AIDS. Following this, each sector should be assisted to come up with innovative and creative response that can empower and stimulate sector staff behavioural change.

Of importance, is the need to ensure that gender issues are integrated (both women issues and male involved) into the design an HIV/AIDS management programmes. Furthermore, staff access to care and operation need to be embodied in the control programme including free access to anti-retroviral drugs. The provision of ARV to employees in public sector will ensure extension of life thereby providing leverage for capacity building.

Since it was observed that a sizable number of staff offered collective team prayers before their daily work in the offices, involvement of leaders of faith-based organizations in behaviour change communication, education, care and support at the ministry level is recommended.

8.5 Programmes for Enhancing Information Sharing and Learning

It will be recalled that one of the objective of the study, was to review and access the number, quality and adequacy of HIV/AIDS awareness, education information sharing and learning programmes in the public sector ministries and institutions in each of the six countries with a view to identifying and documenting the best practices and replicable programmes. This is important for learning, and information sharing is learning from each other by experiencing different situations and taking time to reflect on our own contributions and work with a view to making improvements. However, as prescribed in earlier sections, only few institutions have education, awareness and learning programmes.

While educational and information campaigns should continue to be vigorously pursued in all the countries, it is important that assessment of HIV/AIDS knowledge, attitudes and practices of staff in different ministries need to be conducted including learning programmes that are perceived as appropriate. The conduct of this assessment notwithstanding, there is need to support programmes where staff who are HIV positive or those with "opportunistic infections" can share their experiences with other line ministry staff to enhance information sharing, learning and stimulates behaviour change.

Furthermore, is the observation in respect to absence of computers and staff who are skilled in e-learning programmes in the Universities and who can catalyse the use of e-learning programmes ACBF may wish to support a few ministries in all the six countries such as the Ministries of Education, Finance, Tourism and Women Affairs with inter-active learning programmes on HIV/AIDS.

8.6 Best Practices, Successful Programmes, Policies and Strategies for Replication

During the interviews carried out by the study team in the six countries, it was observed that there were varying types of best practices, successful programmes, policies and strategies which could be replicated within the individual countries, and also in other countries and regions which were not covered.

It can be observed from Table 26 that the Best Practices vary from country to country. However, voluntary counseling and testing, awareness condom distribution and creation of Focal Point Units in some key public sector ministries, universities and institution, were common best practices in two thirds of the study countries. There is no doubt that the effective implementation of these Best Practices would have long term positive impact on evaluating the national response to HIV/AIDS.

Table 26 : Best Practices/Successful Programmes/Policies/Strategies for Replication

Country	Kind of Best Practice/Programmes/Policies and Strategies for Replication
LESOTHO	- Mainstreaming HIV/AIDS activities in the Ministries e.g 2% of the budget or each ministry allocated to support HIV/AIDS. - Peer Education - Life skills - Girls to say no to sex. - Awareness creation through the media , voluntary counselling and testing. - Focal Point persons in the public sector ministries . - Prevention of Mother to Child Transmission (MTCT)
MALAWI	- ABCs of safe sex practices. - Safe/Blood policy. - Voluntary Counselling and Testing (VCT) - Discussion on HIV/AIDS infections. -Door to door counselling. - Focal Point persons and units in public sector ministries and institutions.
MOZAMBIQUE	- VCT. - ARV treatment. - Day care for HIV/AIDS orphans. - Treatment of opportunistic infections. - Home based care for infected person. - Prevention of MTCT (Mother to Child Transmission). - Life skills of students, particularly girls. - Care and protection for children who are vulnerable to HIV/AIDS. - Focal Point Units in each public sector ministry. - Mobile groups against HIV/AIDS. - Awareness creation through Drama and Theatre. - Condom distribution. - Programmes for people living with AIDS.
SWAZILAND	- Voluntary ounselling and Testing. - Rehabilitation of infected persons. - Awareness creation – campaign launched in the entire country. - Condom distribution programme. - Medical Aid for civil servant who are infected. - Care management system.
ZAMBIA	• Treasuring the Gift : which brings together various religious denominations with the aim of developing learning materials for education in reproduction health, sexuality, HIV/AIDS and other sexually transmitted diseases. • How to handle God's Gift of Sex" that contains 18 participatory learning and well illustrated activities, easy to use for replication by youth groups.
ZIMBABWE	- Decentralisation of programmes to cover many areas of the country. - Administrative costs are kept low by maintaing the smallest central organisation possible. - Voluntary activities are more efficient. - Openness to group discussions and information distribution. - Low nominal fees for pre-test, post-test counselling. - Confidential environment to keep people HIV/AIDS secret.

One striking observation is that during the course of this assignment, most ministry officials that the team discussed with during the mission, especially in Swaziland, Lesotho, Zimbabwe, on the subject on impact of HIV/AIDS and programmes appeared as if the ACBF has just given them a wake-up call to their responsibility. Comments like "we never thought of this before", "This is what we should have done years ago", "We are going to start something in our ministry now" echoed loudly from key public sector managemnt and staff.

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ANNEX I

NAMES OF PEOPLE INTERVIEW; MINISTRIES/INSTITUTIONS VISITED

LESOTHO

Name	Position	Ministry/Institution
Mrs. Monaheng	Director of Administration	LAPCA (Lesotho AIDS Coordinating Authority)
Mrs. Lefosa	Economist	Department of Population and Training
Mrs. Jaase Ntisiuoa	Chief Economic Planner	Ministry Development and Planning, Maseru, Lesotho
Mrs. Monaheng	Economic Planner	Ministry Development and Planning, Maseru, Lesotho
Dr. Majero	Director	Ministry of Finance
Mokhothu Makhalanyane	HIV/AIDS Programmes Manager	Maloti Hospital, Mapoteng, Lesotho. Private Hospital
Mr. Ernest Fausther	UNDP Deputy	Resident Representative, United Nations Development Program, UN house, United Nations Road, Lesotho
Mr. Mojakisane Mathana	Social Policy Planner	UNDP, Lesotho

MALAWI

Name	Position	Ministry/Institution
Ms. Tiwonge Thindwa	Monitoring and Evaluation Officer	UNAIDS, Lilongwe, Malawi
Dr. B.S.M. Mwale	Executive Director	National AIDS Commission, Malawi
Mr. Kamanga	Deputy Secretary	Ministry Responsible for HIV/AIDS
Mr. Beenwell Bands	Director of Human Resource Planning	DHRMD
Mr. Dickson Chunga	Director, Human Resources Management	DHRMD
Mr. Sibo Jere	Chief Human Resource Planning Officer	DHRMD
M.P. Magwira	Deputy Secretary	Office of the Vice President, Malawi
Dr. Davies	Director	Centre for Disease Control
Mr. E.C. Kagonegone	Controller of Human Resources Management and Development	Ministry of Agriculture and Irrigation, Lilongwe Malawi
Mr. Tibies Mtokup	Human Development Officer	Irrigation and Food Security
Mr. Mishe Longwe	Principal Economist	Ministry of Agriculture
Mr. Willen Pheawa	Assistant Principal Officer (Agric Extension)	Ministry of Agriculture
Mr. R.P. Mwadiwa	Principal Secretary	Ministry of Gender and Community Services, Malawi
Dr. Rex. C. Mpazange	Director of Clinical and Population Services	Ministry of Health
Mr. Bona Mjojo,	Chief Human Resource Management Officer	Ministry of Education
Fred. W.Y. Mwathengere	Programme Analyst	(HIV/AIDS) UNDP, Malawi

MOZAMBIQUE

Name	Position	Ministry/Institution
Stella Pinto	Assistant Resident Representative	Poverty Eradication Unit, UNDP Maputo, Mozambique
Mr. Ivo Correia and Mrs. Ombietta Badggi O.	Country Coodinator Programme Officer	Deputy Officer in Charge, UNAIDS, Maputo
Ms. Lentira dos Muchaugos	Director	Ministry of Women and Social Affairs, Maputo Mozambique
Ms. Sonia Romao	Focal point Person	Ministry of Women and Social Affairs, Maputo Mozambique
Dr. Duogo C.O. Milagu	Deputy Executive Secretary	National AIDS Council, Mozambique
Ms. Christiana Matusse	Head Dept. of Macro Economic Analysis	Ministry of Planning and Finance, Maputo, Mozambique
Mr. Romeu Rodrisues	Director	Private Sector Companies
Mr. Virgilio Juvane	Director of Planning,	Ministry of Education, Maputo, Mozambique
Mr. Humberto Casso	Director of Planning	Ministry of Health, Maputo
Alexander Aboagye	Economic Adviser	Economic and Policy Analysis Unit UNDP, Mozambique
Eunice Taibo	Programme Assistant	UNDP, Mozambique

SWAZILAND

Name	Position	Ministry/Institution
Ms. Nomathenba Hlore	National Director,	Public Sector Management
Ms. Tehnbekilo Makama	Assistant Manager Analysis	
Mr. Alan Brody	Country Representative	UNICEF, Mbabane, Swaziland
Ms. Loko Mkhabela Mkhabela	Deputy P.S. Under Secretary	Ministry of Health and Social Welfare
Mr. Malo E. Mthande,	Assistant General Manager	Swaziland Royal Insurance Cooperation, Swaziland
Dr. Simelane	Deputy Principal Secretary	Ministry of Education
Mr. Dalmini	Director	National Pension Fund
Derek Von VISSELL	National Director	National Emergency Response Council on HIV/AIDS, Mbabare, Swaziland
Mr. Ton Vriend (NLO)	HIV/AIDS Coordinator	Business Coalition, Babane, Swaziland
Evart V. Dlamini	HIV/AIDS Coordinator	Swaziland National Association of Teachers
Rudolph T.D. Maziya	National Coordinator	The Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL) Swaziland

ZAMBIA

Name	Position	Ministry/Institution
Lawrence Njobvu	Assistant Director	Ministry of Finance, Human Resource Management and Development, Zambia
Ms. Malanbo		Ministry of Education, Lusaka
Kinge Namanga,	OCHA Advisor	UN Resident Coordinator's Office, Alick Nkhata Road, Lusaka, Zambia
		Ministry of Health, Zambia
Dr. George Tembo	Programe Advisor	UNAIDS Country, Programme Advisor, Zambia

ZIMBABWE

Name	Position	Ministry/Institution
Dr. George TEMBO	Country Programme Adviser	UNAIDS, Harare, Zimbabwe
Dr. Xaba Dr. Mugurungi Mrs. Scimbanda	Principal Secretary HIV/AIDS Coordinator Finance Director	Ministry of Health Ministry of Health Ministry of Health
Mrs. Etinle Mr. Mujaya		Reserve Bank of Zimbabwe
Dr. Murewa	Minister of Finance	Ministry of Finance
Dr. E. Njdesani Dr. Makunke Dr. Dhlinwayo	WHO Resident Rep. HIV/AIDS Coordinator Disease Prevention Control	WHO, Harare, Zimbabwe WHO, Harare, Zimbabwe WHO, Harare, Zimbabwe
Dr. Angelo	UNDP Resident Rep.	UNDP, Harare
Hon. K. Manyonda Mrs. Magade Mrs. Zhanje	Deputy Minister Deputy Director Planning Deputy Director Enterprises	Ministry of Industry and International Trade Ministry of Industry and International Trade Ministry of Industry and

		International Trade
Mr. Magavani	Deputy Director, Human Resources	Ministry of Industry and International Trade
Ms. K. Muhambi	National Coordinator	Zimbabwe AIDS Network, Harare, Zimbabwe
Mrs. Chigwamba	General Manager	Public Service Commission, Harare, Zimbabwe