SADC HIV Prevention Meeting: Achieving Prevention Targets

JUNE 7-9 2009 / Johannesburg, South Africa
Acknowledgements

The SADC Secretariat expresses its appreciation to the following individuals who contributed to the final report:
Marelize Gorgens, Antonica Hembe, Helen Jackson,
Lisa-Anne Julien, Alphonse Mulumba and Mary O’Grady.

ISBN 978 99912-0-914-2

© A SADC publication, August 2009

The designations employed in the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of SADC concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitations of its frontiers or boundaries.

The mention of specific companies or certain manufacturers’ products does not imply that they are endorsed or recommended by SADC in reference to others of a similar nature that are not mentioned.

SADC does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

For more information:
SADC HIV and AIDS Unit
SADC Secretariat
P/Bag 0095
Gaborone
Botswana
Tel • (267) 395 1863
Fax • (267) 397284/318 1070
Email • HIVunit@sadc.int
Website • www.sadc.int
SADC HIV PREVENTION MEETING: ACHIEVING PREVENTION TARGETS

JUNE 7-9 2009

Johannesburg, South Africa
Acronyms

AIDS
Acquired immune deficiency syndrome

ARASA
AIDS Rights Alliance for Southern Africa

ART
Antiretroviral therapy

ARV
Antiretroviral

CSO
Civil society organisation

DHS
Demographic and Health Survey

FSW
Female sex worker

GAMET
Global AIDS Monitoring and Evaluation Team of the World Bank

GBV
Gender-based violence

GHAP
World Bank’s Global HIV/AIDS Program

HIV
Human immunodeficiency virus

HTC
HIV testing and counselling

IDU
Injecting drug user

M&E
Monitoring and evaluation

MC
Male circumcision

MCP
Multiple and concurrent sexual partnerships

MSM
Men who have sex with men

MTCT
Mother-to-child transmission of HIV

NAC
National AIDS Council/Commission

NGO
Non-governmental organisation

NSF/ NSP
National strategic framework/plan

OVCY
Orphans and vulnerable children and youth

PLHIV
People living with HIV

PMTCT
Prevention of mother-to-child transmission of HIV

SADC
Southern African Development Community

SAFAIDS
Southern Africa HIV and AIDS Information Dissemination Service

SANAC
South African National AIDS Council

SBCC
Social and behaviour change communication

Sida
Swedish International Development Cooperation Agency

SRHR
Sexual and reproductive health and rights

STI
Sexually transmitted infection

TA
Technical assistance

TB
Tuberculosis

UNAIDS
The Joint United Nations Programme on HIV/AIDS

UNAIDS RST ESA
The Joint United Nations Programme on HIV/AIDS Regional Support Team for Eastern and Southern Africa

UNFPA
United Nations Population Fund

UNGASS
United Nations General Assembly Special Session

UNICEF
United Nations Children’s Fund

VCT
Voluntary counselling and testing

WHO
World Health Organization
# Table of Contents

- Foreword // IV
- Executive Summary // VI
- Background and Objectives // 1
- Keynote Address // 1
- Status of National HIV Prevention Efforts in the Region // 2
- Emerging Issues in the HIV Prevention Agenda // 5
- Criminalisation and HIV // 9
- Thematic Areas for HIV Prevention: Key Issues // 10
- Prevention of mother-to-child transmission (PMTCT) // 10
- HIV testing and counselling // 12
- Male circumcision // 13
- Multiple and concurrent sexual partnerships (MCP) // 14
- Vulnerable and marginalised populations // 17
- Positive health, dignity and prevention // 19
- Gender issues // 21
- Orphans and vulnerable children and youth (OVCY) // 22
- Condom programming // 23
- Leadership // 25
- Resource allocation // 26
- Conclusions and Recommendations // 26
- Closing Session // 29
- Annex 1: Civil Society Indaba Communique // 30
- Annex 2: Meeting Agenda // 31
- Annex 3: Participants List // 33
Despite intensified efforts to halt and reverse the HIV epidemic, an estimated 2.7 million people were newly infected with HIV worldwide in 2007. Southern Africa continues to grapple with the highest burden of HIV infections globally, with 35% of all new HIV infections and 38% of all AIDS-related deaths in 2007.

The 2007 SADC HIV and AIDS Epidemic Report showed that much work is still needed to meet the targets of Universal Access to HIV prevention, treatment, care and support. In 2007 the prevention of mother-to-child transmission (PMTCT) programmatic coverage in the SADC region stood at 48%, while 70% of the individuals in need of antiretroviral therapy (ART) were not yet receiving it.

Preventing new HIV infections in the SADC region is vital to reverse the epidemic and achieve treatment, care and mitigation targets. With the current global economic crisis, less international donor funding available, and the risk of national spending cuts on social development and healthcare, prioritising HIV prevention is the most cost-effective and, in fact, only viable strategy to address the epidemic. Unless new infections of HIV are reduced significantly in the foreseeable future, the rising costs of treatment and care will be overwhelming and unachievable long term, posing a serious threat to the potential for SADC Member States to realise the human, social and economic development goals of the region.

The political commitment to responding to the HIV epidemic in Africa is evident through the signing of various recent declarations across the region in support of the Millennium Declaration and Development Goals and the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) targets. These include the Abuja Declaration on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases (2001), the Maseru Declaration on HIV and AIDS (2003), the Maputo Declaration accelerating HIV prevention (2005), and the 2006 Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and
reach the target of:

Halving new adult HIV infections by 2015 & virtually eliminate mother-to-child HIV transmission.

AIDS Prevention, Treatment, Care and Support in Africa by 2010. All indicate the urgency of tackling the epidemic with greater impact to meet the agreed targets. What is needed now is the translation of these commitments into truly effective, efficient programmes brought to scale across the region. Since the May 2006 SADC Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa, Maseru, Lesotho, both the SADC Secretariat and Member States have prioritised turning off the tap of new HIV infections, as indicated in the SADC HIV Prevention Strategy 2008-2010.

The central recommendations of this important SADC Meeting on HIV Prevention: Achieving Prevention Targets, 7-9 June 2009, is to reach the target of halving new adult HIV infections by 2015 and to virtually eliminate mother-to-child HIV transmission (thereby virtually eliminating new infant infections). To achieve these targets will require increased commitments on prevention resource allocation, policy development and programme implementation based on sound research and evidence - with in depth research into the key drivers of the epidemic where this is not already in place. SADC Member States need the right and sufficient support to revise national strategy frameworks and plans, and to develop prevention strategies and plans that translate into fully operational, funded, evidence-informed programmes.

For the SADC region to achieve success in preventing new HIV infections in the coming years, robust strategic partnerships must be consolidated between government, civil society groups, community-based and faith-based organisations, traditional authorities, regional bodies, international development partners and the private sector. Harnessing efforts and energies across the region will ensure that the response to the HIV epidemic is comprehensively planned, well-coordinated and implemented through dedicated and uncompromising leadership - from the highest levels nationally and internationally to traditional leaderships and the community and household levels. With all of us working together and supporting each other, we can address the recommendations from the wide-ranging partners in this meeting and we can turn back the epidemic in this region.

Dr. Tomaz Augusto Salomão
SADC Executive Secretary
Turning off the tap of new HIV infections is vital to reduce human suffering, to achieve universal access to treatment, care and mitigation, and to achieve wider human and social development goals within the SADC region. As part of its commitment to HIV prevention, the SADC Secretariat HIV and AIDS Unit convened the SADC HIV Prevention Meeting: Achieving Prevention Targets on 7-9 June 2009 in Johannesburg, South Africa. This was three years after the SADC Expert Think Thank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa, Maseru, Lesotho, that identified key drivers of the epidemic and made recommendations for an intensified response. The June 2009 meeting discussed the degree of implementation of the key recommendations of the Maseru meeting and of the SADC HIV Prevention Strategy, reviewed the progress against UNGASS indicators and the SADC Epidemic Report, 2008, reviewed the successes, bottlenecks and the challenges experienced to date, and identified emerging evidence and issues and the highest priorities for HIV prevention in the coming period.

The meeting was well attended by more than 85 participants from national AIDS authorities, ministries of health, youth and public service agencies, offices of the presidency, civil society organisations, research and technical assistance institutions and international cooperating partners, including UN agencies and international donors.

In addition to reviewing progress on HIV prevention, the meeting reviewed a range of thematic areas of HIV prevention and their implementation in SADC countries. These included social and behavioural change interventions, a focus on vulnerable populations and sexual risk, prevention of mother-to-child transmission (PMTCT), HIV testing and counselling (HTC), male circumcision (MC) and multiple and concurrent partnerships (MCP). The implications of the challenges facing people living with HIV (PLHIV), such as the criminalisation of HIV transmission, were also discussed. Participants agreed that more effective monitoring and evaluation (M&E) systems, including those designed to measure multiple and concurrent sexual partnerships (MCP) and HIV incidence, are urgently needed.

The participants recommended that SADC countries set the targets of halving new adult HIV infections by 2015 and the virtual elimination of mother-to-child HIV transmission (thereby virtually eliminating new infant infections). To achieve these targets, participants agreed that countries should give priority attention to:

- Rapid analysis of current national strategic frameworks and plans to ensure a strong evidence-based prevention component
- Mobilising effective leadership at all levels of government to take ownership and accountability of the HIV prevention agenda in general and, in particular, of the proposed SADC prevention targets
- Revising budget allocations to ensure adequate funding for prevention, capacity building and mobilising for increased funding where necessary
- Increasing strategic partnerships for full implementation of HIV prevention strategies, in particular with traditional leaders, civil society organisations and youth organisations
- Understanding and establishing a stronger connection between HIV prevention and treatment.

Participants also recommended the establishment of a small Working Group on Leadership as a vehicle to present issues to the SADC Heads of State Summit and to continuously engage with SADC leadership on issues related to HIV and AIDS.
Mobilising efforts and scaling up the HIV prevention response across southern Africa has been a growing priority for SADC since 2005. The SADC Secretariat, with the support of the Regional HIV Prevention Working Group comprising UNAIDS, UNFPA, WHO, UNICEF, and Sida, convened the Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa in Maseru, Lesotho, in May 2006. Experts identified key drivers of the HIV epidemic and made recommendations for the acceleration of prevention efforts to address them over the coming two years, including recommendations for National AIDS Councils, SADC, and international cooperating partners. At a regional policy level, The SADC Regional Strategy and Action Plan for Universal Access to Prevention 2008-2010 aims to harmonise country policies and practices and mobilise for the effective use of resources with the goal of significantly reducing new HIV infections by 2010. SADC has also undertaken an epidemiological review of the epidemic against UNGASS targets.

The SADC HIV Prevention Meeting: Achieving Prevention Targets, 7-9 June 2009, Johannesburg, was organised by the SADC HIV and AIDS Unit with support from a small working group (UNAIDS, UNICEF, UNFPA, Southern African AIDS Trust, and the US Government). This group was drawn from the SADC’s wider HIV Prevention Group of SADC Member States, international collaborating partners and non-government organisations, with the addition of Jonathan Gunthorp, acting Executive Director of the Health Economics and AIDS Research Department of the University of KwaZulu Natal, who facilitated the meeting. The meeting objectives were to review progress on prevention in the SADC Member States towards the prevention recommendations from the Think Tank meeting, and the SADC regional HIV prevention strategy and targets; to discuss key issues and identify challenges; to raise understanding of measurement issues for prevention; to make recommendations for strengthening evidence-based strategies; to reinforce commitment to and strengthen targets for prevention; and to identify critical technical needs to achieve them.

Mr. Mark Stirling, Regional Director of UNAIDS Regional Support Team for Eastern and Southern Africa (RST ESA), reminded the meeting participants of the grim reality of the challenges facing the SADC region: nearly 15 million people living with HIV (PLHIV), 1.15 million additional people infected during 2008, meaning an average 3,150 new HIV infections each day. Preventing new infections not only signals preventing potential harm, death and orphanhood on a massive scale, but it also safeguards the human and financial resources required to expand and sustain treatment for the large and growing population of people in need.

In some severely hit parts of the SADC region, there is growing evidence of a decline in adult HIV prevalence, including in Zimbabwe and Botswana and in some urban settings in Malawi and Zambia, for example. Seven SADC countries show prevalence declines in young women attending antenatal clinics: Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe, although the rates remain stubbornly high in South Africa and Mozambique. In countries where there has been a decline in HIV prevalence in young people, this is associated with significant changes in sexual behaviour, including delays in the age of first sex, reductions in the number of sexual partners and increases in condom use in casual sexual relations. These findings confirm that investments made in social and behavioural change interventions can work for HIV prevention, but they must be scaled up with rigour, and in combination with other actions that reduce HIV risk and vulnerability.

To meet Millennium Development Goal (MDG) 6, to halt and reverse the spread of AIDS by 2015, Mr. Stirling identified two requirements from SADC Member States: (1) to achieve universal access to treatment to keep PLHIV alive; and (2) to bring about a significant and sustained reduction in the number of new HIV infections. He urged participants to consider a SADC target of halving new HIV infections by 2015. Meeting this goal would reduce projected new infections of 1.15 million to about 575,000 annually by 2015 and avert 1.6 million new infections, save approximately $10.7 billion in treatment costs, and enable the Member States to
deliver on their commitment to MDG 6. He also suggested the following five actions to bring about social transformation and the ultimate achievement of this target:

- The most senior leadership in government, civil society, traditional authorities, private sector and faith-based communities need to adopt, own and drive this goal, thus ensuring stewardship across the SADC region towards achieving an AIDS-free generation. The 2010 SADC Heads of State Meeting is an opportunity for such leadership to be expressed.
- Encouraging all SADC Member States to ensure that national targets, prevention strategies, budgets and partnerships reinforce the regional SADC target of halving new HIV infections by 2015.
- Advocating for a combination approach to HIV prevention that is locally tailored to act simultaneously on the immediate risks and underlying drivers of the epidemic by choosing the right mix of prevention actions and tactics to respond to the unique epidemics in each country, rather than adopting a quick and/or single intervention fix. A combination approach involves linking prevention with treatment access and improving the quality and reach of prevention of mother-to-child transmission of HIV services.
- Clarifying accountability for HIV prevention by strengthening national capacities to lead and manage the prevention agenda with unambiguous authority; strengthening the role of Cabinet members and Parliamentarians to provide the stewardship, coordination, resources and public accountability will be required for a successful response.
- Engineering ways to hold governments accountable for HIV prevention strategy implementation, donors accountable for the required financial resource and technical support provision, and faith and traditional leaders accountable for clear messaging and consistent leadership on HIV prevention at the community level. Activism ensures that communities are involved, informed and participating in realising their rights to HIV prevention.

The meeting should address these aims, determine an action agenda and commit to keeping pressure on us all to prioritise HIV prevention.

Review of national HIV prevention efforts was based on several sources to supplement the 2007 SADC HIV and AIDS Epidemic Report (September 2008). Supplementary information on addressing the 2006 Think Tank recommendations and alignment with the SADC Prevention Strategy and Plan of Action 2008-2010 was supplied by 13 SADC Member States in template form prior to the meeting, and some additional information was garnered from a ‘Gallery Walk’, an exhibition on status, progress, successes and challenges of SADC Member States on the first evening. The SADC strategy on prevention, endorsed by SADC Ministries responsible for health and those responsible for HIV and AIDS, is an important development at regional level to harmonise HIV prevention policies and assist SADC Member States in implementing effective prevention strategies. The present meeting was one of the commitments within the regional prevention strategy.

Twelve Member States have reviewed national policies and programmes to align them with the recommendations and with the regional commitments and declarations on HIV prevention. Of these, six Member States are fully aligned with the SADC regional HIV prevention strategy, five are partially aligned, and one is not aligned. Five Member States have implemented communication strategies on reducing multiple concurrent sexual partnerships (MCP). Seven Member States have held national consultations on male circumcision (MC), and four have MC policies currently under development. Five have strengthened the technical capacity of their HIV prevention specialists. More than 50% of the Member States have fully aligned their M&E systems with the SADC frameworks.

Policy guidelines relating to HIV testing and counselling have been implemented, and voluntary counselling and testing and also management of sexually transmitted infections have expanded. Increased networking among partners in the region has also occurred. Regarding monitoring and evaluation (M&E), all Member States have prepared annual epidemic reports, and some countries have conducted training on the design, planning and management of M&E systems. Across the region, a system needs to be established to transfer knowledge between Member States and their capacity increased to incorporate and build on indigenous knowledge.
Nearly all Member States are reporting either a reduction in their HIV prevalence rates or a stabilisation, with some positive results against a number of indicators. Member states are also aware of the need to measure HIV incidence rates (the percentage of new infections in a population in a year), in addition to HIV prevalence rates (the percentage of the population living with HIV); treatment roll out can increase prevalence and mask achievements in reducing new infections.

**Figure 1:** HIV prevalence among 15-24 year olds, December 2007 • **Source:** SADC Member States HIV and AIDS epidemic reports

<table>
<thead>
<tr>
<th>Country</th>
<th>Time period for which prevalence data were available</th>
<th>Prevalence trend</th>
<th>Percent of young people (15-19 years) having had sex before age of 15</th>
<th>Proportion having sex with more than one partner in the last 12 months</th>
<th>Condom use during last sex among those with more than one partner in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>ID, ID</td>
<td>ID</td>
<td>ID</td>
<td>ID</td>
<td>ID</td>
</tr>
<tr>
<td>Botswana</td>
<td>2001-2006</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Ethiopia</td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Kenya</td>
<td>2000-2005</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Lesotho</td>
<td>2003-2007</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Malawi</td>
<td>1999-2005</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Mozambique</td>
<td>2000-2007</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Namibia</td>
<td>2002-2006</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Rwanda</td>
<td>1998-2003</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>South Africa</td>
<td>2000-2006</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Swaziland</td>
<td>2002-2006</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Uganda</td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>2000-2006</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Zambia</td>
<td>1998-2004</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>2000-2004</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

**Key:**

1. Highlighted cells indicate positive trends in prevalence or behavior.
2. * indicates that consistent sites only were used in the analysis of change in HIV prevalence over time, for a minimum of three years.
3. Significance test based on H0: slope = 0
4. ▲ Observed increase in HIV prevalence or behaviour
5. ▼ Observed decrease in HIV prevalence or behaviour
6. ◀ No evidence of change
7. ID Insufficient data
8. ND Data not received

**Figure 2:** Prevalence and behavioural trends among 15 – 24-year-olds in the eastern and southern Africa • **Source:** UNAIDS Global Report on the HIV Epidemic, 2008
The 2007 SADC HIV Epidemic Report Summary and United Nations General Assembly Special Session (UNGASS) 2008 Report on Indicators highlighted a distinct gap, however, between the Universal Access targets and country achievements to date. By 2007, there was 30% coverage of ART, with just over 4.5 million people still in need of treatment. On average in 2007, the region saw 44% prevention of mother-to-child transmission (PMTCT) coverage, with 720,000 individuals still in need. In regard to both targets, countries such as Botswana, Swaziland and Namibia have made considerable progress. One concern is that HIV prevention programmes largely focus on primary prevention of infection in uninfected individuals and only marginally address issues related to preventing onward transmission of infection by people who know they are HIV positive.

Reports show early sexual debut of many young men and women in several SADC countries. In Madagascar, for example, 36% of men and women aged 15-24 reported having had sexual intercourse before the age of 15, and 32% in Angola. Reviews also show increased knowledge of HIV prevention in many countries. In South Africa, for example, 88% of young women and men in the age group 15-24 could correctly identify ways of preventing sexual transmission of HIV and rejected major misconceptions. Nonetheless, accurate personal risk perception is likely far lower.
In 2007 a number of SADC Member States failed to report on their financial commitments to HIV and AIDS derived from the national budgets and requested technical assistance on tracking the financial resources spent on healthcare and how to secure validated, disaggregated data.

Many Member States cited the continuing challenges of HIV-related stigma and discrimination, poor leadership on HIV prevention and a lack of sufficient resources to scale up prevention efforts. Gender inequality and access to condoms were also identified as major challenges. In addition, Member States noted the lack of a comprehensive M&E strategy and, more specifically, the complexity of measuring HIV incidence as key barriers in meeting their HIV prevention targets and measuring progress.

The Member States agreed that stronger, bolder leadership was necessary to scale up HIV prevention efforts. Initiatives such as male circumcision roll out, reducing multiple and concurrent sexual partnerships and increasing condom uptake have been shown to be important and should be scaled up with urgency. Moreover, HIV prevention strategies are not stand-alone initiatives, but must be integrated into a country’s comprehensive HIV response strategy through an effective combination of evidence-informed approaches.

The nature of the HIV epidemic has changed over several decades, and understanding and responding to the crisis must be rooted in current evidence and analysis. In the last few years, UNAIDS and the World Bank Global HIV and AIDS Program (GHAP) have championed the ‘Know your Epidemic, Know your Response’ approach to provide better information on which to design effective national HIV prevention programmes. Several SADC countries are starting to benefit from this approach. It involves synthesis of Demographic and Health Survey (DHS) and other data and research studies and modelling of the modes of transmission of HIV (where is most new infection taking place); review of the existing national prevention response; and recommendations to strengthen alignment of the response with the evidence of the epidemic drivers in the country and evidence for what works for prevention in the settings where most new infections are occurring. Five countries set the scene for this approach, including three within SADC: Lesotho, Mozambique and Swaziland, and several others, such as Zambia, have followed suit. South Africa is initiating the work in all its provinces in 2009. The Indian Ocean Islands have undertaken analysis of key vulnerable populations in order to streamline their prevention responses.

Data were presented from six ‘Know your epidemic’ studies conducted in eastern and southern Africa as well as other recent research results to present key developments and themes in HIV epidemiology in the region.

**Figure 6:** Incidence by modes of transmission  
*Source:* Kenya, Lesotho, Mozambique, Swaziland, Uganda and Zambia NACs, UNAIDS and GAMET (2009)

The findings indicate the complexity of the epidemics, and the need to redefine the term “low risk heterosexual” sex, given that in high prevalence epidemics, this is where most new infections are occurring – in long-term stable partnerships (in other words, being in a stable relationship is not necessarily protective against HIV transmission). The following slide summarises the estimates for the distribution of new infections in the next 12 months that will occur in the five SADC countries listed.
Five themes emerged from the presentation.

First, the current global economic crisis has the potential of reducing or flattening the domestic and international funding available for HIV programmes in the region. The escalating HIV treatment costs because of increasing numbers of people starting treatment and increased survival rates and therefore fast-escalating treatment costs may crowd out HIV prevention funding (see the hypothetical example below, based on data from the region). Both aspects, prevention and treatment, are essential for an effective HIV response, and the choice should not be made to do one or the other.

Second, there is heterogeneity within the generalised and hyper-endemic epidemics (15% or more of the adult population infected with HIV) in the region. This heterogeneity is visible in the modes of transmission of new HIV infections, in the variation in HIV infection per sub-national level in the country, and in the higher than expected HIV prevalence amongst older adults. One in 14 adults aged 50 and older in eastern and southern Africa is estimated to be living with HIV.
The prevalence of HIV is also much higher in urban than rural areas. Significant proportions of PLHIV live in urban areas in Africa, including in the SADC region, and a much stronger, coordinated focus on HIV prevention in metropolitan areas is overdue. The data highlight the influences that higher population mobility, wealth and education can have on HIV transmission.

The graph shows a rough estimate of the proportion of people living with HIV in the cities counted for that country. For example, in South Africa, half of the people living with HIV are estimated to be in four cities or urban conurbations (this includes Gauteng Province as one extended metropolitan conurbation rather than as three separate cities); in Zimbabwe, 30% of people living with HIV are estimated to live in two cities, Harare and Bulawayo. This analysis is still ongoing and will be firmed up later.

Third, in the hyperendemic countries and some of the higher-burden generalised epidemics in East and southern Africa, HIV prevalence could rise in future as the number of people accessing ART increase and live longer (see the example based on modelled and actual data from Zambia).

This has two implications: first, advocacy is needed among policy makers and the media to foster increased understanding that HIV prevalence rates in countries may increase, not because of increased numbers of new HIV infections, but because of the longer life expectancy of individuals on ART. Second, countries need to focus more on HIV incidence measures: this requires additional HIV surveillance efforts. To help support these additional efforts, guidelines on HIV incidence measures, (differing methods and different ways to express incidence), are being developed by UNAIDS and the World Bank.
Fourth, evidence exists beyond network modeling of the relationship between rates of concurrency (MCP) and HIV prevalence. However, there are challenges in measuring concurrency. So far, different study methods to measure concurrency have produced widely differing results (even in the same study, results differ depending on how and what questions are asked). There is also evidence of recall bias (ability to remember correctly) in men and women, reporting bias (for instance, under-reporting a behaviour if it is thought to be seen as socially undesirable), and difficulties in measuring changes in social norms at the community level. Recently, agreement was reached by the global HIV estimates and projections reference group on ways to measure concurrency in national population-based surveys and on guidelines for measuring multiple and concurrent partnerships.

Fifth, although the relationship between population migration and HIV transmission is known, the special nature of migration patterns in the region warrants comment and attention. An oscillatory migration pattern exists, whereby many people leave home for several months of the year and return home in between work periods to bring back remittances, as the figure below highlights.

Recommendations:

- Implement communication interventions through different media and mechanisms to challenge perceptions around male power, social acceptability of multiple and concurrent sexual partnerships, age-disparate sexual relationships and male circumcision.

- Roll out comprehensive male circumcision programmes particularly in high HIV prevalence countries with low rates of full male circumcision.

- Aim for 100% quality, cost-effective prevention of mother-to-child HIV transmission (PMTCT) services (we know how to do it, and do it right). Services need to range from prevention of infection in young adults and particularly in pregnant women, reducing unwanted pregnancies in HIV-positive women, and ensuring availability and uptake of antiretroviral therapy and treatment, and optimal breast feeding practices.

- Implement combination HIV prevention, which involves biomedical approaches, social and behavioural change, access to ART, and promotion of human rights, all supported by progressive leadership and strong community involvement.

- Ensure HIV prevention programmes are nuanced, targeted, of high quality and brought to scale with sufficient intensity to make an impact. Strong monitoring and evaluation is essential.

Figure 12: Circular migration patterns in Botswana, Lesotho, Namibia and Swaziland • Sources: Government of Swaziland, UNAIDS and the World Bank, 2009; UN-INSTRAW, 2007
Criminalisation and HIV

The AIDS Rights Alliance for Southern Africa (ARASA) outlined the basis for criminalising HIV transmission in Africa. The N’djamena African Model Law (2004), currently in effect in several African countries criminalises HIV transmission. The law requires disclosure of HIV-positive status to a ‘spouse or regular sexual partner as soon as possible and at most within six weeks of diagnosis’. In requiring such disclosure, the law also creates an offence of ‘wilful’ transmission that may be broad enough to include mother-to-child transmission of HIV. This law negates the reproductive right of HIV-positive women to choose to bear children.

Although the SADC Model Law on HIV does not criminalise HIV transmission, there are pieces of legislation in existence or about to be passed that do (or may) criminalise transmission. Countries including Mozambique, the Democratic Republic of the Congo (DRC), Zimbabwe and Tanzania require immediate disclosure of HIV status to a spouse. Such disclosure requirements contradict the right to privacy of HIV-positive individuals and may increase women’s vulnerability to gender-based violence (GBV) or other types of abuse. Many countries have laws to address intentional HIV infection, and in some countries the sentence for ‘wilful’ transmission can vary from five years in prison to life.

The motivation for criminalising wilful HIV transmission lies in the attempt to reduce HIV infection rates, protect vulnerable groups and encourage HIV-positive persons to disclose their status to a partner. However, when HIV transmission is perceived as a criminal act, the result is often decreased disclosure of positive HIV status, decreased interest in testing for HIV (and reduced access to treatment), and increased fear, stigma and discrimination associated with infection. It drives HIV underground and impedes prevention efforts. Also, the broadness of a law on wilful HIV transmission can be exploited and applied to groups who already experience social stigma, such as men who have sex with men (MSM), sex workers and injecting drug users (IDUs). Recommendations:

Rather than adopting legislation that criminalizes HIV transmission, countries should seek to remove legal barriers to HIV prevention, treatment, care and support. The meeting participants suggested that the SADC Secretariat introduce this issue at the SADC Parliamentary Forum and urge countries to endorse the SADC Model Law. Participants also urged better partnerships between government, Parliamentarians and civil society organisations to address criminalisation related to HIV. Advocacy is needed that shows how the good intentions behind the move to criminalise ‘wilful’ HIV transmission, particularly the protection of women, are actually best achieved by other means than criminalisation. Most countries have existing legislation, such as for grievous bodily harm, that would address clearcut cases of wilful HIV transmission without the need for a new law.

Table 1: Examples of criminalisation of ‘wilful’ HIV transmission in southern Africa (ARASA) • Source ARASA

<table>
<thead>
<tr>
<th>Country</th>
<th>Result of ‘wilful’ HIV transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRC</td>
<td>Requires immediate notification of spouse and sexual partners. Life imprisonment and a fine of 200 000 FC (reduced to 10 years after submissions by civil society) for ‘wilful transmission’</td>
</tr>
<tr>
<td>Madagascar</td>
<td>A sentence of 6 months to 2 years and a fine of 100 000 to 400 000 ariary</td>
</tr>
<tr>
<td>Malawi</td>
<td>Liable to imprisonment of 14 years</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Prison term higher than two and up to eight years</td>
</tr>
<tr>
<td>Tanzania</td>
<td>HIV and AIDS Prevention and Control Act, 2008 requires immediate disclosure to a spouse or sexual partner. The penalty for ‘wilful transmission’ is 5-10 years imprisonment</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Criminal Law (Codification and Reform) Act 23 of 2004 criminalizes ‘wilful’ HIV transmission</td>
</tr>
</tbody>
</table>
Building on the conclusions of the SADC Think Tank on prevention regarding the epidemic drivers, the meeting focused on key thematic areas of prevention for discussion and review of progress in different Member States. The process involved short plenary presentations on thematic areas by Member States and brief updates by prevention experts on selected themes. In addition, feedback was provided on the following recent meetings: the SADC Parliamentary Forum, the SADC OVC and Youth Meeting, and the SADC meeting on guidelines on HIV testing and counselling, and on PMTCT.

Prevention of mother-to-child HIV transmission (PMTCT)

The meeting participants agreed that with the knowledge and technology currently available, virtual elimination of mother-to-child transmission is a realistic target by 2015. This proposed target echoed the recommendations from the regional meeting held in Nairobi, Kenya, in May 2009 on PMTCT and paediatric care, which called for the virtual elimination of MTCT by 2015. The key outcomes of the Nairobi meeting included the following three targets for 2010:

- Reaching 80% of pregnant women and mothers with core PMTCT services; HIV testing and counselling and maternal provision of ARVs
- ‘Closing the gap’ in the uptake of interventions across the PMTCT package (from intake to follow-up) and halving the gap between maternal and infant ARV coverage
- Doubling the number of children initiated on antiretroviral therapy (ART).

Despite some recent achievements in greater programmatic coverage, better integration of PMTCT and paediatric ART into sexual and reproductive health and family planning services is needed. In addition to the disparity in the quality of PMTCT services in rural and urban areas, linkages between families, communities and facilities need to be strengthened to ensure proper follow-up. Effective leadership and accountability mechanisms are also critical to comprehensive PMTCT and paediatric service delivery at all service points. Ownership and capacity building at the local level are essential to strengthen systems for human resources development and data management.

Participants also argued for an increased use of rights-based approaches, including increased knowledge of rights and choices regarding to reproductive health and HIV. There should not be any coercion against HIV-positive women and men choosing to have children.

While ART coverage has been increasing steadily across eastern and southern Africa since 2003, PMTCT coverage in the region has been more disparate. Botswana, however, has excelled in meeting its targets in this area. According to the World Health Organization (WHO), the side effects of ART and subsequent patient non-adherence are a cause for concern. Similarly, the link between HIV and tuberculosis (TB) and the opportunities for co-infection are significant, but often integration of related services does not occur at the programmatic level. The standardisation of treatment regimens across the region was welcomed, and lessons learned by WHO’s 3x5 initiative (3 million people accessing ART by 2005) need to be internalised at both national and regional levels.

While PMTCT interventions have been very successful in Botswana, participants...
from Lesotho reported that in their country PMTCT services, obviously involving HIV testing, have resulted in an increase in home deliveries and linked infant mortality. Countries need to develop locally appropriate PMTCT intervention strategies with effective community mobilisation, and to analyse the quality of the existing PMTCT services and counselling provisions.

Botswana’s PMTCT programme was introduced in 1999 and piloted in two districts. By 2001, when the HIV prevalence rate in pregnant women was 36.2%, financial support from various partners resulted in a national roll out of the PMTCT programme and the related services were offered in all health facilities. The result was that the rate of mother-to-child HIV transmission went down from around 40% transmission from HIV-positive mothers to just 3% in 2008, a phenomenal success. As shown in the graph, Botswana is the only Member State to have achieved its targeted coverage for 2010 over two years ahead of schedule (with the exception of Mozambique, which had achieved more than double its low target of 22% coverage.

Various factors have contributed to the success of the PMTCT programme in Botswana, including a significant degree of community mobilisation. The programme included modified obstetric practices, the introduction of ART, the establishment of a peer mother programme and the provision of infant formula for children for one year. The programme also achieved the following:

- Integration of PMTCT into sexual and reproductive health (SRH) services
- Increase in HIV testing uptake in pregnant women from 49% in 2002 to 85% in 2008
- Expansion of psychosocial support services to pregnant women, their partners and their family members run by non-governmental organisations (NGOs).

Continuing challenges include: increased partner involvement, a more efficient tendering process for the provision of infant formula, repeat pregnancies and stronger male involvement in general.
HIV testing and counselling (HTC)

HIV testing and counselling is an entry point for both treatment access and HIV prevention. However, research has shown limited impact of free-standing and unlinked voluntary counselling and testing services for those who test negative, while there is demonstrable impact on people who test positive in adopting safer sexual practices, at least in the short term. In particular, couple counselling is recognised as increasingly important in order to identify discordant couples and assist them to prevent infection. Routine provider initiated testing and counselling is increasing in various countries and is an important route for earlier access to treatment. SADC presented its draft guidelines on HIV testing and counselling, these having been reviewed in a regional meeting the previous week and being due for finalisation in the near future.

Country Experience of HIV testing and counselling – Malawi

In Malawi, there has been a steady uptake of HIV testing and counselling (HTC), increasing from approximately 215,000 in 2003 to just over 1.4 million people tested in 2008.

Voluntary counselling and testing (VCT) was first introduced in Malawi in 1985 and has expanded in recent years in medical settings, having been formally adopted and integrated by the Ministry of Health. Entry points for HTC include antenatal clinics, labour and postnatal services, family planning services, TB and STI services and diagnostic services for various illnesses. Also, HTC has been popularised via an annual ‘HTC week’ and has served as an entry point for ART. The HTC programme is decentralised, with district-specific scale-up plans. Home-based counselling has increased couple counselling and testing for HIV, and the use of trained lay counsellors has facilitated scaling up and reduced costs of HTC services.

Various challenges noted are the untimely flow of quarterly data from districts to the national level, as well as a lack of forecasting capacity among service providers, resulting in stock-out of reagents. At times, the delivery of HTC services has not been able to meet the high demand.

Figure 15: Annual HTC uptake, Malawi 2002-2008 • Source: HTC Nkhata
Malawi presentation
Male circumcision

Some SADC Member States have officially endorsed male circumcision (MC) as an HIV prevention strategy. The cost effectiveness of MC per infection averted increases the higher the HIV prevalence in the population, as highlighted in the modelling below, and the cost effectiveness of male circumcision compares extremely favourably with other prevention interventions in generalised, heterosexually driven epidemics. Recent cost-effectiveness modelling in Kenya came to the same conclusion. MC should be a key priority in high prevalence, low circumcision populations. Eight SADC and East African Community (EAC) countries have conducted situational analyses of MC, and three have an approved or draft MC policies available. Four other Member States are in the midst of developing their MC policies and are planning national programmes. Botswana and Swaziland are implementing MC programmes. Opportunities for MC programming are increasing with growing political support, increased funding from major donors, increasing technical support available and strengthened inter-country support and sharing of experiences and lessons learned.

Key discussion points and recommendations:

Participants agreed that it was imperative to address the lack of institutional preparedness for rolling out safe male circumcision services, including equipment shortages, inadequate numbers of skilled staff, and other challenges. Male circumcision, as part of a combination of proven HIV prevention strategies, also requires a high degree of social mobilisation and community engagement so that there is accurate understanding that MC only provides partial protection. Demand creation may be needed although, at present, demand far outpaces service provision in many countries.

Where traditional male circumcision is practised, traditional service providers need to be brought on board in national planning for MC, as this is often a highly sensitive cultural issue. While highly valued as an entry to manhood, traditional male circumcision also creates a direct health risk and may be associated with rites of passage that include high-risk sexual initiation.

The participants from Malawi agreed that completing a situational analysis on MC was a priority for them, and participants in general raised the need to lobby leaderships to provide active support for MC. The participants from Mozambique suggested that health personnel and traditional male circumcision providers be trained adequately and supplied with the necessary equipment to perform safe procedures as part of national planning and implementation of MC.
Country experience of male circumcision – Swaziland

Although male circumcision is no longer a cultural practice in Swaziland, interest in and demand for the procedure have rapidly grown since initial developments in 2004. In 2006, a national task force on MC was established under the guidance of the Ministry of Health. As a result, MC services have been rolled out significantly and the procedure has received high levels of support from both the Head of State and parliamentarians. The MC roll-out plan includes a national MC Strategic Plan and an Operational Plan, along with a national policy, costing assessments, integration of MC into the National Strategic Plan (NSP) and training and capacity building of healthcare professionals. There are plans to scale up MC in public health facilities in Swaziland and integrate the services into existing reproductive health and HIV programmes. Currently, 40 to 50 circumcision procedures are conducted monthly in 60% of the public health facilities in the country, and skilled NGOs also conduct approximately 60 procedures a month. Plans are in place to make circumcision much more widely available in health facilities in the near future.

Multiple and concurrent sexual partnerships (MCP)

The SADC Expert Think Tank meeting of 2006, and more recent analyses, have identified multiple and concurrent sexual partnerships (MCP) as a key driver of the HIV epidemic in high prevalence countries. Reducing multiple and concurrent partnerships would break up intensive and extensive sexual networks that allow HIV to spread rapidly through a population. Concurrency may involve low overall numbers of sexual partners per individual, but many men and some women having two or more overlapping long-term stable relationships in which condom use is low, and some men and/or women having occasional sex outside the main relationships. Concurrent sexual partnerships spread HIV more rapidly through a population for two reasons: first, because sex may occur with a second partner during the period of high viral load in the days and weeks after someone is newly infected, and this greatly increases the risk of transmission; and second, because the time gap from when one person is infected and has sex with another partner, who may very soon have sex with another partner, is short. Reducing multiple and concurrent partnerships is challenging, however, because of the complex socio-cultural, gender, mobility, economic and other factors that underpin this pattern of sexual networking.

Defining concurrency has also been a matter of debate. In April 2009 the UNAIDS Epidemiology Reference Group Meeting on Measurement and Definition of Concurrency held in Nairobi defined concurrency as 'overlapping sexual partnerships where sexual intercourse with one partner occurs between

Figure 17: Examples of different ways of reporting on sexual behaviours •
Source: Masauso Nzima, UNAIDS RST ESA presentation
two acts of intercourse with another partner’. Measurement is complex and different research methods find widely differing levels of reporting of multiple partnerships, including concurrency.

The example from Swaziland highlights how different research methods can capture widely differing levels of reporting on multiple (and concurrent) partners: for instance the 2006-7 DHS found only 2.3% of females reporting more than one partner in the last 12 months, while an in depth study (Ngudzeni ADP in 2006) found over 60% of females reporting two or three partners in the previous three months.

![Figure 18: Importance of interviewing technique. Swaziland • Sources: James, V. and Matikanya, R (2006). Prospective Factors: A case Study for Ngudzeni ADP (Swaziland), Central Statistical Office (Swaziland) and ORC Marco (Unpublished). Swaziland Demographic and Health Survey, 2006-2007. Calverton, Maryland, Central Statistical Office and ORC Marco.](image)

Caution is needed in interpreting the results to take into account whether the Ngudzeni study included women and men at higher than average risk of MCP; but nonetheless, the results do point to considerable under-reporting in the DHS.

Guidelines to help standardise measurement are being developed, with indicators to measure changes on the input, output, individual and community levels. Input indicators on MCP include the percentage of the allocated budget spent on prevention in general and the strategies relating to MCP in particular, and assessing the number of policies and strategies in place to address multiple and concurrent partnerships. Output level indicators encompass, among other things, the number of people or organizations reached and trained as a result of a specific MCP reduction intervention. The changes on an individual or couple level are measured by the prevalence of multiple or concurrent sexual partners, being able to identify the risks of HIV infection associated with MCP and the levels of communication between couples. Outcome level indicators at the community and societal levels measure the changes in social norms regarding MCP, while impact-level indicators measure the changes in HIV incidence.

The meeting participants discussed the need to strike a balance between challenging multiple and concurrent as a social norm, while at the same time promoting harm-reduction strategies. For instance, how should polygamy be addressed? It was agreed that closed polygamy (where nobody brings HIV into the marriage) can be safe, but if just one person is already, or becomes infected, all are at high risk. Social and behavioural change communications that take into account cultural factors including polygamy need to be developed to generate accurate risk perception and motivation for safer patterns of sexual behaviour and partnerships.

Many participants from different Member States identified the need for assistance to develop the tools and methods to measure MCP programmes effectively. They also commented that the indicators need to take into account the local contexts within which MCP is occurring. UNAIDS and the World Bank are developing guidelines for measuring concurrency that will be widely circulated.

Country experience of reducing multiple and concurrent sexual partnerships

- Zambia

In Zambia, MCP in conjunction with low rates of male circumcision, low levels of condom use and high population mobility are fuelling the HIV epidemic. The results of several studies, including the 2007 Demographic and Health Survey (DHS), have highlighted the high prevalence of multiple sexual partnerships across Zambian society, particularly by men. According to the DHS results, 6.5% of never-married
women, as compared to 19.8% of never-married men, reported having sex with two or more partners during the previous twelve months. However, there was likely a high level of underreporting by women, and population surveys such as the DHS are known to identify much lower levels of multiple sexual partnerships than do some other study methods.

The Zambian HIV and STI Strategy includes a strong focus on reducing multiple and concurrent sexual partnerships. Under the auspices of the NAC, a MCP multimedia campaign was developed by the Health Communication Partnership, with the Zambia Centre for Communication Programmes and the Society for Family Health. Among other activities, the programme trains musicians and engages young people in discussions on issues relating to MCP. The programme, however, requires a multi-pronged approach to address the varied individual motivations for having multiple and concurrent partners, such as material gain, sexual satisfaction, peer pressure, social prestige and revenge against a partner seen as unfaithful.

Although in Lesotho an estimated 62 people are newly infected with HIV each day, spending on HIV prevention is declining. The largest portion of the HIV prevention budget has been allocated to prevention, diagnosis and treatment of sexually transmitted infections (STIs).

Lesotho has one of the highest reported levels of MCP in the region, with a prevalence rate of 36% for men and 16% for women, and these figures could still be an under-representation of MCP prevalence. The practice of MCP in Lesotho is largely transactional and motivated by material benefits for women; however, cultural norms and beliefs also play an important role. Many sexual relationships involve inter-generational or age-disparate sex (sex with a partner five or more years older). This is a high-risk pattern of sexual networking because it brings together young women with low HIV prevalence and older men with high HIV prevalence, leading to high incidence of new infection in young women who may then also infect other sexual partners. Condom use with non-cohabiting partners has been estimated at 49%, while it is much lower in long-term stable partnerships.

Based on recent studies in Lesotho, including an analysis of multiple and concurrent partnerships, as well as the modes of transmission study supported by UNAIDS and the World Bank GHAP, Lesotho’s newly revised National Strategic Plan (NSP) will reallocate resources to more evidence-informed and strategic HIV prevention programmes. The new NSP will increase spending on HIV prevention, and the high priorities will include social and behaviour change communication (SBCC) particularly to reduce multiple and concurrent partnerships, and increase condom use, male circumcision and PMTCT.

![Figure 19: Spending on HIV prevention categories in Lesotho](https://example.com/figure19.png)
Vulnerable and marginalised populations

Vulnerable populations such as men who have sex with men (MSM), injecting drug users (IDU), sex workers and prisoners are too often marginalised in HIV prevention efforts. Numerically they contribute far fewer new infections in high-prevalence countries than occur in long-term stable partnerships between discordant couples, and through concurrent relationships in the mainstream population, but their HIV prevalence rates are usually far higher. In Mozambique, Swaziland, Lesotho and Zambia the modes of transmission modelling and know your epidemic syntheses identified that a small but significant percentage of new HIV infections were occurring in MSM. IDU are increasing in islands such as Mauritius and some major mainland coastal cities. In the Indian Ocean Islands in general, the epidemic is concentrated in populations of sex workers, MSM and IDU. Stigma and discrimination still accompany same-sex relationships across southern Africa and this discourages the disclosure of sexual orientation or positive HIV status. Therefore, many men hide their same-sex relationships and are not reached effectively with appropriate prevention interventions and messages. It is also important to utilise strategies such as those associated with MCP with vulnerable groups including MSM.

The United Nations Office on Drugs and Crime (UNODC) summarised the implications of the very limited coverage of HIV prevention efforts involving prisoners. Although southern Africa represents only 10% of Africa’s population, it houses the highest number of prisoners in Africa. Prison conditions, including extensive overcrowding, the commonality of high-risk sexual behaviours, sexual abuse and lack of access to prevention information and commodities as well as poor health services generally increase prisoners’ vulnerability to HIV infection and to other STIs and health risks.

The high rates of sexual activity and sexual abuse, particularly of women, combined with the lack of condoms, the use of injecting drugs with contaminated equipment and blood pooling, skin piercing, tattooing and a general lack of knowledge of HIV prevention contribute to the spread of HIV within prisons. In addition, prisoners have higher than average HIV prevalence prior to incarceration, because many have been involved in high-risk behaviours. The situation in prisons is exacerbated by the denial by various government authorities of the levels of sexual activity and drug use occurring in prisons, and their reluctance to provide harm reduction measures. When prisoners re-enter communities after release, they contribute to the spread of HIV, especially if they remain unaware of their infection or how to prevent onward transmission. Prisoners generally have little access to HIV testing and counselling and to treatment.

![Figure 20: Comparison of HIV prevalence rates in adults 15-49 and prisoners](source)

**Source:** Compiled from UNAIDS, 2006; Directory of Prisons in Africa 2005; World Prison Population List 2007
Key discussion areas and recommendations:

The participants agreed on the urgent need to support harm-reduction programmes, such as condom provision, peer education and HIV prevention capacity building for both prisoners and prison authorities. A rights-based approach is needed to address the issue of HIV in prisons, and among injecting drug users and other marginalised groups, including those made vulnerable by disabilities. There is need to acknowledge the overlapping of risks for HIV infection, such as MSM or sex workers who may also inject drugs, and that these risks are even higher in prison settings. More generally, the denial of the existence of sex in prisons, and of anal sex between men and heterosexual relationships are barriers to effective responses to address the issue of HIV in prisons.

Meeting participants from Malawi recommended a situational analysis of the extent of sex work in their country as a foundation for more effective responses to address their needs. The participants from Lesotho highlighted the challenge that condom provision in prisons and for MSM poses for them because of the country’s religion-based sodomy laws.

Mauritius is currently grappling with high HIV prevalence rates in prisons and among injecting drug users. Although Mauritius has a low HIV prevalence rate of 0.32% in the general population, among IDUs prevalence is estimated at between 30% and 60%, with the great majority of IDUs concentrated in two main urban areas. In addition, some and 50 NGO-managed needle exchange programmes. Mauritius has adopted the following strategies:

- A methadone substitution programme in which 13 dispensing sites currently cater for 1054 males and 137 females.
- 30 government-managed and 10 NGO-managed needle exchange programmes.
- HIV testing upon entry into prison and before release (to estimate the rate of HIV transmission in prisons).

Despite positive collaboration between government and civil society, civil society organisations still lack the capacity to fully implement some aspects of the programme. Stigma, particularly for mothers seeking methadone substitution, is still a major issue and consequently, communities are often reluctant to support establishing programmes locally. In addition, the level of psychosocial support offered is inadequate. In Mauritius, HIV is largely perceived as a disease affecting only IDU and other high-risk groups.

Country experience of injecting drug use

- Homosexual/bisexual 0.4%
- Intravenous Drug Users 71.9%
- Heterosexual 22.1%
- Mother To Child 0.7%
- Hetero/IV Drug User 4.5%
- Other and Undetermined 0.4%

In order to deal with these vulnerable groups, Mauritius has adopted the following strategies:
Country experience with sex work and HIV – Democratic Republic of the Congo (DRC)

The new strategic plan on HIV and AIDS in the DRC targets sex workers as a vulnerable group, particularly in the context of conflict, population displacement, rape and violence. Sex workers provide their services in the DRC to lorry drivers, street children, miners, prisoners and the military. Strategies to address the HIV in sex work include behaviour change communication and training on peer education. There has been some degree of success in condom social marketing, and plans are underway to extend the programme nationwide. Sex workers who are HIV-positive are reported to receive ART, and income-generating strategies have been implemented in the hopes of bringing some strategic, long-term change to their socioeconomic circumstances. Although sex work may be perceived as an urban reality, the plan underway advocates also targeting sex workers in villages and rural areas to increase intervention coverage.

Implementation of the plan to date has highlighted the need to involve sex workers in the design and implementation of programmes to reduce their risks. In the context of political violence and conflict, HIV prevention programming also needs to be integrated into the response to the humanitarian crisis. Rape and other forms of gender-based violence are also rife in the DRC and this situation greatly exacerbates the vulnerability of sex workers, among others, to HIV.

Positive health, dignity and prevention (positive prevention)

The multifaceted nature of the HIV epidemic requires a combination of interventions. Until recently, HIV prevention strategies have generally focused mainly on keeping HIV-negative people negative. ‘Positive prevention’ or ‘positive health, dignity and prevention’ (PHDP), aims to involve HIV-positive people actively in HIV prevention efforts by respecting their full human rights and building their capacity and motivation for prevention of HIV transmission – as well as avoiding HIV re-infection, STIs and TB.

With greater access to ART, PLHIV are easier to reach in health-care settings, providing the opportunity to provide important ART adherence and HIV prevention messages. They can play key roles in opening up dialogue in communities as well as become role models for others.

Based on their experiences, PLHIV can give expert insight into appropriate prevention strategies to use for positive-prevention interventions and contribute to effective communication strategies in specific settings. In addition, PLHIV continue to be sexually active. They may desire to have children or may prefer to access family planning services; either way, they need access to the right support to prevent onward transmission and to access the types of support they need. Consequently, understanding has grown that PLHIV need access to a range of health, psychosocial and other social support services and their family members do as well. Prevention interventions with PLHIV are essential to include in a comprehensive HIV prevention strategy, ideally in consultation with PLHIV for optimum design.

An essential element of this is identifying and supporting discordant couples, and developing experience and guidelines for HIV prevention among discordant couples is an urgent HIV prevention priority in high-prevalence epidemics.
Tanzania has scaled up HIV prevention in clinic settings by integrating it into interventions focusing on male circumcision, HIV testing and counselling, family planning, primary healthcare, and TB. In addition, community-based efforts relating to HIV prevention with PLHIV have been integrated into ongoing community programmes, in particular those including home-based care, community-based counselling and PLHIV support groups, as well as VCT and programmes involving faith-based organisations. The experience of ‘positive living’ by PLHIV is important to share across communities. Relating personal experiences of living with the virus in group settings has been found to be especially effective in helping others to understand the need for prevention, plan to access HIV testing and to accept and cope with their own HIV infection. Knowing that being diagnosed HIV positive need not be even a long-term death sentence and accessing post-test clubs and other support groups, as well as a range of health services, are important for all community members.

Some of the lessons learned through the positive prevention interventions implemented in Tanzania include the need to focus more on discordant couples, increase public awareness of the importance of knowing one’s HIV status, promote a non-fatalistic attitude among PLHIV, increase access to condoms for discordant couples and in casual and transactional sex, including in the rural areas, and increase interventions to reduce stigma and discrimination.

In Namibia, where almost half of the 14,000 new HIV infections in 2008 occurred in young people aged 15-24 years, greatly increased access to ART provides an opportunity for prevention messaging to PLHIV in care and treatment settings. Namibia is planning a nationwide roll out of a comprehensive HIV prevention package for PLHIV in health care settings, following a successful pilot project in Windhoek. A training curriculum is being developed, and community-based structures will be integral to establishing support groups for PLHIV and individuals accessing VCT and home-based care services.

While the pilot study in Windhoek confirmed that the intervention was appropriate and welcomed by the community, challenges included: the need for privacy screens for confidentiality, for sufficient condom supplies and for penile and pelvic models for demonstrations, STI diagnostic materials for health care workers, HIV educational materials for clients and adequate office supplies for all staff. Health care workers also highlighted the time constraints with clients, and that the roll-out sites will need to ensure strong linkages with and consistent referrals to other community-based efforts for HIV prevention and health and social support services.
Gender issues

In general, women are more vulnerable to HIV from a biological perspective, their lower socio-economic status and gendered perceptions of how men and women should behave. Unequal access to resources, economic dependence and higher levels of poverty among women, as well as widespread gender-based violence and some negative aspects of cultural practices and beliefs also increase women’s vulnerability to HIV infection. The figure shows the disparity in HIV prevalence between males and females across different age groups in five countries in southern Africa.

South African participants endorsed the importance of gender mainstreaming within their programmes by focusing on male participation in preventing HIV infection and including a range of interventions to eliminate gender-based violence.

In Mozambique, 960,000 of the estimated 1.6 million people living with HIV are women. In addition to high levels of gender-based violence, there is widespread tolerance for traditional practices such as multiple and concurrent partnerships, particularly for men, and purification rituals, which contribute to women’s higher HIV risk.

The need to work actively with men to reduce the vulnerability of women is well recognised around the world. In Mozambique, some government policies underscore this strategy, but others do not. The current National Strategic Plan on HIV and AIDS (2005-2009) aims to reduce women’s vulnerability, but it does not specifically mention male involvement. However, a planned gender-focused assessment of the National Strategic Plan (NSP) will focus on this and other gender-related recommendations for the new plan. In addition, a National Plan of Action on Gender and HIV and AIDS is under development. The national Strategy to Accelerate HIV Prevention also highlights the need for male involvement to improve the understanding of the importance of PMTCT. Current HIV prevention strategies include capacitating gender focal points in various agencies and settings to promote the use of the female condom and to establish the Network of Men for Change.

While there is an evident gap of male involvement in gender-related HIV prevention issues, the lack of involvement of women’s organisations in HIV policy and practice is also an issue. Inadequate gender analyses of policies, lack of disaggregated relevant data, and poor mainstreaming of gender issues into HIV planning processes all require urgent attention.
South Africa has made major strides in developing HIV prevention programmes with young people. The need for further strengthening of prevention is indicated in the prevalence data. In South Africa, as in other SADC Member States, HIV prevalence rates in young women greatly outpace prevalence in young men. Orphans and vulnerable children and youth (OVCY)

Young women are especially at risk of HIV and other sexually transmitted infections. Among 15-24 year olds, the great majority of HIV infections in the SADC region are in women. The current situation of already high and increasing numbers of orphans and vulnerable children and youth (OVCY), an estimated 16.8 million aged 0-17 in 2009, is a failure not only to realise the human rights of children, but a threat to the future social and economic development of the region. To address this issue, the SADC Secretariat recently developed the SADC Comprehensive OVCY Strategy and Business Plan, with the stated goal ‘to improve the capacity of SADC Member States to adequately respond to the rights and developmental needs of orphans and other vulnerable children and youth’. This goal will be addressed through a number of agreed priority interventions incorporating the following principles:

- **Holistic development:** ‘whole child development,’ using different approaches and methodologies and implementation partnerships to achieve comprehensive care and support
- **Developmental focus:** age-sensitive empowerment of children and youth to reach their full potential
- **Gender sensitivity:** identification of gender-driven causes of vulnerability, inequality and deprivation
- **Participation:** child and youth leadership supported through community ownership of strategies
- **Sustainability:** focus on meeting needs over the long term by addressing causal risk factors and vulnerability
- **Child rights centredness:** child rights-based programming producing real benefits for orphans, vulnerable children and youth.

The SADC Secretariat intends to enhance the capabilities of Member States to implement comprehensive programmes addressing the various issues pertaining to OVCY. The South African participants particularly considered it important for them to build technical and leadership for programme implementers in the youth sector.

### Country experience with young people and HIV – South Africa

South Africa has made major strides in developing HIV prevention programmes with young people. The need for further strengthening of prevention is indicated in the prevalence data. In South Africa, as in other SADC Member States, HIV prevalence rates in young women greatly outpace prevalence in young men.

#### Table 2: HIV prevalence rates per age group from 2005 to 2007 in South Africa

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>3334</td>
<td>6299</td>
<td>6377</td>
</tr>
<tr>
<td></td>
<td>20.2%</td>
<td>19.1%</td>
<td>19.0%</td>
</tr>
<tr>
<td>20-24</td>
<td>5068</td>
<td>10478</td>
<td>10616</td>
</tr>
<tr>
<td></td>
<td>30.7%</td>
<td>31.7%</td>
<td>31.5%</td>
</tr>
<tr>
<td>25-29</td>
<td>3906</td>
<td>7661</td>
<td>7912</td>
</tr>
<tr>
<td></td>
<td>23.7%</td>
<td>23.2%</td>
<td>23.5%</td>
</tr>
<tr>
<td>30-34</td>
<td>2534</td>
<td>5018</td>
<td>5091</td>
</tr>
<tr>
<td></td>
<td>15.3%</td>
<td>15.2%</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

The National HIV Prevention Plan is currently being developed to enable the country to meet the target of halving new HIV infections by 2011, and youth will be a major focus. On a programme level, national and well known campaigns such as Lovelife and Khomanani, as well as campaigns run by the Soul City Institute, highlight the vulnerabilities to HIV infection faced by young people, and they champion the active involvement of young people in addressing the epidemic. Peer education programmes are also conducted in schools, as well as with out-of-school youth. Youth-friendly health services have been established in some provinces, and government departments are required to mainstream youth issues into their planning processes. Also, there are several programmes under implementation in various provinces that aim to encourage male involvement in issues around gender-based violence and accessing VCT.

Current challenges include strengthening coordination between the various actors working on youth issues, securing adequate resources to support programming, and developing and implementing M&E systems to track implementation and the attainment of targets.
Condom programming

Despite repeated messages and numerous programmes championing the correct and consistent use of condoms for preventing HIV infection, ensuring condom use still remains a challenge in southern Africa, especially in long-term relationships and among discordant couples. The figure below shows the percentage of people reporting condom use during their last ‘risky’ sexual encounter (sex with a non-cohabiting partner), and far fewer use condoms in stable relationships. Strategic comprehensive condom programming needs to be multi-pronged in its communication, focusing on different types of relationships and involving both HIV-positive and negative persons, as well as identified vulnerable groups. A robust supply chain is essential for all condom outlets, and demand creation should particularly focus on casual and commercial sex, including mobile populations, MSM and in prisons and, increasingly, with discordant couples and people who know their positive HIV status. Pregnant women are an entry point for condom use in couples and to prevent new infection during pregnancy, with its high risk of MTCT because of the viral peak in new infection.

Key discussion points and recommendations:

Participants suggested the need to reflect a different intensity for condom programming with different groups, such as discordant couples or individuals with MCP, and to promote the consistent use of condoms in these relationships, including casual sex. In particular, discordant couples need accurate risk perception and assistance with disclosure of HIV status decisions, and in making reproductive choices including for child-bearing and PMTCT. Participants noted that condom promotion associated only with extramarital activities or risky/casual sex may result in slow uptake in stable relationships because of stigma. Condom programming should not be seen in isolation, but linked to other programmes and activities related to HIV prevention, such as the need for increased communication between sex partners. It is important to recognise the importance of prevention programming synergies, such as how increased HIV testing and counselling for individuals and couples can ultimately increase condom use.

The participants from Mozambique noted the need in their country for condom distribution to be better coordinated, and that condom programming should be validated in provincial prevention plans.
Zimbabwe has made impressive strides in scaling up promotion of both male and female condoms. The introduction of the female condom in 1996 resulted from pressure by women’s organisations to make available a female-controlled HIV prevention method. Since 2001 there has been a steady rise in the distribution and uptake of both male and female condoms, with particular escalation of female condom distribution from 2006 to 2008. In 2008, more than half a million female condoms were distributed; although far lower than the over 90 million male condoms that were distributed that year, this is nonetheless a significant achievement.

It is evident that negative attitudes toward the female condom still need to be addressed in order to increase demand. Also, availability of both male and female condoms is still a challenge, as several retail outlets and public health facilities that supplied them have closed due to the economic crisis in Zimbabwe. Moreover, condom use in long-term relationships and age disparate relationships is still relatively low.

Figure 25: Male condom consumption and distribution by year • Source: Data on social marketing of condoms is from Population Services International (PSI); data on public sector condoms from ZNFPC and John Snow International (JSI)

Figure 26: Female condom distribution by year in Zimbabwe • Source: Data on social marketing of condoms is from PSI; data on public sector condoms is from ZNFPC and JSI
Leadership

The critical role of bold and high-quality leadership on HIV prevention in the SADC region was endorsed throughout the meeting. The ‘Champions for an HIV Free Generation’ initiative is an example of prominent African leaders and high-profile personalities coming together to raise national and regional leadership awareness of the imperative for HIV prevention, and to build their commitment to action.

Participants agreed that specific leaders on HIV prevention should be identified, and leadership commitments should be reflected in budget allocations. At a regional level, more clarity is needed on the role of Parliamentarians, including Speakers, on the issues of accountability, resource mobilisation, related national and regional polices and laws, and the need for engagement with international development partners on HIV prevention.

The 25th SADC Parliamentary Forum Plenary Assembly held in Swakopmund, Namibia, immediately prior to the SADC Prevention Meeting discussed the global economic crisis and its likely impact on HIV and AIDS. Great concern was expressed that the current economic crisis threatens achievement of the Millennium Development Goals by the SADC Member States. Many development gains, including those made in health, may be reversed. Funding for HIV prevention may be cut, particularly if prevention and treatment continue to be polarised rather than being seen as mutually complementary. Recognition must be built that treatment is totally unsustainable in the absence of effective prevention.

Key discussion points and recommendations:

Country delegation discussions developed on similar lines and with complementary recommendations for their countries.

- Recommendations from the Botswana, Lesotho and Swaziland discussion group centred on developing a strategy to meaningfully engage the political leaders in these countries in providing more effective support and additional resources.
- Mozambique participants included mobilising leaders and educating them on the status of the epidemic, including epidemic drivers, and the strategies for prevention.
- Recommendations from the Tanzanian discussion group included developing roles and responsibilities with leaders at the national, regional, district, ward and village levels. In addition, they recommended that every Member of Parliament should attend a review meeting of HIV prevention needs and interventions at the district level. Further, the Standing Committee on HIV in Parliament should take leadership of HIV prevention in consultation with a Standing Committee under the President to address the ‘50 by 15’ target.
Conclusions and Recommendations

Resource allocation

Delegates in country groups suggested the following activities to increase resource allocation to scale up HIV prevention activities:

- Participants from Malawi noted the need to make more effective use of available resources.
- Participants from Botswana, Lesotho and Swaziland collectively suggested a quick analysis of National Strategic Frameworks (NSFs) to ensure that HIV prevention is given the desired focus. They also recommended that programmes be introduced to expand resource mobilisation from all sectors, including the private sector. In addition, they suggested direct engagement with their ministries of finance to discuss the budget allocations and argued for developing better accountability mechanisms.
- Mozambique delegates suggested identifying, developing and planning appropriate regional programmes, such as those involving mobile populations, for which resource mobilisation may be easier if done on a regional basis.
- Participants from the Tanzania group suggested that each village, ward and district develop a list of their specific resource needs and identify the mechanisms for resource mobilization. The group also recommended developing local funding mechanisms, such as AIDS trust funds.
- The Zambian group recommended highlighting the value of HIV prevention services, including the long-term savings that can result (including savings on treatment and in other areas) to help to free up some additional resources for prevention.

In addition to the recommendations made during the presentations and group discussions, the participants concluded that SADC Member States should set the target of a 50% reduction in new HIV infections by 2015 and the virtual elimination of MTCT. Participants discussed the priority actions needed to meet the ‘50 by 15’ target and the required technical assistance in each country to do so. A regional civil society group also convened to discuss their HIV prevention-related needs. The members of civil society organisations (CSOs) welcomed the opportunity to participate in the SADC HIV Prevention meeting and to be able to present suggestions towards meeting the target. Their contributions represented a positive partnership between government and civil society. Brief feedback was provided on priority action on technical assistance needs to achieve them.
<table>
<thead>
<tr>
<th>Country</th>
<th>Priority Actions</th>
<th>Technical assistance (TA) required</th>
</tr>
</thead>
</table>
| **Botswana, Lesotho and Swaziland** | • Strengthen and scale up evidence-based programmes on male circumcision, prevention of mother-to-child HIV transmission and multiple and concurrent partnerships  
• Strengthen collaboration and strategic partnerships  
• Strengthen access to ART as a strategy for prevention  
Key stakeholder meeting to be held to discuss outcome of SADC HIV Prevention Meeting  
• Develop strategy for effective leadership  
• Quick analysis of national strategic framework to prioritise prevention  
• Develop tool to measure incidence | • Tools and technical assistance for more effective programming and prioritisation on multiple and concurrent partnerships and male circumcision and for identified capacity/skills gaps  
• Tools and technical assistance for measurement of success in reducing multiple and concurrent partnerships  
• Tools and technical assistance for measurement of HIV incidence |
| **DRC**                | • Reduce MTCT  
• Increase access to testing and counselling  
• Increase activities involving young people  
• Improvement of strategies relating to condom distribution  
• Increase prevention programmes with HIV positive people  
• Increase communication for behaviour change strategies  
• Integrate prevention activities into the education sector  
• Increase the capacity to implement prevention activities | • Capacity building in order to fully implement strategy |
| **Malawi**             | • Complete analysis of male circumcision involving traditional leaders  
• Lobby leadership to act on male circumcision  
• Continue providing safe male circumcision  
• Conduct situational analysis on sex work  
• Review the condom strategy  
• Increase blood safety  
• Develop an effective M&E system for measuring prevention | • Tools and TA in counselling and testing, MC and M&E  
• Communication for behaviour change, including developing a package for leaders  
• Coordination between actors  
• Research and studies on HIV |
| **Mozambique**         | • Expansion of HIV testing and counselling  
• Training and capacity building of different groups on behaviour change  
• Increase M&E  
• Roll out male circumcision  
• Ensure the availability of condoms  
• Improve coordination between the national and provincial structures  
• Improve coordination and communication between the NAC, Ministry of Health and partners  
• Mobilise leaders to address prevention and organise yearly meetings  
• NAC provincial coordinators to organise monthly meetings | • Tools and TA in counselling and testing, MC and M&E  
• Communication for behaviour change, including developing a package for leaders  
• Coordination between actors  
• Research and studies on HIV  
• Tools and technical assistance in counselling and testing, MC and M&E  
• Results-based programming in prevention: costing of prevention interventions and measurement for prevention results on output, outcome and impact levels |
| **Tanzania**           | • Strengthen district, ward and village governance capacity to take leadership in HIV prevention  
• Develop the roles and responsibilities of leaders at national, regional, district, ward and village levels  
• Each village/ward to identify the drivers of the epidemic in their own areas and prioritize and develop interventions in relation to the drivers, including measurement and reporting  
• Parliamentarians to attend review meetings at the district level  
• Standing Committee on HIV in Parliament to work in partnership with a Standing Committee under the President.  
• Further research needed on the drivers of epidemic  
• Engage top government officials on target of halving new infections by 2015 | • Results-based programming in prevention: costing of prevention interventions and measurement for prevention results on output, outcome and impact levels |
From a regional perspective, the key and immediate priority actions needed to halve new HIV infections by 2015 ‘50 by 15’ and achieve the virtual elimination of mother-to-child HIV transmission include:

- Rapidly analysing current national strategic frameworks and plans to ensure a strong HIV prevention component
- Mobilising effective leadership capacity and commitment at all tiers of government to achieve the set targets, including Parliament, the Executive, national AIDS authorities, civil society and traditional structures

<table>
<thead>
<tr>
<th>Country</th>
<th>Priority Actions</th>
<th>Technical assistance (TA) required</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>• Develop robust implementation plan for all role players</td>
<td>• Capacity building for implementers, including those in the youth sector</td>
</tr>
<tr>
<td></td>
<td>• Establish a multisectoral body responsible for M&amp;E for prevention</td>
<td>• Training on M&amp;E; empowerment of women and children; gender mainstreaming; male participation;</td>
</tr>
<tr>
<td></td>
<td>• Ensure leadership and management are aware of community needs and social</td>
<td>research and data management and collection;</td>
</tr>
<tr>
<td></td>
<td>mobilisation</td>
<td>• Funding linked to sustainability</td>
</tr>
<tr>
<td></td>
<td>• Market the national strategic plan to all stakeholders</td>
<td>Sourcing of national and international resources</td>
</tr>
<tr>
<td></td>
<td>• Increase involvement of all sectors, including communities, in the national</td>
<td>• Expanding database for HIV incidence</td>
</tr>
<tr>
<td></td>
<td>strategic plan</td>
<td>• Communication for behaviour change</td>
</tr>
<tr>
<td></td>
<td>• Strengthen ‘know your status’ campaign</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increase qualitative research on drivers and the impact of the epidemic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop a tool to measure HIV incidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Internal review of the current national strategy on prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop and implement a strategy for young people and HIV prevention strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Present the HIV and AIDS framework to different organs of State</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>• Improve coordination of prevention interventions, including defining ‘ownership’ of</td>
<td>• Improve baseline database on HIV incidence</td>
</tr>
<tr>
<td></td>
<td>prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increase access to prevention services, in particular through information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dissemination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Scale up resource mobilisation and revise resource allocation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conduct a high visibility launch of the HIV prevention strategy</td>
<td></td>
</tr>
<tr>
<td>Regional civil society</td>
<td>• Establish baseline data on incidence</td>
<td>• Costing of HIV prevention and development of tools</td>
</tr>
<tr>
<td></td>
<td>• Develop intermediate or yearly targets</td>
<td>• Increase capacity to move regional organisations from planning to action through supply chain</td>
</tr>
<tr>
<td></td>
<td>• Contribute to targets in national plans</td>
<td>management, project management and budget management</td>
</tr>
<tr>
<td></td>
<td>• Develop stigma-reduction targets</td>
<td>• Development of long-term ongoing training facilities for Parliamentarians</td>
</tr>
<tr>
<td></td>
<td>• Develop indicators involving political, religious and traditional leaders and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>disclosure among leadership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensure resources match targets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mobilize communities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Advocate regionally with partners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Expanding database for HIV incidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Communication for behaviour change</td>
<td></td>
</tr>
</tbody>
</table>

From a regional perspective, the key and immediate priority actions needed to halve new HIV infections by 2015 ‘50 by 15’ and achieve the virtual elimination of mother-to-child HIV transmission include:

- Rapidly analysing current national strategic frameworks and plans to ensure a strong HIV prevention component
- Mobilising effective leadership capacity and commitment at all tiers of government to achieve the set targets, including Parliament, the Executive, national AIDS authorities, civil society and traditional structures
- Capacity building for implementers, including those in the youth sector
- Training on M&E; empowerment of women and children; gender mainstreaming; male participation; research and data management and collection;
- Funding linked to sustainability
- Sourcing of national and international resources
- Expanding database for HIV incidence
- Communication for behaviour change
In his closing remarks, UNAIDS Regional Director Mr. Mark Stirling endorsed the commitments of participants, and noted that leadership commitment must extend far beyond rhetorical statements into active engagement and accountability for reaching prevention targets. It is critical to maximise the upcoming opportunities to engage heads of state, national AIDS authorities and other leaderships on HIV prevention, including active engagement with Parliamentarians. He welcomed the civil society communiqué drafted and presented during the meeting as an important platform regarding political and civil society engagement in a movement for HIV prevention (see Annex 1). Finally, he urged the close monitoring by national authorities of the use of law and human rights in the response to HIV and AIDS, to avoid stigmatisation and criminalisation.

Dr. Peter Iveroth of the Swedish International Development Cooperation Agency (Sida) thanked the SADC Secretariat for setting the example of regional leadership, and he reiterated the importance of coordinated regional efforts in support of stronger country responses. Mr. Bunmi Makinwa, Regional Director of the United Nations Population Fund (UNFPA), applauded the partnerships between government and the non-government sector present at the meeting. He stressed the need to develop and implement programmes based on research and empirical evidence, and stressed the potential for scaled up, effective prevention of mother-to-child HIV transmission.

Dr. Antonica Hembe, on behalf of the SADC Secretariat, accepted the challenge to strengthen leadership in the region on HIV prevention. She urged delegates after the meeting to present the issues relating to leadership to the Secretariat for presentation to the Heads of State Summit, and acknowledged the need to establish a working group on leadership.

Dr. Thobile Mbengashe of the SANAC Secretariat in South Africa formally closed the meeting, after congratulating the participants for elaborating clear and positive commitments towards reducing new HIV infections.

Technical requirements to achieve the prevention targets include:

- Linkage of treatment and evidence-informed prevention strategies to maximise efficiencies
- Better and more qualitative understanding of the drivers of the epidemic
- Advocacy against stigma and discrimination and HIV criminalisation
- Strengthened social and behavioural efforts and also measurement of multiple and concurrent partnerships, and a particular focus on risk reduction within discordant couples
- Better definition and understanding of the key role of communities and civil society in the HIV prevention response, and championing of social mobilisation for social and behavioural change
- Increased efforts to understand and address prevention in vulnerable groups, including advocacy for condom provision and awareness in prisons
- More detailed understanding of home-based care and its role in prevention, as well as addressing the issues of HIV-related stigma and discrimination

The SADC Secretariat confirmed its commitment to strengthening the leaderships in the region and at national levels for HIV prevention. SADC will set up a small Working Group on Leadership to, among other things, consolidate recommendations in preparation for the Heads of State Summit in August.
Annex 1 - Civil Society Indaba Communiqués - 8 June 2009

Headlines: 10 Things we agree on

1 // We support the 50 by 15 campaign- reducing new infections by 50% by 2015. We call on other sectors to support and take action now on this target. We urge the plenary of the SADC prevention meeting at the Indaba Hotel to support this campaign.

2 // We are committed to mobilizing leaders and communities in our countries around this target and around prevention in general.

3 // We will speak truth to leadership on the issue of prevention and foreground and publicize successes and failures in prevention action. We will break silences and taboos in our countries, communities and societies and will lead meaningful discussions on difficult prevention issues.

4 // We believe that treatment cannot be meaningful or affordable without turning off the tap of new infections. As strongly, we believe that that prevention cannot ignore the need to treat those in need of treatment.

5 // In support of prevention mobilization, we are committed to building capacity and systems in communities.

6 // We intend to grasp the opportunity and to participate in and contribute to country reviews of National Strategic Plans and the development of prevention plans.

7 // We recognize the need for common and complimentary messaging and approaches in messaging on prevention, and have agreed to a workshop to take this forward.

8 // We appreciate the role of legislatures and legislators in providing national leadership on HIV prevention and commit to working with parliamentary leaders in forwarding prevention. We call on parliaments to work with and listen to the voice of civil society and we commit to working with legislators on indicators for measuring the impact of parliaments on HIV responses.

9 // We will engage with development partners to discuss issues of prevention resourcing, long-term indicators for programming, and community-derived and driven programming. We call upon development partners, UN agencies and national AIDS coordinating bodies to better resource community leadership on prevention.

10 // We are agreed to meet together as civil society on July 15 2009 to take forward the above mobilization.

Annex 2: Meeting Agenda

SADC HIV Prevention Meeting: Achieving Prevention Targets

7-9 June 2009, Indaba Hotel, Johannesburg

Chair: Senior Official South Africa
Session chairs: Member States
Session rapporteurs: Member States
Supporting facilitation to session chairs: Jonathan Gunthorp, Acting Executive Director, HEARD
Coordinating rapporteur: Lisa-Anne Julien

Expected Outcomes:
- State of the epidemic, good practices and progress on HIV prevention within SADC Members States identified;
- Key issues and challenges in meeting the SADC HIV Prevention Strategy, including recommendations of the 2006 Expert Think Tank meeting explored;
- Understanding built regarding measurement, emerging evidence, issues and gaps related to implementing prevention programmes;
- Recommendations made for strengthening evidence-based prevention strategies towards universal access to halve new infections;
- Areas of need for strengthening technical capacity, and options and opportunities to build capacity identified.

SUNDAY 7th JUNE 2009

17.00-18.00 Registration
- Chairs briefing session (Antonica Hembe)
- Rapporteurs briefing session (Alphonse Mulumba and Lisa-Anne Julien)

SESSION 1: Welcome and setting the scene

18.00-19.00 Official opening of the meeting: SADC
- Welcome: South Africa
- Meeting agenda, objectives/expectations/introductions: SADC Secretariat
- Keynote Speech: Mark Stirling, UNAIDS
- Vote of Thanks: Member State

19.00-21:00 Opening reception
- National overview: Gallery walk (Country displays with presentations: status, progress made, challenges faced)

MONDAY 8th JUNE 2009

SESSION 2: Taking stock: Where are we now?
Chair: South Africa •Rapporteur: Tanzania (Dr Subilaga Kaganda)
8.00  Welcome: SADC Secretariat

8.15 – 10.30
2. SADC HIV Prevention Strategy: A. Mulumba, SADC Secretariat
3. Epidemic Update: Understanding the epidemic patterns, incidence, and key emerging issues: Marelize Gorgens, World Bank
4. Overview and conclusions from country reviews (gallery walk): Lois Chingandu, SAfAIDS Points of clarification

10.30 – 11.00  Tea/Coffee Break

SESSION 3: Thematic country evidence: progress, challenges and gaps; and updating evidence
CHAIR: Malawi (Dr Eliam Kamanga) • Facilitator: Jonathan Gunthorp • Rapporteur: Botswana

11.00 – 13.00
1. Social and behavioural change
   Zambia: Multiple and concurrent partners: social change communication
   Lesotho: Young women and age-disparate sex
   South Africa: Young People
   Tanzania: Positive prevention and discordant couples
   Mozambique: Gender issues and male involvement
   Brief: Rick Olson, UNICEF
2. Biomedical interventions
   Swaziland: Male circumcision service provision
   Zimbabwe: condom programming
   Brief: Helen Jackson, UNAIDS

13.00 -14.00  Lunch

SESSION 3: continued
Chair: Swaziland (Ms Futhi Dennis) • Rapporteur: Zimbabwe (Mr Oscar Mundida)

14.00 – 15.30
3. Hard to reach vulnerable populations and sexual risk
   Angola: Populations at greatest risk
   DRC: Sex work
   Mauritius and Seychelles: IDU
   Brief: Prisons: Brian Tkachuk, UNODC
4. Testing, MTCT and ART
   Botswana: PMTCT
   Malawi: HTC
   Namibia: ART for prevention
   Brief: Buhle Ncube, WHO

15.30 – 16.00  Tea/coffee break

SESSION 4: Measuring Success and selected areas
Chair: Angola (Mr. Santos Quiame) • Rapporteur: Lesotho (Mrs Nthabiseng Tapole)

16.00 – 17.00
1. Concurrency measurement: Masauso Nzima, UNAIDS RST ESA
2. Criminalisation: Nyaradzo Chari-Imbayago, ARASA

SESSION 5: Information Sharing
Chair: DRC (Dr Jonathan Kawunda) Rapporteur: Zambia (Dr Chama Chanda)

17.00 – 18.00
Panel presentations:
   • Key outcomes SADC PMTCT and HTC Guidelines Meeting, 25-27 May 2009: SADC Secretariat
   • Key outcomes Regional PMTCT Meeting, Nairobi, 21-22 May 2009, UNICEF
   • Key outcomes SADC OVC and Youth Meeting, 4-5 June 2009: Manasa Dzirikure, SADC Secretariat

TUESDAY 9th JUNE 2009

SESSION 6: Moving forward
Chair: Mozambique • Rapporteur: VSO-RAITA

8.30 – 9.30  Recap of Day 1, review of main issues and recommendations
Facilitator: Jonathan Gunthorp

9.30 – 11.30 (including working tea break)
Group work:
1. What would it take in your country to halve new infections by 2015?
2. What would be your technical assistance needs?
11.30 – 12.30  Plenary feedback and discussion, agreement on recommendations: Mark Stirling, UNAIDS

SESSION 7: Official closing

12.30 – 13.00  Closing Session: Facilitator: South Africa
Antonica Hembe, SADC Secretariat
Peter Iveroth, SIDA
Bunmi Makinwa, UNFPA

13.00  Lunch and departure
### Annex 3: Participant list
**SADC HIV Prevention Meeting 7 – 9 June 2009, Johannesburg**

#### SADC Member State Delegations

**Botswana**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kebaabetswe Kelebemang</td>
<td>PMTCT Project Officer</td>
<td>BONEPWA, P.O. Box 60788, Gaborone, Tel: 267 3906224, <a href="mailto:kelebemang_kebaabetswe@yahoo.com">kelebemang_kebaabetswe@yahoo.com</a></td>
</tr>
<tr>
<td>Elizabeth Koko</td>
<td>Principal Health Officer</td>
<td>Department of HIV/AIDS, Private Bag 0045, Gaborone, Tel: 267 3710314/3632054</td>
</tr>
<tr>
<td>Kereng Masupu</td>
<td>Champion Player, Champion for an HIV Free Generation</td>
<td>Private Bag 0318, Gaborone, Tel: 267 3914078, Fax: 267 3914097</td>
</tr>
<tr>
<td>Richard K. Mathlere</td>
<td>IEC Consultant</td>
<td>National AIDS Coordinating Agency, Private Bag 00463, Gaborone, Tel: 267 3710314, Fax: 267 3710312</td>
</tr>
<tr>
<td>Montle Ponatshego</td>
<td>Prison Health Coordinator</td>
<td>Private Bag X02, Gaborone, Tel: 267 3611 717/3611700, Fax: 267 3975003/3975398</td>
</tr>
<tr>
<td>Elizabeth Pule</td>
<td>Minister of Labour &amp; Home Affairs</td>
<td>Gaborone, Tel: 267 3710314/3632054, Fax: 267 3975003/3975398</td>
</tr>
</tbody>
</table>

**Democratic Republic of the Congo**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jonathan Kitapindu Kawunda</td>
<td>National Sector Public et Prevention</td>
<td>Programme National Multisectorial, Avenue Basoko no. 16, Commune de la Gombe, Kinshasa,</td>
</tr>
<tr>
<td>Tresor Kasia Kitom</td>
<td>RACOJ/SIDA</td>
<td>Kinshasa, Tel: 243 998 423154/0810155023, <a href="mailto:racoj-sida@yahoo.fr">racoj-sida@yahoo.fr</a>,<a href="mailto:trexorkasia@yahoo.fr">trexorkasia@yahoo.fr</a></td>
</tr>
<tr>
<td>Constantin Mingina Mbuolieng</td>
<td>Chef de Division de Prise en Charge des IST PLNS Minisante, Kinshasa, Tel: 243 998599983, <a href="mailto:mingconstantin@yahoo.fr">mingconstantin@yahoo.fr</a></td>
<td></td>
</tr>
<tr>
<td>Andre Mbongompasi</td>
<td>Coordonnateur Provincial PNMLS</td>
<td>Avenue Charpentier N° 1342 C/Linete, Kinshasa, Tel: 243818135017, <a href="mailto:andrembongompasi@yahoo.fr">andrembongompasi@yahoo.fr</a></td>
</tr>
</tbody>
</table>

**Lesotho**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mpoetsi Mothibeli</td>
<td>Health &amp; Social Welfare Department</td>
<td>P.O. Box 514, Maseru, Tel: 266 22 260 000/266 580 23969, Fax: 266 22 325 686, <a href="mailto:m_mothibeli@yahoo.co.uk">m_mothibeli@yahoo.co.uk</a></td>
</tr>
<tr>
<td>Sekonyela Lelepwa Mapetja</td>
<td>Lesotho Council of NGOs</td>
<td>Private Bag A544, Maseru 100, Tel: 266 62849564, Fax: 266 22 310 412, <a href="mailto:mptsekonyela@yahoo.co.uk">mptsekonyela@yahoo.co.uk</a></td>
</tr>
<tr>
<td>Nthabiseng Tapole</td>
<td>National AIDS Commission</td>
<td>P.O. Box 11232, Maseru, Tel: 266 58840985/23262794, Fax: 266 327 210, <a href="mailto:tapolen@nas.org.ls">tapolen@nas.org.ls</a></td>
</tr>
</tbody>
</table>

**Malawi**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliam Kamanga</td>
<td>National AIDS Commission</td>
<td>P.O. Box 30622, Lilongwe, Tel: 265 88819985, Fax: 265 1 776249, <a href="mailto:kamangae@acidsmalawi.org.mw">kamangae@acidsmalawi.org.mw</a></td>
</tr>
<tr>
<td>Amon Nkhata</td>
<td>STI Program Manager</td>
<td>HIV and AIDS Department, Ministry of Health, P.O. Box 30377, Lilongwe 3, Tel: 265 999 494399/265 1788 068/265 8888 76277, Fax: 265 1788068/789365, <a href="mailto:amonnkhata@yahoo.co.uk">amonnkhata@yahoo.co.uk</a></td>
</tr>
</tbody>
</table>

**Mauritius**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amita Pathack</td>
<td>Prime Minister’s Office</td>
<td>5th Floor, Foeks House, Port Louis, <a href="mailto:apathack@mail.gov.mu">apathack@mail.gov.mu</a>, <a href="mailto:nas@mail.gov.mu">nas@mail.gov.mu</a></td>
</tr>
</tbody>
</table>

**Mozambique**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rogerio Paulo Moreira</td>
<td>Provincial Coordinator</td>
<td>National AIDS Council, Matola, Tel: 258 21724 283/258 827056364, Fax: 258 21724 283, <a href="mailto:isazuku@yahoo.com.br">isazuku@yahoo.com.br</a></td>
</tr>
<tr>
<td>Isabel Blanchette Zukulu</td>
<td>Provincial Coordinator</td>
<td>National AIDS Council, Matola, Tel: 258 21724 283/258 827056364, Fax: 258 21724 283, <a href="mailto:isazuku@yahoo.com.br">isazuku@yahoo.com.br</a></td>
</tr>
</tbody>
</table>
### South Africa

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Program</th>
<th>Address/Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thato Chidarikire</td>
<td>National Department of Health</td>
<td>231 Proes Street, Pretoria Tel: 27 12 312 3323 Fax: 27 12 312 3332 <a href="mailto:chidat@health.gov.za">chidat@health.gov.za</a></td>
</tr>
<tr>
<td>Monica Dea</td>
<td>Prevention Coordinator</td>
<td>US Centers for Disease Control and Prevention (CDC) P.O. Box 9536, Pretoria 0001 Tel: 27 79111 6374 Fax: 27 12 366 4286 <a href="mailto:deam@sa.cdc.gov">deam@sa.cdc.gov</a></td>
</tr>
<tr>
<td>Dayanund Loykissonlal</td>
<td>Acting Director, HIV Prevention National Department of Health Private Bag X828, Pretoria 0001 Tel: 27 12 312 0411, 27 71 603344 Fax: 27 12 312 332 <a href="mailto:loykid@health.gov.za">loykid@health.gov.za</a></td>
<td></td>
</tr>
<tr>
<td>Lawrence Matemba</td>
<td>Office of The Presidency</td>
<td>Union Building, Govt. Ave., Pretoria Tel: 27 12 300 5465 Fax: 27 086 683 5465 <a href="mailto:lawrence@po.gov.za">lawrence@po.gov.za</a></td>
</tr>
</tbody>
</table>

### Swaziland

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Program</th>
<th>Address/Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Futhi Dennis</td>
<td>National Emergency Response Council on HIV &amp; AIDS (NERCHA) P.O. Box 1937 Tel: 268 404 1708/268 615 1473 Fax: 268 404 1692 <a href="mailto:fdennis@nercha.org.sz">fdennis@nercha.org.sz</a></td>
<td></td>
</tr>
<tr>
<td>Khanya L. Mabuza</td>
<td>Director</td>
<td>National Emergency Response Council on HIV &amp; AIDS (NERCHA) P.O. Box 1315, Matsapha, Manzini Tel: 268 6028845 Fax: 268 404 1708 <a href="mailto:kmabuza@nercha.org.sz">kmabuza@nercha.org.sz</a></td>
</tr>
</tbody>
</table>

### Tanzania

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Program</th>
<th>Address/Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Bujari</td>
<td>Executive Chairperson</td>
<td>Tanzania AIDS Forum P.O. Box 65147, Dar es Salaam Tel: 255 784 217127 Fax: 255 22 277 2299 <a href="mailto:ed@hdt.or.tz">ed@hdt.or.tz</a></td>
</tr>
<tr>
<td>Bennett Fimbo</td>
<td>National AIDS Programme</td>
<td>Dar es Salaam Tel: 255 754 329829 <a href="mailto:benfimbo@yahoo.com">benfimbo@yahoo.com</a></td>
</tr>
<tr>
<td>Khany L. Mabuza</td>
<td>Director</td>
<td>National Emergency Response Council on HIV &amp; AIDS (NERCHA) P.O. Box 1315, Matsapha, Manzini Tel: 268 6028845 Fax: 268 404 1708 <a href="mailto:kmabuza@nercha.org.sz">kmabuza@nercha.org.sz</a></td>
</tr>
<tr>
<td>Subilaga Kasesela-Kaganda</td>
<td>National Programme Coordinator Tanzania Commission for AIDS (TACAIDS) P.O. Box 65300, Dar es Salaam Tel: 255 754 659303 Fax: 255 22 2122 427 <a href="mailto:sublagakk@tacads.go.tz">sublagakk@tacads.go.tz</a>; <a href="mailto:sublagakk@gmail.com">sublagakk@gmail.com</a></td>
<td></td>
</tr>
</tbody>
</table>

### Zambia

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Program</th>
<th>Address/Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chama Chanda</td>
<td>TB/STI Specialist</td>
<td>National HIV/AIDS/STI/TB Council P.O. Box 38718, Lusaka Tel: 260 976 478466 Fax: 260 211 253 881 <a href="mailto:echanda@nacssec.org.zm">echanda@nacssec.org.zm</a></td>
</tr>
<tr>
<td>Mabvuto Katwizi Kango</td>
<td>Ministry of Health</td>
<td>Ndeke House, Longacres P.O. Box 30205, Lusaka Tel: 260 211 253040 Fax: 260 211 253344 <a href="mailto:kango@email.com">kango@email.com</a></td>
</tr>
<tr>
<td>Sarah N. Ngoma</td>
<td>RAPIDS – World Vision</td>
<td>P.O. Box 320432, Lusaka Tel: 260 97827226 Fax: 260 211 263718 <a href="mailto:sara_ngoma@wwv.org">sara_ngoma@wwv.org</a></td>
</tr>
<tr>
<td>Arlene H. Phiri</td>
<td>Projects Manager</td>
<td>SAI AIDS-Zambia No. 4 Lukasu Road, Rhodespark, Lusaka Tel: 260 211 257652 <a href="mailto:achphiri@yahoo.com">achphiri@yahoo.com</a></td>
</tr>
</tbody>
</table>

### Zimbabwe

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Program</th>
<th>Address/Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Buzuzi</td>
<td>Project Coordinator</td>
<td>Biomedical Research 4th Floor Nicoz Diamond, Harare Tel: 263 4 739500 Fax: 263 4 735033 <a href="mailto:sbuzuzi@yahoo.com">sbuzuzi@yahoo.com</a></td>
</tr>
<tr>
<td>Lindwiwe Chaza Jangira</td>
<td>National Director</td>
<td>Zimbabwe AIDS Network 154 S. Machel Ave. West Belvedere, Harare Tel: 263 4 795 337/263 912 220579 Fax: 263 4 775520 <a href="mailto:lchaza-jangira@zan.co.zw">lchaza-jangira@zan.co.zw</a></td>
</tr>
<tr>
<td>Anna Machiha</td>
<td>STI/HIV/ Prevention Officer</td>
<td>Ministry of Health &amp; Child Welfare Box CY 1122, Causeway, Harare Tel: 263 11704 556 <a href="mailto:annamachiha@yahoo.com">annamachiha@yahoo.com</a></td>
</tr>
<tr>
<td>Oscar Mundida</td>
<td>National Behaviour Change Coordinator</td>
<td>National AIDS Council 100 Central Avenue, Harare Tel: 263 912481333 Fax: 263 4 7911 <a href="mailto:mundidao@yahoo.co.uk">mundidao@yahoo.co.uk</a></td>
</tr>
</tbody>
</table>

### Non-governmental Organizations

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Program</th>
<th>Address/Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lois B. Chingandu</td>
<td>Executive Director</td>
<td>Southern African HIV/AIDS Dissemination Service (SAF AIDS) 479 Sappes Contour, Pretoria South Africa Tel: 27 12 369 0889 Fax: 27 12 361 6871 <a href="mailto:lois@safaidsw.net">lois@safaidsw.net</a></td>
</tr>
<tr>
<td>Michelle Evans</td>
<td>International HIV/AIDS Alliance</td>
<td>Hove BN3 IRE, Hove United Kingdom Tel: 44 1273 718900 <a href="mailto:mevans@aidsalliance.org">mevans@aidsalliance.org</a></td>
</tr>
<tr>
<td>Jonathan Gunthorp</td>
<td>Health Economics</td>
<td>Health Economics and HIV/AIDS Research Division (HEARD) University of KwaZulu Natal Durban, South Africa Tel: 27 828933072 <a href="mailto:jonggun@mweb.co.za">jonggun@mweb.co.za</a></td>
</tr>
</tbody>
</table>
### Johannes P. Heath
Acting Executive Director
International Network of Religious Leaders Living with or Personally Affected by HIV or AIDS (INERELA)
19 Girten Rd, Parktown, Johannesburg
Tel: 27 11 484 0088
Fax: 27 11 484 4422
jheath@inerela.org

### Nyaradzo Chari Imbayago
AIDS & Rights Alliance of South Africa (ARASA)
41 de Korte Street
Braamfontein, Johannesburg
South Africa
Tel: 27 11 403 7720
Fax: 27 11 403 7719
nyaradzo@arasa.org

### Agai Jones
Interim Director
Population Services International (PSI)
8 Hillside Road, 2nd Floor
Johannesburg
South Africa
Tel: 27 11 484 5220
Fax: 27 11 531 5961
agai@sffh.co.za

### Kevin Kelly
Director
Centre for AIDS Development, Research and Evaluation (CADRE)
23 Jorissen Street
Braamfontein 2017 Johannesburg
South Africa
Tel: 27 11 267 9935
Fax: 27 11 267 9935
kk@cadre.org.za

### Phillip Methula
Deputy Director
Regional Psychosocial Support Initiative (REPSSI)
372 Oak Avenue, Randburg
South Africa
Tel: 27 11 998 5828
Fax: 27 11 789 6525
phillip@repssi.org

### Anita Sandstrom
Southern African AIDS Trust (SAT)
Dunkeld West Centre
Johannesburg, South Africa
Tel: 27 11 341 0660/83
Fax: 27 11 341 0661
sandstrom@satregional.org

### Shereen Usdin
Soul City
Johannesburg
South Africa
Tel: 27 11 341 0360
Fax: 27 11 341 0370
shereenu@soulcity.org.za

### UN Agency Staff

#### International Labour Organization (ILO)

**Evelyn Serima**
Sub-Regional Office for Southern Africa
International Labour Organization (ILO)
Harare, Zimbabwe
Tel: 263 4 369805
serima@ilo.org

#### UNAIDS

**Kwame Ampomah**
UNAIDS Country Coordinator
6th Floor, Takura House
Harare, Zimbabwe
Tel: 263 912 469367
kwame.ampomah@undp.org

**Robert Bennoun**
Acting UNAIDS Country Coordinator
38 Stein Street,
Klein, Windhoek, Namibia
Tel: 264 811 341 0660/83
Fax: 264 811 341 0661
bennounr@unaid.org

**Boaz Cheluget**
M&E Advisor
UN House, Maseru
Tel: 266 22 313571
Fax: 266 22 313571
chelugetb@unaids.org

**Barbara de Zalduondo**
Chief, Program Priorities Division
Geneva, Switzerland
Tel: 41 22 791 1557
dezalduondob@unaids.org

**Mamoudou Diallo**
UNAIDS Country Coordinator
BP 1348, Zone Galany
Antananarivo, Madagascar
Tel: 261 33 11 44176
diallom@unaids.org

**Sibongile Dludlu**
11 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: 27 11 517 1515
dludlus@unaids.org

**Helen Jackson**
Senior HIV Prevention Advisor
11 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: 27 11 517 1529
Fax: 27 11 517 1511
jacksonh@unaids.org

**Desmond Johns**
UNAIDS Country Coordinator
P.O. Box 30135
Lilongwe 3, Malawi
Tel: 265 1 773 329
johnsd@unaids.org

**Mari Luntamo**
Programme Officer
Maputo, Mozambique
Tel: 258 82 527 6337
Fax: 258 21 492 345
luntamon@unaids.org

**Sophia Mukasa Monico**
UNAIDS Country Coordinator
5th Floor, Lilunga House
Mbabane, Swaziland
Tel: 268 6021056
Fax: 268 404 9336
mukasamonico@unaids.org

**Mbulawa Mugabe**
Senior Regional Policy Adviser
11 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: 27 11 517 1529
Fax: 27 11 517 1511
mugabem@unaids.org

**Masauso Nzima**
Regional M&E Advisor
11 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: 27 11 517 1559
Fax: 27 11 517 1511
nzimam@unaids.org

**Mary O’Grady**
HIV Prevention Consultant
11 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: 27 73 278 9170
Fax: 27 11 517 1511
maryogrady2@aol.com

**Bathsheba Okwenje**
Communications Officer
11 Naivasha Road
Sunninghill 2157
Johannesburg
South Africa
Tel: 27 11 517 1524
Fax: 27 11 517 1511
okwenjeb@unaids.org

**Marc Saba**
Adviser
Avenue du Livre No. 57, Gombe
Kinshasa, Democratic Republic of the Congo
Tel: 243 999308302
sabam@unaids.org

**Tamsir Oumar Sall**
UNAIDS Country Coordinator
UN Building, 8th Floor
Luanda, Angola
Tel: 244-926 366930
Fax: 27 11 517 1511
sallt@unaids.org
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Stirling</td>
<td>Regional Director</td>
<td>11 Naivasha Road Sunninghill 2157, Johannesburg</td>
<td>Tel: 27 11 517 1503 PO Box 12934 <a href="mailto:stirlingm@unaids.org">stirlingm@unaids.org</a></td>
</tr>
<tr>
<td>Catherine Sozi</td>
<td>UNAIDS Country Coordinator</td>
<td>351 Schoeman Street Pretoria 0001 The Tramshed, Pretoria 0126</td>
<td>Tel: 27 12 354 8490 Fax: 27 12 354 8491 <a href="mailto:sozic@unaids.org">sozic@unaids.org</a></td>
</tr>
<tr>
<td>Henk Van Renterghem</td>
<td>Regional Adviser</td>
<td>11 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td>Tel: 27 11 517 1694 Fax: 27 11 517 1511 <a href="mailto:vanrenterghem@unaids.org">vanrenterghem@unaids.org</a></td>
</tr>
</tbody>
</table>

**UNAIDS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Sozi</td>
<td>UNAIDS Country Coordinator</td>
<td>351 Schoeman Street Pretoria 0001 The Tramshed, Pretoria 0126</td>
<td>Tel: 27 12 354 8490 Fax: 27 12 354 8491 <a href="mailto:sozic@unaids.org">sozic@unaids.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Sozi</td>
<td>UNAIDS Country Coordinator</td>
<td>351 Schoeman Street Pretoria 0001 The Tramshed, Pretoria 0126</td>
<td>Tel: 27 12 354 8490 Fax: 27 12 354 8491 <a href="mailto:sozic@unaids.org">sozic@unaids.org</a></td>
</tr>
</tbody>
</table>

**UNFPA**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margaret Agama</td>
<td>HIV/AIDS Advisor - SRO</td>
<td>7 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td><a href="mailto:agama@unfpa.org">agama@unfpa.org</a></td>
</tr>
<tr>
<td>Bunmi Makinwa</td>
<td>Regional Director</td>
<td>7 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td><a href="mailto:makinwa@unfpa.org">makinwa@unfpa.org</a></td>
</tr>
<tr>
<td>Naisiadet Mason</td>
<td>HIV/AIDS Advisor</td>
<td>7 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td>Tel: 27 723379767 <a href="mailto:mason@unfpa.org">mason@unfpa.org</a></td>
</tr>
<tr>
<td>Asha Mohamud</td>
<td>Youth &amp; HIV/AIDS Advisor</td>
<td>7 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td><a href="mailto:mohamud@unfpa.org">mohamud@unfpa.org</a></td>
</tr>
</tbody>
</table>

**UNICEF**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheila Mangan</td>
<td>HIV/AIDS Specialist</td>
<td>P.O. Box 1706 Windhoek, Namibia</td>
<td>Tel: 264 81 395 4838 Fax: 264 61 204 6206 <a href="mailto:smangan@unicef.org">smangan@unicef.org</a></td>
</tr>
<tr>
<td>Rick Olson</td>
<td>Regional HIV Prevention Specialist</td>
<td>UNICEF Regional Office 11 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td>Tel: 27 11 517 1650 <a href="mailto:rolson@unicef.org">rolson@unicef.org</a></td>
</tr>
</tbody>
</table>

**UN Office on Drugs and Crime (UNODC)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brian Tkachuk</td>
<td>Regional Advisor</td>
<td>HIV/AIDS in Prisons UNODC Pretoria, South Africa</td>
<td>Tel: 27 12 342 2424 <a href="mailto:brian.tkachuk@unodc.org">brian.tkachuk@unodc.org</a></td>
</tr>
</tbody>
</table>

**World Health Organization (WHO)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innocent Ntaganira</td>
<td>WHO Regional Office for Africa</td>
<td>Cité De Djoue, Brazzaville, Congo</td>
<td>Tel: 242 5473268/47 241 39271 <a href="mailto:ntaganira@afro.who.int">ntaganira@afro.who.int</a></td>
</tr>
<tr>
<td>Buhle Ncube</td>
<td>World Health Organization (WHO)</td>
<td>86, Enterprise Road Highlands, Harare, Zimbabwe</td>
<td>Tel: 263 4 746000 <a href="mailto:ncubebi@zw.afro.who-int">ncubebi@zw.afro.who-int</a></td>
</tr>
</tbody>
</table>

**World Bank**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marelize Gorgens</td>
<td>M&amp;E Specialist</td>
<td>Global HIV/AIDS Program World Bank 1818 H Street NW,Washington DC United States of America</td>
<td><a href="mailto:mgorgens@worldbank.org">mgorgens@worldbank.org</a></td>
</tr>
</tbody>
</table>

**International Donor Agency Staff**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean-François Aguiller</td>
<td>European Commission (EC)</td>
<td>11 Naivasha Road Sunninghill 2157, Johannesburg South Africa</td>
<td>Tel: 27 721996066</td>
</tr>
<tr>
<td>Ellen Hagerman</td>
<td>Counsellor, Regional Development</td>
<td>The High Commission of Canada 1103 Arcadia Street Hatfield, Pretoria, South Africa</td>
<td>Tel: 27 12 422 3000 Fax: 27 12 422 3052 <a href="mailto:ellen.hagerman@international.gc.ca">ellen.hagerman@international.gc.ca</a></td>
</tr>
<tr>
<td>Peter Iveroth</td>
<td>Deputy Regional Director</td>
<td>Swedish/Norwegian Regional HIV Team Swedish Embassy Lusaka, Zambia</td>
<td>Tel: 260 211 251117 <a href="mailto:peter.iveroth@foreign.ministry.se">peter.iveroth@foreign.ministry.se</a></td>
</tr>
<tr>
<td>Michiko Tajima</td>
<td>Regional HIV/AIDS Advisor</td>
<td>Japan International Cooperation Agency (JICA) - South Africa Office P.O. Box 14068 Hatfield 0028, Pretoria, South Africa</td>
<td>Tel: 27 12 346 4493/076 901 9475 Fax: 27 12 346 4966 <a href="mailto:mogino@usa.net">mogino@usa.net</a></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Organization</td>
<td>Address</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------</td>
<td>----------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Isabelle van Tol</td>
<td>First Secretary, HIV &amp; AIDS</td>
<td>Royal Netherlands Embassy</td>
<td>210 Queen Wilhelmina Avenue, New Muckleneuk 0181 Pretoria, South Africa</td>
</tr>
<tr>
<td>Manasa Dzirikure</td>
<td>Technical Advisor, OVC &amp; Youth</td>
<td>SADC Secretariat</td>
<td>Post Bag 0095, Gaborone</td>
</tr>
<tr>
<td>Antonica Hembé</td>
<td>Head, HIV &amp; AIDS Unit</td>
<td>SADC Secretariat</td>
<td>Post Bag 0095, Gaborone</td>
</tr>
<tr>
<td>Lebogang Lebese</td>
<td>Technical Advisor, Health</td>
<td>SADC Secretariat</td>
<td>Post Bag 0095, Gaborone</td>
</tr>
<tr>
<td>Alphonse Mulumba</td>
<td>Programme Officer</td>
<td>SADC Secretariat</td>
<td>Post Bag 0095, Gaborone</td>
</tr>
</tbody>
</table>

**SADC Secretariat**

**Manasa Dzirikure**
Technical Advisor, OVC & Youth
SADC Secretariat
Post Bag 0095, Gaborone
Tel: 267 395 1863
Fax: 267 397 2848/391 3474
mdzirikure@sadc.int

**Antonica Hembé**
Head, HIV & AIDS Unit
SADC Secretariat
Post Bag 0095, Gaborone
Tel: 267 390 1056/390 1047
Fax: 267 397 2848
ahembe@sadc.int

**Lebogang Lebese**
Technical Advisor, Health
SADC Secretariat
Post Bag 0095, Gaborone
Tel: 267 3951863
Fax: 267 397 2848/391 3474
llebese@sadc.int

**Alphonse Mulumba**
Programme Officer
SADC Secretariat
Post Bag 0095, Gaborone
Tel: 267 390 1056/390 1047
Fax: 267 397 2848
amulumba@sadc.int
amulumba@yahoo.fr