A COMPARISON OF THE HIV AND AIDS POLICIES OF ECOWAS AND SADC

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DECLARATION

I hereby declare that the thesis submitted for the MA Politics degree to the University of Johannesburg, apart from the help recognised, is my own work and has not been formerly submitted to another university for a degree.

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ABSTRACT

The HIV and AIDS pandemic has swept through sub-Saharan Africa at an alarming pace, gaining momentum each year as millions of people are infected and affected by the virus. A range of social, political and economic consequences have already begun to emerge as a result of this disease, and a comprehensive response is essential to halt the spread of HIV and AIDS, and to manage the impact of the pandemic.

This study examines the response of the two dominant regional organisations in sub-Saharan Africa, namely the Economic Community of West African States (ECOWAS) and the Southern African Development Community (SADC), through an analysis of their policies on HIV and AIDS. The comparison of the HIV and AIDS policies of these regional organisations is conducted by means of three sets of identified indicators, covering education and awareness campaigns, prevention strategies, and treatment and care programmes. Further, the extent to which the regional guidelines contained in the policies are incorporated into the HIV and AIDS policies of member states is discussed with reference to Nigeria and South Africa, identified as the strongest states within their respective groupings with the highest prevalence rates.

Given the acknowledged impact of the disease, the regional response is not as comprehensive as would be expected. The SADC policy is generally more elaborative on the key issues than the ECOWAS policy. Vital issues such as the provision of condoms and addressing the disproportionate impact of HIV and AIDS on women are not dealt with, and the overall policies lack detail and practical guidance. In comparison, the policies of member states such as Nigeria and South Africa are far more elaborative, containing creative solutions to daunting problems, although some of the weaknesses identified in the regional HIV and AIDS policies shine through in the national policies of member states.

The study concludes that while practical restrictions such as lack of infrastructure, resources, and diverse cultural and religious beliefs hamper the formulation of a single, comprehensive regional policy on HIV and AIDS, the current guidelines provided by both ECOWAS and SADC fall short of the necessary response to a crisis of the magnitude of the HIV and AIDS pandemic.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AU	African Union
CBO	Community-Based Organisation
DoH	Department of Health
ECOWAS	Economic Community of West African States
GDP	Gross Domestic Product
GFATM	Global Fund to Fight HIV and AIDS, Tuberculosis and Malaria
HIPC	Enhanced Heavily Indebted Poor Countries Initiative
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug User
ILO	International Labour Organisation
LACA	Local Action Committee on AIDS
MAP	Multi-Country AIDS Programme for Africa
MNC	Multi-National Corporation
NACA	National Action Committee on AIDS
NGO	Non-Governmental Organisation
NSF	Nigerian Strategic Framework
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
SACA	State Action Committee on AIDS
SADC	Southern African Development Community
SANAC	South African National AIDS Council
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TRIPS	Trade Related Intellectual Property Rights
UN	United Nations

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UNAIDS	Joint and Co-Sponsored UN Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNPFA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WAHO	West African Health Organisation
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation
WTO	World Trade Organisation

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CHAPTER 1: AIM AND SCOPE OF THE STUDY

1.1 INTRODUCTION

HIV and AIDS prevalence has grown astronomically in sub-Saharan Africa. In the period from 1996 to 2003, the prevalence rate for the region has shot up by 36 000 percent (UNAIDS/WHO, 1999:612; UNDP, 2004:Internet source).[1] The Secretary-general for the Common Market for Eastern and Southern Africa (COMESA), Erastus Mwencha, has acknowledged that 80 per cent of AIDS (Acquired Immune Deficiency Syndrome) sufferers reside in Africa, with 3.8 million people dying of AIDS-related illnesses in sub-Saharan Africa during 2003 alone (*Zambezi Times*, 2004:Internet source). Southern African Development Community (SADC) member South Africa is estimated to lose more than ten million citizens as a result of AIDS-related illnesses by 2015, mostly economically active 25 – 45 year olds (Arndt & Lewis, 2000:857). Nigeria has shown an increase in HIV (Human Immunodeficiency Virus) positive individuals of almost 115 000 percent since 1996, while South Africa reports an increase of over one million percent during the same period (UNAIDS/WHO, 1999:612; UNDP, 2004:Internet source).[2]

The above two states are not alone; every state within the two regional groupings of the Economic Community of West African States (ECOWAS) and the Southern African Development Community (SADC) is facing this disease. Within ECOWAS, the state with the highest number of HIV infected individuals is Cote d'Ivoire (1.23 million or 7% of its population), with Senegal reporting the lowest with 88 800 people (0.8%) living with HIV and AIDS (UNDP, 2004:Internet source). SADC is consistently showing both the highest infection rate and death rate amongst African states, with ten million infected South Africans, which is roughly 21.5% of its population. Swaziland reports that a third of its one million citizens are infected (UNDP, 2004:Internet source). At the other end of the spectrum lies Madagascar which has the least infected citizens, with 299 000 affected people (1.7% of the population).

[1] Own calculations based on statistics contained in Table 1.1. (p. 3).

[2] Madagascar shows an almost 6 million per cent increase in HIV cases, while Guinea's infection rate shows the lowest rate of increase at just over 3000% for the period 1996-2003. The figures for all the states in both regional groupings can be seen in Appendix 1.1. The percentage increase of HIV and AIDS are own calculations based on the statistics in Table 1.1. and Appendix 1.1.

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Turning to the death rate represented in Table 1.1 below, the ECOWAS member state with the highest AIDS-related death rate for 2003 is Nigeria at 310 000 (0.25% of the population), while Gambia (which has roughly the same population size as Swaziland) lost 600 individuals in the same year (UNAIDS, 2004a:Internet source). Excluding Cape Verde, Guinea-Bissau, and Sierra Leone, the ECOWAS grouping reported almost half a million deaths attributed to HIV and AIDS during 2003.

More than a million people died of AIDS in the SADC region during 2003 (UNAIDS, 2004a:Internet source). The lowest death rate in the region was reported by Madagascar, at 7 500 individuals (0.04% of its population), with Zimbabwe falling into the second most afflicted state at 170 000 (1.32% of its population) behind South Africa (370 000 people or 0.79% of the population). Within ECOWAS, AIDS deaths claimed 0.02 % of the population (438 900), while the SADC shows a markedly higher figure of 0.83%, or 1 116 200 individuals (own calculations based on Table 1.1 below).

Although the prevalence and death rates for malaria and tuberculosis (TB) appear higher in some instances (see Table 1.1), it is important to note that opportunistic infections such as pneumonia and tuberculosis are often listed on death certificates as the primary cause of death instead of AIDS, resulting in a somewhat skewed representation of the true situation.

A further factor which inflates the prevalence figures is the population growth rate. For example, Benin's HIV and AIDS prevalence rate remained at 1.9% for 2001 and 2003, but the population grew at a rate of 3.2%, indicating that a further 4 803 people became infected. Thus, at times, retaining a constant infection rate does not imply that the spread of the disease is being halted.

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Table 1.1: Disease Statistics by Regional Grouping

State	Total Population[1]	HIV/AIDS Prevalence[1]/ Deaths[2]		Malaria Prevalence[1]/ Deaths[3]		Tuberculosis Prevalence[1]/ Deaths[3]	
ECOWAS							
Benin	7 900 000	150 100	5 800	845 300	14 220	10 270	790
Burkina Faso	12 400 000	520 800	29 000	76 880	35 960	33 480	3 720
Cape Verde	500 000	-	-	-	100	1 750	200
Cote d'Ivoire	17 600 000	1 232 000	47 000	2 138 400	14 080	110 880	12 320
Gambia	1 400 000	16 800	600	242 760	700	4 620	560
Guinea	9 000 000	28 800	9 000	6 785 100	180 000	34 200	3 600
Guinea-Bissau	1 500 000	-	-	36 300	2 250	4 800	600
Liberia	3 300 000	-	7 200	-	-	-	-
Mali	12 700 000	241 300	12 000	509 270	57 150	88 900	7 620
Niger	13 100 000	157 200	4 800	221 390	61 570	51 090	3 930
Nigeria	125 900 000	6 798 600	310 000	37 770	176 260	717 630	75 540
Senegal	11 100 000	88 800	3 500	1 324 230	7 770	48 840	5 550
Sierra Leone	5 100 000	-	-	-	15 810	32 130	4 080
Togo	5 800 000	237 800	10 000	446 600	2 900	40 020	4 640
TOTAL	227 300 000	9 472 200	438 900	12 664 000	568 770	1 178 610	123 150
AVERAGE	16 235 714	947 220	39 900	1 151 273	43 752	90 662	9 473
SADC							
Angola	15 100 000	585 000	21 000	1 315 500	52 850	60 000	3 020
Botswana	1 800 000	671 400	33 000	876 600	360	6 120	540
DR Congo	54 200 000	2 655 800	9 700	1 604 320	119 240	319 780	32 520
Lesotho	1 800 000	520 200	29 000	-	1 440	8 100	720
Madagascar	17 600 000	299 200	7 500	-	31 680	72 160	7 040
Malawi	12 300 000	1 746 600	84 000	3 191 850	34 440	56 580	6 150
Mauritius	1 200 000	-	-	120	0	1 680	120
Mozambique	19 100 000	2 330 200	110 000	3 460 920	43 930	105 050	11 460
Namibia	2 000 000	426 000	16 000	30 000	1 000	9 600	800
South Africa	46 900 000	10 083 500	370 000	65 660	0	173 530	14 070
Swaziland	1 000 000	388 000	17 000	28 400	0	7 700	800
Tanzania	36 900 000	3 247 200	160 000	446 490	47 970	173 430	18 450
Zambia	11 300 000	1 864 500	89 000	3 864 600	15 820	66 670	7 910
Zimbabwe	12 900 000	3 173 400	170 000	697 890	0	58 050	7 740
TOTAL	234 100 000	27 991 000	1 116 200	15 582 350	348 730	1 118 450	111 340
AVERAGE	16 721 429	2 153 154	85 862	1 298 529	24 909	79 889	7 953

[1] UNDP (2004:Internet source); [2] UNAIDS (2004a:Internet source); [3] UNSTATS (2005:Internet source).

A UNAIDS report entitled "AIDS in Africa: Three scenarios to 2025" states that without a dramatic turnaround in AIDS policies, 80 million Africans will die in the next ten years (Katabira & Mckinnell, 2005:34). An emphasis is placed on finding creative and diverse responses tailored to the unique African context. The report also notes that resources are being mobilized as states around the world face the reality of a "health crisis with global economic and security consequences" (Katabira & Mckinnell, 2005:34). This view is shared by Bonnel (2000:831), who notes that "HIV and AIDS undermine the main determinants of growth, which in turn facilitates the spread of the HIV epidemic and further reduces economic growth". These economic growth

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variables, including life expectancy, labour migration, income and gender inequality, as well as access to health services, are thus at the centre of policy formulation for these economic groupings (Bonnel, 2000:831).

As with all matters, the HIV and AIDS crisis did not develop in a vacuum, nor will it be solved without some consideration of contributory factors. The first complicating issue to be considered is the debt crisis, which has been escalating since the 1970s and severely affects the ability of African states to devote the necessary resources to the AIDS pandemic. The debt crisis has stretched Africa to the breaking point in terms of lending (Kajimpanga, 1998:Internet source). During the 12 year period between 1980 and 1992, the debt of developing states rose from US$567 billion to almost US$1.4 trillion (Kumar & Sharma, 2002:45). There appears to be a clear connection between the debt burden of these states and the prevalence of the three most rampant diseases in Africa.

Amongst the ECOWAS states, Nigeria has the highest total external debt (US$34.96 billion), the third highest HIV and AIDS prevalence rate (5.4%), as well as a comparatively high tuberculosis prevalence rate. Cote d'Ivoire has high external debt (US$12.19 billion), and as mentioned above, the worst HIV and AIDS infection rate of all the ECOWAS states (7%), ranking third for both tuberculosis and malaria prevalence in the region (UNDP, 2004:Internet source).[3]

Examining the link between debt and disease within SADC states shows that the Democratic Republic of Congo has an external debt burden second only to South Africa (US$11.17 billion), and has one of the highest tuberculosis prevalence rates of the grouping (0.59%) (UNDP, 2004:Internet source). Zambia, with a total external debt of US$6.43 billion, also reports high HIV and AIDS (16.5%), malaria (34.20%), and tuberculosis infection rates (0.59%) (UNDP, 2004:Internet source).

Up to 40% of the export earnings of states such as Mozambique, Tanzania, and Zambia were used towards paying off external debts, while social development, health and

[3] Senegal, with the third highest debt burden in ECOWAS (US$4 419 million), also struggles with high HIV and AIDS (0.8%) and tuberculosis (0.44%) infection rates. Mali has the highest tuberculosis prevalence (0.7%) and Guinea has the most malaria infections (75.39%) (UNDP, 2004:Internet source).

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education expenditure in sub-Saharan Africa is dropping, as it is estimated that between 30% and 40% of new aid money in sub-Saharan Africa was directed towards repaying old debts (Kajimpanga, 1998:Internet source). The push for faster and more substantial debt relief has intensified, as government expenditure on debt repayments has risen from 40.9% in 1999 to 48.5% in 2003 (Walker, 2005:Internet source).[4]

The costs of treating patients for up to ten years, together with the expense of caring for orphans and households without earners, are potentially crippling for developing states even without the added burden of repaying debt threefold, as has happened (Kumar & Sharma, 2002:45).[5] In other words, as the prevalence rate increases, the cost of intervention, care, and long term treatment soars beyond the capacity of developing states (Bonnel, 2000:849).

The second issue which African economies will be challenged to overcome is the erosion of human and social capital. The drastic depletion of their workforce, especially during this critical time of integration and rapid development, is potentially disastrous, as states with a high proportion of infected citizens could expect their workforce to shrink by between 10% and 30% by 2020 (Bowen, 2005:Internet source). Bonnel (2000:845) estimates that Africa's per capita income would have increased three-fold had the HIV and AIDS prevalence rate not increased at such a rapid pace.

The higher labour turnover rate increases training costs and leads to disinvestment in high prevalence areas as the health care costs for the state and corporations mounts (Phillips, 2004:Internet source). The informal sector, which currently accounts for 80% of African employment, is expected to grow exponentially as the disease spreads. While HIV and AIDS initially destroyed the human capital of highly afflicted states, largely due to a lack of research and understanding about the disease, it has moved to a stage of eroding the accumulated national human capital, rather than decimating it

[4] SADC states Zimbabwe, Mozambique, and Tanzania have all reported prevalence rates for HIV and AIDS, malaria, and tuberculosis which fall into the highest affliction ranges, as well as all dealing with a considerable debt burden (UNDP, 2004:Internet source).

[5] The Group of Eight, representing the most powerful developed states, recently agreed to commit US$50 billion in aid to developing countries. In addition, the debt of nine African states will be cancelled, with a further nine states eligible for debt cancellation in 18 months (Herbert, 2005:12). The states which are eligible for debt cancellation include Benin, Burkina Faso, Madagascar, Mozambique, and Tanzania. Nigeria received US$18 billion worth of debt relief from the Paris Club.

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(Bonnel, 2000:827). Social capital, referring to the level of trust and cooperation between citizens and government, has also taken a direct hit as a result of HIV and AIDS (Bonnel, 2000: 829).

The scourge of HIV and AIDS is therefore a massive drain on African states, which are already battling against malnutrition, widespread poverty and underdevelopment. The impact of the disease will continue to grow to the detriment of the African people until leaders devise a workable strategy that addresses the many effects of the pandemic (World Economic Forum, 2003:Internet source).

The statistics mentioned above demonstrate the sobering future facing African states. The United Nations Security Council recognised the far-reaching consequences of the pandemic in 2000 when it held its historic first meeting centred around development and health issues, particularly related to HIV and AIDS (Collins, 2001:Internet source). The Security Council cited the pandemic as a contributing factor in social instability, conflicts and other emergency situations.

Although there are currently an assortment of disparate state-level as well as multilateral governmental programmes and policies for dealing with HIV and AIDS across the African continent[6], the question arises as to what the two largest regional organisations in Africa, i.e. ECOWAS and SADC, are doing in terms of addressing the devastating health issues in their respective regions. The question is especially relevant when considering that these organisations were specifically established to promote development in the region, which is obviously not possible with the current health situation of their populations. According to the World Bank (2004:Internet source), the majority of sub-Saharan AIDS prevention programmes have been unsuccessful due to inadequate funding and resource allocation, insufficient leadership from governments, poor adoption rates of improved programmes (especially in terms of "scaling up"), and a narrow focus on the health sector.

[6] Individually these actions have had limited success in small, local pockets but have not been collectively effective in overcoming the widespread effects of the pandemic.

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1.2 PURPOSE OF THE STUDY

With the above short background in mind, the purpose of this study is to compare the approaches of the two major regional organisations, namely ECOWAS and SADC, towards HIV and AIDS through an analysis of their health policies.

These two regional organisations have been selected for the comparative analysis as the member states of both, as has been shown above, have high incidences of HIV and AIDS. Further, ECOWAS and SADC are the two most prominent regional bodies on the African continent. They are, for example, "the only groupings in which intra-community trade accounted for considerably more than 10% of their total exports in 2002, at 17% and 22%, respectively" (Ntamack, 2004:13). Furthermore, the key characteristics of these two regional organisations lend themselves to comparison, as is discussed later in this chapter. Finally, as regionalism is the leading approach being followed by African states in the pursuit of their development objectives, it is fitting to contrast these two bodies.

The second part of the study assesses the extent to which the health policy guidelines, specifically the aspects relating to HIV and AIDS, are implemented in the policies of member states, particularly Nigeria and South Africa. The selection of Nigeria and South Africa as representative states for ECOWAS and SADC respectively, is based on a number of similarities between the states, as well as their corresponding positions as the dominant forces within their regional organisations (Hettne, 2001:93; Greer, 1992:31). Nigeria has the largest population of all ECOWAS states (125.9 million), the highest GDP (US$43.5 billion), and the highest external debt at US$34.96 billion (UNDP, 2004:Internet source). South Africa has the second largest population behind the Democratic Republic of the Congo, at 46.9 million people. South Africa has the highest GDP of the SADC states, earning US$104.2 billion annually, as well as having the highest external debt burden at US$27.8 billion (UNDP, 2004:Internet source). Both Nigeria and South Africa have by far the largest number of individuals infected with HIV and AIDS and tuberculosis. Nigeria has almost 6.8 million HIV positive individuals (5.4%), and South Africa has a massive 10.1 million HIV positive individuals within its borders (21.5%). Nigeria reported 717 630 tuberculosis cases and South Africa 173 630 (UNDP, 2004:Internet source). Lastly, the health policies and

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statistics on health and health-related issues are readily available for these states, enabling a balanced comparison of their health policies.

Specific issues that will be addressed in a comparative manner include:

- The extent to which their policies on HIV and AIDS stress education and prevention programmes;
- Their position on the provision of drugs and antiretrovirals (ARVs);
- The extent to which gender is incorporated into their policies on HIV and AIDS is of particular importance, as is discussed below.

Due to the patriarchal nature of African society, which inhibits the ability of women to ensure that they practice safe sex at all times, the health policies of these groupings must ensure that gender issues are taken into consideration. The vital connection between gender mainstreaming and HIV and AIDS is outlined by Lowe Morna (2004:290) as

> *"a key test case … because of its importance, its cross-cutting nature and the fact that there are aspects of the pandemic that are specific to women, such as the transmission of the virus from mother to child during pregnancy, as well as the not so obvious gender dimensions such as the added burden of care that inevitably falls on women".*

The concept of "gender mainstreaming" grew out of the adoption of the Beijing Declaration and Platform for Action of 1995, which argues that addressing the needs of women as a separate issue does not necessarily further their interest. Rather, women should be empowered to participate in the formulation of policies which impact on their lives, especially around issues of health and development (Elsey, Tolhurst & Theobald, 2005:988). The principle behind gender mainstreaming is that the differing responsibilities of women and men are recognised in policy formulation, and that this "implies the integration of women's needs and the realities of their daily lives into all aspects of policy making informed by knowledge of the diversity of needs" between men and women (Sadie, 2005a:455). The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), adopted by the UN in 1979, provided the

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groundwork for this movement.[7] Widely regarded as the "international bill of rights for women", it formally recognises the legal equality of women (UN Women Watch, 2005:Internet source). Notably, it also acknowledges the reproductive rights of all women.

Women are disproportionately affected by HIV and AIDS, as they account for approximately 60% of the total prevalence across ECOWAS and SADC states (UNDP, 2004:Internet source). Further, women must also cope with the correlative issues of child care and assuming the burden of becoming the sole earners in their households (Lowe Morna, 2004:290). By facilitating the participation of women in policy formulation, health policies would begin to address these concerns in a more meaningful manner. Former Speaker of the South African National Assembly Frene Ginwala argues that as more women partake in this process "inclusion of their perspectives and experience will inevitably lead to solutions that are more viable and satisfy a broader range of society" (quoted by Lowe Morna, 2004:29).

The disproportionate ratio of women to men within decision making forums is thus troubling, with women making up just 11% of ECOWAS parliamentarians and SADC faring a little better at almost 16%. Guinea has the highest percentage of women in parliament (19%), while Nigeria has the lowest within the ECOWAS states at 4.7% (UNSTATS, 2005:Internet source). SADC has shown greater commitment in this regard, with women comprising more than 32% of South Africa's parliament, and Mauritius reporting a low of 5.7% (UNSTATS, 2005:Internet source).[8] While this study does not focus on the representation of women in decision making structures, this is a crucial aspect in the addressing of the structural inequalities facing women in Africa, and must therefore be noted. However, each chapter of this study will include an overview of how gender mainstreaming has been addressed by both ECOWAS and SADC in their HIV and AIDS policy documents.

[7] Since its adoption by the UN General Assembly, CEDAW has been ratified by 180 states, including all the member states of ECOWAS and SADC.

[8] At the time of writing, the representation of women in SADC improved somewhat, reaching almost 20% on average, with Mauritius improving substantially to 17.14% (Sadie, 2005b:18).

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1.3 LITERATURE OVERVIEW

A search of current and recent studies on the development of a regional political regime for dealing with the HIV and AIDS pandemic in Africa was conducted, and showed paucity in scholarly research.

The majority of the completed research topics deal with specific sectors and their individual response to HIV and AIDS within the African context. These include the work of Rezelman (2003) which outlines the response of the South African Navy towards HIV positive officer candidates, in terms of the impact of the disease on the armed forces of SADC, and Dube (2003) who considers the management of HIV and AIDS information in SADC institutions of higher learning.

A second category of research examines individual industries within each economic grouping, although HIV and AIDS do not feature prominently in these studies. These include the work of Pakote (1997), and Phiri (2000), who respectively examine the Namibian Beef Industry within SADC, and nursing education in SADC states.

A third set of research concentrates on certain groups which experience the effects of the pandemic more severely, such as orphans, displaced persons, and the elderly. The role of religion is also explored. Notable works in this grouping include Joslin (2002), Benn (2002), Mbuqua (2004), and Cels and Ogata (2003).

The policies of the individual states within the two regional economic groupings have drawn much attention, especially in recent years as the pandemic has gathered momentum.[9] The number of studies of the state level response is extensive, including Fourie (2005), Crewe (2000), Dike (2002), Epstein (2000), Wolfe (2004), Harris and Siplon (2001), and Zachariah (2004), to name just a few. The health policies of South Africa in particular are extensively dealt with by these authors. Nigeria's HIV and AIDS response has been scrutinised in the work of Pearce (2000), Ebomoyi and

[9] HIV and AIDS policy related issues such as the macroeconomic and investment implications of health policies are discussed by authors such as Arndt and Lewis (2000), Bonnel (2000), Stremlou (2002) and Nyikuli (1999).

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Afoaku (2000), and Keller and Brown (2002), with the latter providing an analysis of the role of the media in education and awareness campaigns.

The role of other actors involved in partnerships with regional organisations such as ECOWAS and SADC is the subject of numerous papers and books. The influence of interest groups in ensuring collective community action and how they affect the efficacy of policy implementation is gauged by Ainsworth (2000). Jennings and Anderson (2003) explore the importance of AIDS activism within both the political and social spheres, as well as detailing some of the actions these non-state actors have taken within the African context. Naidu (2001) studies the opportunities created by globalisation for the emergence of civic organisations such as Non-Governmental Organisations (NGOs). The study reveals the role these NGOs play in assisting the state in fulfilling its obligations in terms of health and social services, with SADC states providing case studies. The contribution made by small and medium enterprises is discussed by Fraser, Grant, Mwanza and Naidoo (2002) and the involvement of the private sector in ensuring a comprehensive response to the AIDS epidemic in Africa is questioned by Rosen and Simon (2003).

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Some attention has been paid to the health policies of the ECOWAS and SADC groupings individually, but no comparative study of both has been performed. These take into account studies of treatment policies (Berger, 2001), especially in terms of the African situation regarding patents and access. The spending policies practised by SADC are scrutinised by Hickey (2002), while a more general overview of the sub-Saharan region's spending policies is provided by Kumaranayake and Watts (2000). The protection of sub-regional security is delved into by Van Nieuwkerk (2001a), focusing on the SADC perspective. Addressing the need for ensuring that the African context is taken into account, Richter (2003) investigates the incorporation of traditional cultures into policy formulation.

This literature review highlights a number of the varied facets surrounding the issue of HIV and AIDS and the health policy formulation within both ECOWAS and SADC, as well as the implications of these policy guidelines in the two dominant member states of Nigeria and South Africa. However, a comparative analysis of these two regional organisations has not been conducted, and the study will therefore hopefully fill a much

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needed gap in the examination of the regional African response to HIV and AIDS at a multilateral level.

1.4 METHOD OF RESEARCH

This study is based on a literature analysis of primary and secondary sources, including the official documentation of the two regional organs. A comparative approach is followed in analysing the respective health policies of the two regional organisations of ECOWAS and SADC. A number of key issues, identified above, form an integral part of the analysis, and are therefore integrated into the framework and the indicators outlined below.

In order to make meaningful comparisons, as opposed to merely pointing out differences (O'Neil, 2004:4), the comparative approach necessitates that cases to be compared share meaningful similarities, or "distinct categories with identifiable and shared characteristics" (Landman, 2000:5). ECOWAS and SADC lend themselves to comparison since, apart from consisting of developing African states, they share further meaningful similarities required for successful comparison of their regional response to HIV and AIDS. These similarities include:

- The shared goal of development and sustainable economic growth, which will be compromised with a weakened workforce;
- HIV and AIDS prevalence across all states (to varying degrees of severity);
- High rates of malaria and tuberculosis prevalence across all states (to varying degrees of severity);
- Multiple funding sources for programmatic actions involved with communicable diseases, poverty and development as a direct result of being classified as developing states.

An accurate contextual description is essential when dealing with a wide variety of states (Landman, 2000:5), both in terms of defining the scope of the problem, as well as evaluating the scale of an effective response.

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Both regional organisations have to contend with similar factors influencing their health policies. These include;

- Poverty;
- Illiteracy;
- Underdevelopment of national health and social infrastructures;
- Armed conflicts;
- Natural disasters;
- Debt.

While a direct line can not necessarily be drawn from these issues to the approaches followed by the regional organisations towards HIV and AIDS, the influence of the environment on the respective health policies of member states is discussed further in chapter two.[10]

A second requirement for effective comparison entails the ability to control the variables being studied to avoid a distortion of results (O'Neil, 2004:5). Therefore clear indicators need to be identified to serve as controllable variables for comparison. Indicators that are used for comparison in this study relate to two broad aspects: the health policies of each regional economic grouping, and the resources at the disposal of ECOWAS and SADC that allow for the funding of these policies.

The health policies, in particular the HIV and AIDS policies, will be compared in terms of three broad issues, namely the existence and nature of education and awareness campaigns, prevention programmes, and treatment and care policies, which form the basis of the health policy guidelines in the literature. A further aspect which will be considered is health expenditure and funding. The literature on HIV and AIDS awareness programmes generally seeks to inform all sectors of the population about a variety of issues surrounding the disease, including high risk behaviour, means of avoiding such behaviour, and addressing social concerns such as discrimination.[11]

[10] Health Statistics for all member states in both regional organisations are included in Appendix 1.2.
[11] For examples, see Hickey (2002), as well as Kumaranayake & Watts (2000), Love Life (2004:Internet source) and Red Ribbon (2004:Internet source).

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The aspects below, which serve as indicators in terms of the education and awareness policies of the regional bodies, are scrutinised (based on the literature) to ascertain to what extent the following issues are underlined:

- Information about safe sex, the transmission of HIV and AIDS, nutrition and health care services;
- Condom social marketing (including female condoms), to ensure that it becomes more culturally and socially acceptable to practice safe sex;
- Workplace interventions, which necessitate the participation of employers in protecting the health of their workforce;
- Addressing stigma and discrimination, particularly against women;
- Gender and youth participation for maximum impact and sustainability.

Prevention programmes, the second issue, tie in with education and awareness campaigns. The literature provides various preventative initiatives, which include testing, counselling, vaccinations and other medication.[12] The prevention campaigns are looked at in terms of scope, by examining the use of public-private partnerships and the increasing role of corporate responsibility legislation. The inclusion of the following indicators in the health policies of ECOWAS and SADC are examined:

- Increased voluntary counselling and testing;
- Increased availability and non-discriminatory access to vaccines, condoms, sterile injecting equipment, and drugs (including ARVs) in a sustainable, long term manner;
- Prevention of Mother-To-Child-Transmission of HIV and AIDS (PMTCT);
- Focused interventions for individuals working within the sex industry.

Thirdly, with regard to treatment, the literature specifically refers to two aspects: infrastructure in terms of facilities, and the drugs and services necessary for effective treatment.[13] Within the former, attention is paid to the importance which the health policies of ECOWAS and SADC place on:

- The need to expand and strengthen the infrastructures of member states in various sectors to ensure the effective delivery of essential services;

[12] For examples, see Collins (2001:Internet source), Phillips (2004:Internet source), Wilson (2005), World Bank (1995).
[13] For examples, see Berger (2001), Chatora and Tumusime (2004) and Motjuwadi (2000).

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- The need to develop domestic industries (consistent with international law) to increase the access of the general population to essential medicines;
- The emphasis on offering improved access to home-based care for those sections of the population without adequate access to medical facilities.

The second group of indicators included in the discussion of treatment policies concern the drugs and services required for effective treatment. The extent to which the following is addressed in the health policies will be examined:

- The need to increase the number of health care workers and ensure proper training;
- The provision of psycho-social support and counselling wherever possible;
- Identifying methods of affordable drug procurement, focusing on long term sustainability;
- Providing access to medication for sexually transmitted diseases (including ARVs), as well as ensuring that treatment for opportunistic infections is included.

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Lastly, neither the member states nor the regional organisations have the resources to implement these guidelines entirely on their own. Thus, the policies produced by the regional bodies which outline the expenditure and funding protocols for member states are included in the comparative study. Funding can be divided into two clearly distinguishable categories. Firstly, funding received from member states of the regional organisations, and secondly, money (and other aid) obtained through partners such as USAID, the UN, and the like.

The analysis of the first category, namely individual state contributions to the regional organisations, is done by taking into consideration the annual fees contributed (relative to factors such as GDP, and infected population statistics), and the percentage of the member states' health budget which the regional organisation stipulates should be devoted to HIV and AIDS. In the second category, aid awarded to the regional organisations from bodies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), USAID and the World Bank is broken down in terms of allocation by state, region and grouping, and notes the express purpose for certain

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grants.[14] Attention is also paid to debt relief for purposes of funding AIDS programmes. Funding from NGOs will also be included as this source of revenue is a significant enabling factor for many programmatic actions of the regional organisations.

Therefore, the study of the regional organisations will be compared in terms of two broad aspects. Firstly, the health policies of the respective economic groupings with regard to education and awareness campaigns, prevention programmes, and treatment policies, based on the identified indicators. Secondly, the means of funding as proposed by the two regional organisations, which will be examined by indicators such as member state contributions, and non-state aid.

1.5 STRUCTURE OF THE STUDY

The study consists of six chapters. This chapter provides the purpose and scope of the study, and discusses the establishment and purpose of the two regional organisations under scrutiny, namely ECOWAS and SADC.

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Following a brief discussion of the general characteristics of public policy and an overview of Trade Related Intellectual Property Rights (TRIPS), chapter two uses the indicators outlined above to examine the content of the HIV and AIDS policies of ECOWAS and SADC in a comparative manner. The third chapter is devoted to the sources of funding for all the initiatives discussed in the preceding chapters. These include the resources made available through debt relief programmes, loans, grants and the national budget contributions from member states in the regional economic groupings.

Chapters four and five use the HIV and AIDS policies of the dominant states of each grouping, namely Nigeria and South Africa, to illustrate the extent to which the regional guidelines on overcoming HIV and AIDS are adhered to. The indicators identified previously are applied to the policies of Nigeria and South Africa to facilitate this analysis. Lastly, chapter six provides an overview of the main findings together

[14] See UNAIDS (2005a:Internet source), UNDP (1998:Internet source), USDS (2005), and Collins (2001:Internet source) for a more detailed analysis of these initiatives.

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with recommendations for an effective collective response to the HIV and AIDS pandemic.

1.6 REGIONAL ECONOMIC GROUPINGS IN AFRICA

The creation of regional organisations to achieve common goals is gaining popularity around the globe. These range from India, Pakistan and others forming the South Asian Association for Regional Cooperation (SAARC), Italy, Portugal, France and many other European states coming together to form the European Union (EU), to Canada, Mexico and the United States grouping together in the North American Free Trade Agreement (NAFTA). As mentioned previously, ECOWAS and SADC are two of the strongest regional organisations on the African continent, and thus form the basis for this study. This section will provide a brief introduction to the rationale behind regionalism, and outlines the establishment, purpose and goals of both regional organisations.

The concept of regionalism has a multitude of definitions, largely depending on the range of actions being included. In its narrowest sense, it involves only the economic sphere of creating policies which facilitate trade between a number of actors in a region (Lee, 2003:9). In a broader conceptualisation, it encapsulates any number of activities within the political, economic, social, cultural, or security arenas.

The definition which will be applied for the purposes of this study is put forward by Lee (2003:9) as:

> *"The adoption of a regional project by a formal regional economic organisation designed to enhance the political, economic, social, cultural, and security integration and/or cooperation of member states".*

This definition takes into account the planned progression from forging partnerships between states for limited purposes, to more formally integrating into a more comprehensive body, such as the AU (Nyikuli, 1999:623).

Partnerships allow common goals to be attained with greater ease and success, while integration offers more long term benefits. By viewing regional integration as a process

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whereby a group of states shift their allegiances towards a new institution which then has jurisdiction over the state (Acharya, 1999:Internet source), a course of action can be followed which takes the "bigger picture" into account. Within the context of African developing states, this allows the comparatively weak states to build a cohesive unit with the stronger states, benefiting all in different ways. The strengths of one state make up for the weaknesses in another.

This course of action permits the regional organisations to share the costs of development and integration, and promotes the disclosure of critical knowledge in order to achieve common policy aims. This strategy has previously been effective for African states. The East African Community, consisting of Kenya, Uganda and Tanzania, formed a cooperative unit shortly after their independence from Britain in the 1960s (Nyikuli, 1999:623). By sharing their railways, telecommunications and harbour systems, these states were on a more solid footing than some of their other newly-independent contemporaries who had to go through it alone. Although the federation dissolved in 1976 due to incompatible political systems, the value of cooperation was clearly demonstrated.[15]

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Developing states view this regional approach as a means of protecting their economic and political interests from interference by the powerful developed states (Acharya, 1999:Internet source). By utilising complementary policies, these states aim to stimulate economic activity in the area, promote security, or accomplish any number of agreed objectives, becoming stronger individually and as a unit (Mansfield & Milner, 1997:3). The boost given to intra-regional trade and investments, as well as the forging of common institutions, therefore places the regional grouping as a whole on a more competitive footing within the global market (Ntamack, 2004:13).

The pursuit of regionalism in the economic sense is perceived as a helpful tool for developing states to achieve the necessary market reforms within the neo-liberalist framework under which the majority of states in the global market operate. Nyikuli (1999:623) argues that "the ideal of the African common market is perhaps one of the major factors that will unleash Africa's potential as an economic giant".

[15] Kenya elected to pursue capitalism, and Uganda followed an "African-socialist" model under the dictatorship of Idi Amin (Nyikuli, 1999:623).

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Specific measures which are undertaken to achieve this economic ideal include reducing fiscal deficits; reprioritizing public expenditure towards health, infrastructure, education and development; minimising tariffs; stimulating foreign direct investment; privatising state enterprises; and removing disproportionate government regulation (Lee, 2003:11).

While many of the facets outlined above fall strongly within the economic sphere, their ramifications are widespread. The state structures, which are reorganised to accommodate the necessary changes of both internal matters such as privatisation, and external transformations bought about by regional integration, become more efficient and effective. The power and capital gains bought about by the economic reforms allow a greater range of actions in all spheres, including public health and education, enabling the states within the regional organisations to consider solutions that were previously not within their economic reach.

Within developing regions such as Africa, the approach to better development is characterised as "new regionalism", describing non-superpower led alliances that come from "within and below", as opposed to superpower-led regionalism which comes from "outside and above" (Acharya, 1999:Internet source). In other words, there is greater equality and participation between states. The emphasis on "African ownership" is emphasised within many of the regional organisations' policies, as it is imperative not only for the success of programmatic actions, but also for their long term sustainability.

Lastly, it is necessary to make a distinction between the concepts of regionalism and regionalisation. Regionalisation can occur between any actors, whether they are part of a formal decision making forum or not. Thus, NGOs and the informal sector may initiate activities which transcend national borders and be considered as actors in the regionalisation process, without necessarily being part of the regionalism drive (Lee, 2003:9). These non-state actors can however be included as integral parts of courses of action being pursued by the formal parties involved with the regionalism process, in which case they are considered part of the process. Therefore, the key lies in the relationship between the state and non-state actors.

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The particular needs of the states within each regional organisation determine the structure and operating style of the organisation. However, a number of common institutions are generally present in both, such as a Council of Ministers and Court of Justice, with the overriding purpose remaining eventual integration into one large entity similar to the European Union.

The next section provides a brief overview of ECOWAS and SADC, starting with a description of their creation and organisational structure. The approach of both organisations to gender equality is outlined. Since this study is a comparison of their health policies, a thorough discussion of the strengths and weaknesses of the two organisations falls beyond the scope of this study. However, some of their major achievements and failures are highlighted in order to adequately explain possible differences in the application of their health policies.

1.6.1 Economic Community of West African States (ECOWAS)

The Economic Community of West African States (ECOWAS) was established in 1975 by the Treaty of Lagos, in order to accelerate economic and social development through increased cooperation and integration (ECOWAS, 2005:Internet source). Cape Verde was the last state to join the grouping in 1977, and Mauritania withdrew in 2002, leaving the total membership of the body at its current roster of 15 states.

The member states of the organisation have a combined population of almost 247 million people, and a collective GDP of US$75.1 billion (EIA, 2005a:Internet source). As stated above, Nigeria contributes more than half of this amount, with a GDP of US$43.5 billion (UNDP, 2004:Internet source). Nigeria is also the largest state in this grouping, with a population of 120.9 million people, followed by Cote d'Ivoire (16.4 million) and Burkina Faso (12.6 million). Cape Verde is the smallest state in the grouping, with a population of 0.5 million and a GDP of US$0.6 billion (UNDP, 2004:Internet source).[16]

[16] The fifteen member states of ECOWAS are: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo.

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A revised treaty was signed in 1993 to incorporate a range of political and social concerns into the body's aims, such as the creation of a West African Parliament, and to expand its economic goals to include the development of a single currency and the creation of a common market (ECOWAS, 2005:Internet source). These long term aims have not yet achieved fruition, but remain as common goals for the body's member states.

1.6.1.1 Organisational structure

The primary decision making power within ECOWAS rests with the Authority of Heads of State and Government. This body provides the general policy direction for the group and coordinates the policies of member states. All states are represented equally within this body, with one head of state acting as a chairperson for a one-year term (ECOWAS, 2005:Internet source). At the time of writing, President Mamadou Tandja of Niger was the chairperson. The Council of Ministers then coordinates and harmonises programmes, and approves the budgets for all programmes.

The Community Parliament, situated in Nigeria, provides a forum for discussions between member states' parliamentarians in order to reach consensus. The parliament reviews contributions made to and by the regional organisation, as well as overseeing the use of the communal levy (Ntamack, 2004:13). Seats are divided proportionately by population size, with Nigeria claiming the highest number of seats (35) while smaller states such as Cape Verde and Gambia receive the mandatory minimum of 5 seats each (ECOWAS, 2005:Internet source). Despite being established in 1993, the parliament held its first session in Abuja in 2001, when it elected 150 representatives from its member states (Van Nieuwkerk, 2001b).

The daily administrative functions of the organisation are attended to by the Executive Secretary, who is elected for a four year term (ECOWAS, 2005:Internet source). The Court of Justice provides a forum for grievances between member states, as well as ensuring that treaties and protocols are correctly interpreted. The Court of Justice has the power to impose sanctions on deviant member states (Ntamack, 2004:13).

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Financing for the various activities undertaken by the regional organisation is coordinated through the ECOWAS Bank for Investment and Development (EBID). In addition to the annual levies paid by member states, a further 0.5% community levy is applied on goods imported from a third country (Ntamack, 2004:14). This is to ensure a steady source of income into the institutions of ECOWAS, thereby maintaining the smooth operation of the body.

The regional organisation also recognises that the costs of development can be more severe for some member states than others. The toll of wars, tumultuous regime changes, and the aftermath of foreign interference, can further destabilise the playing field. As a result, ECOWAS established the "Fund for Cooperation, Compensation, and Development" (ECOWAS, 1976:Internet source). This fund is used for a variety of purposes, including research and grants, and ensures that the less developed states in the organisation receive the assistance necessary to catch up. The fund also provides incentives for states to comply with the implementation of protocols which may be perceived as damaging in the short term. For example, the fund pledges compensation for losses due to the "location of community enterprises" (ECOWAS, 1976:Internet source).

ECOWAS has consistently built its infrastructure and institutions to accommodate the implementation of its policies. For example, the West African Health Organisation (WAHO) was established to harmonise health policies and pool resources to create a collective response for the region in dealing with HIV and AIDS (ECOWAS, 2005:Internet source). All ECOWAS member states are involved with this entity.

1.6.1.2 Gender

During the 26th Session of the Authority of Heads of State and Government in Dakar (2003), two structures were created to address the issue of gender mainstreaming within ECOWAS and its member states. The Gender Unit at the Executive Secretariat in Abuja, and the Centre for Gender Development in Dakar, aim to integrate the needs of women into ECOWAS policies and programmes. These two bodies replace the General Secretariat of the West African Women Association (WAWA) in ensuring that the

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skills needed for women to participate meaningfully are developed (ECOWAS, 2005:Internet source).

The objectives of these two bodies are clearly outlined, although the proposed methods of achieving these aims are not. Some of the activities in which the groups partake include the monitoring of women's representation in various structures, and studying means for mobilising more women to lobby for their rights (ECOWAS, 2005:Internet source).

1.6.1.3 Achievements

The political institutions established by the regional organisations are considered amongst the strongest in Africa. For example, the 1978 and 1981 Defence Protocols permit "limited intervention by ECOWAS in the internal affairs of member states" (Ntamack, 2004:13). Consequently, successful conflict resolutions could be undertaken in Liberia, Sierra Leone, and Sao Tome e Principe. These operations were assisted by the ECOWAS Economic Monitoring Group (ECOMOG), whose mandate was extended in 1999 to include conflict management and prevention, peacekeeping, and security (Asante, 2005:21; Ntamack, 2004:13). This body is used by member states as a mediator, and oversaw the electoral process in Togo after the death of Gnassingbe Eyadema (Versi, 2005:25).

A major achievement of the organisation was the introduction of a common passport, which has been in use since 1999 (Asante, 2005:27). The implementation of this protocol greatly enhances the flow of people and goods across member states (Ntamack, 2004:13). The massive reduction in tariff barriers and border delays which resulted has also promoted the development of the region's trade.

Consolidating the resources of member states for development projects has also showed excellent results, such as the construction of a gas pipeline for moving Nigerian gas through Benin and Togo to Ghana, providing cheap, reliable energy. The project cost US$500 million, and was achieved through partnerships with a number of private investors (Asante, 2005:27).

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1.6.1.4 Weaknesses

West Africa shares the same setbacks as the rest of the developing states in Africa in terms of underdevelopment and poverty, but has had the additional burden of dealing with a vast number of conflicts, including clashes in Cote d'Ivoire, Sierra Leone, and Liberia (Africa Recovery, 2003:Internet source). Borders which arbitrarily divide tribes and ethnic groups have contributed to such conflicts in the region (Greer, 1992:31). Apart from the economic costs, this has aided the spread of HIV and AIDS in the region, a factor which will be addressed further in chapter two.

A lingering issue plaguing ECOWAS has been the tension between former British and French colonies. Greer (1992:30) attributes this to the vastly different institutions, laws and business practices inherited from the colonial powers, as well as the more active role which France has played in its former colonies.[17] This problem continues to plague ECOWAS, and Hettne (2001:93) cites it as one of the contributing factors in the poor communication between member states.

ECOWAS states remain disproportionably reliant on agriculture, with the regional organisation generating more than 61% of its income from this sector, followed by services (28%), and industry (10%) (ECOSTATS, 2001:Internet source). The poor gender representation and lack of progress in mainstreaming women's issues in the policies of the regional body continue to be problematic.

Lastly, the dominance of Nigeria, both in terms of population and GDP, has been a consistent issue of contention, in much the same way that South Africa's dominance within SADC has created problems (Hettne, 2001:93; Greer, 1992:31). Corruption, together with the lack of cooperation, coordination and communication between states has also done little to further progress within the regional organisation, and the same holds true for SADC (Hettne, 2001:93; Greer, 1992:33).

[17] In 1972 France proposed an alternative to the formation of ECOWAS; the *Communauté Economique de l'Afrique de l'Ouest* (CEAO) which would bring the former French colonies together. However, only Burkina Faso, Cote d'Ivoire, Mali, Mauritania, Niger and Senegal joined. With the exception of Mauritania, all of these states opted to join ECOWAS.

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1.6.2 Southern African Development Community (SADC)

The Southern African Development Community (SADC) was established in 1992 as the successor to the 1980 alliance formed under the Southern African Development Coordination Conference (SADCC), which resulted from the adoption of the Lusaka Declaration (SADC, 2005:Internet source). [18] SADCC's core concern was to limit the dependence of Southern African states on Apartheid South Africa. This was largely due to South Africa's involvement in the "destabilisation of 'hostile' regimes" (Hettne, 2001:94). As all SADCC members were part of the "Frontline States" which participated in various political struggles in the region, they had some experience in harnessing cooperative actions to bring about broad changes. The decision was made to collectively pursue economic and social development in the region. The 1992 transformation aimed to endow SADC with greater legality, and to diversify the goals of the organisation to include economic integration as well as development. At this point it became clear that South Africa's strong economy (on which many SADCC states were still fairly dependent) would be needed for the body to work. As South Africa's political system was already in the process of transitioning to majority rule, it was deemed an acceptable ally in the regional integration being proposed by SADC. SADC membership increased to thirteen states, and Madagascar applied to join the grouping in 2004, while Seychelles withdrew in the same year (EIA, 2005b:Internet source).[19]

SADC member states have a combined population approaching 210 million people, and a combined annual GDP of US$233 billion (SADC, 2005:Internet source). South Africa has the highest GDP in the grouping (US$104.2 billion), followed by Angola (US$11.2 billion), while Lesotho has the lowest (US$0.7 billion). The Democratic Republic of the Congo has the largest population (51.2 million), followed by South Africa (44.8 million). Swaziland has the smallest population at 1.1 million (UNDP, 2004:Internet source).

[18] SADCC member states were Angola, Botswana, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Zambia and Zimbabwe. Namibia joined SADCC upon independence in 1990.

[19] The fourteen SADC members are: Angola, Botswana, The Democratic Republic of the Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. Madagascar is included in this study, as it was admitted as a full member in 2005.

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1.6.2.1 Organisational structure

The Summit, comprising the heads of state and government from all member states, is the ultimate policy making institution. Similar to ECOWAS, this body oversees the general policy direction of the organisation and meets annually. At the time of writing, the chairperson was President Sam Nujoma of Namibia. A troika made up of the chair, incoming chair and outgoing chair, provides policy direction between SADC meetings (SADC, 2005:Internet source).

A Council of Ministers, usually drawn from the Foreign Affairs, Economic or Finance Ministries of member states, oversees the development and implementation of policies. The integrated Committee of Ministers coordinates cross-sectoral programmes, and continues to monitor their effectiveness (SADC, 2005:Internet source). Consultations are held with key stakeholders and partners (such as the private sector and civil society) during the policy formulation process through SADC National Committees. SADC, like ECOWAS, has a parliament which monitors the implementation of programmes. Established in 1996 and based in Windhoek, the Parliamentary Forum can not formulate policy or make binding SADC policy (Van Nieuwkerk, 2001a:85).

Similar to the ECOWAS organisational structure, SADC has a tribunal which adjudicates disputes over the interpretation of protocols and treaties, as well as settling grievances between member states. The administrative aspects of the organisation are handled by the Secretariat based in Gabarone, Botswana (SADC, 2005:Internet source). The Secretariat also assumes overall responsibility for gender mainstreaming.

The fundamental goals of the grouping are outlined in Article 5 of the Treaty establishing the body. The common focus areas are sustained development and economic growth, which are the means by which target issues such as poverty, increased standards of living and security matters may be addressed (SADC, 2005:Internet source). Some of SADC's economic goals and their estimated timeframes include the establishment of a free trade area (2008), a SADC customs union (2010), a common market (2012), and a SADC central bank and a single currency for the region (2016) (EIA, 2005b:Internet source).

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There are currently 407 programmes being run, or in the process of being implemented, at a cost of approximately US$8.09 billion (SADC, 2005:Internet source). The SADC Programme of Action designates specific sectoral responsibilities to each member state for the more effective achievement of these goals. This entails overseeing the development and implementation of activities within that sector (Lee, 2003:50). For example, South Africa has been allocated the health, finance and investment sectors, while Mozambique assumes the responsibility for transport and communications. In terms of HIV and AIDS, SADC has released a strategic framework and programme of action which outlines prevention and social mobilisation efforts, treatment and access frameworks, as well as accelerated development and resource mobilisation drives in an effort to remedy this problem (SARPN, 2003:Internet source). These steps are considered in greater detail in chapter two.

The harmonising of the political systems and institutions of member states is a further step in achieving these objectives, which form part of the larger picture of regional integration and interdependence. Once this goal of self-reliance has been attained, the region will be in a stronger position to form the cohesive network of states envisioned by the African Union (AU).

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1.6.2.2 Gender

The Gender and Development Framework followed by SADC was adopted in 1997 in Windhoek, and was heavily influenced by the 1995 Beijing Declaration (SADC, 2000b:5). The framework established a Standing Committee of Ministers for Gender Affairs. Together with an Advisory Committee, they consult with the SADC Council of Ministers during policy formulation. “Gender Focal Points” were then developed within each sectoral level of the organisation, as was a Gender Unit within the Secretariat.

The Declaration on Gender and Development was endorsed at the 1997 Malawi Summit, and included goals such as increasing the representation of women in decision making structures, creating awareness of gender issues, and providing women with the skills needed to participate more meaningfully within the economy (particularly in terms of creating partnerships and methods of expanding businesses). Targets are set out in terms of representation within various levels of decision making bodies, and

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although SADC is ahead of ECOWAS, there is still some way to go. For example, only a third of SADC member states have achieved a 15% representation in parliament, half of the 30% goal stated in the Declaration on Gender and Development (UNDP, 2004:Internet source).

All SADC member states have created bodies which address gender at an institutional level. While they take on different titles and vary in size, they all aim to ensure that gender-related programmes at the national and regional level are properly implemented and coordinated (SADC, 2000b:3). These initiatives flow directly from The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). It has been ratified by all the SADC member states. This was a significant step as the customary law has traditionally diminished the rights of women, relegating their needs as secondary to those of their spouses, especially in terms of reproductive health and education (SADC, 2000b:7). From the above documents and initiatives (and the plethora of other programmes not mentioned here), it is obvious that SADC has a well developed gender framework in place, and is showing a greater commitment to gender equality than ECOWAS.

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1.6.2.3 Achievements

An achievement of SADC, and one of its first goals set into motion, is the establishment of a Free Trade Area by 2008. Initiated in 1996 with the ratification of the SADC Protocol on Trade, which established the free trade area (RSA DFA, 2005:Internet source), more than half of SADC's members have already submitted the resources necessary for the achievement of this goal, and results can already be seen. SADC is the leader amongst the African regional organisations as its intra-community trade has reached the 22% level, higher than that of any other body (Ntamack, 2004:14). A range of infrastructural development programmes have also been implemented, and include the successful repair and upgrading of roads, railways and harbours. These are critical steps in ensuring more effective transport of goods, thereby assisting in the economic development of the region (SADC, 2005:Internet source).

The slow rate at which SADC initially developed has been cause for concern, as has the body's inability to timeously adopt agreements. For example, only 11 of the regional

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organisation's 22 protocols have been ratified (Ntamack, 2004:14). However, important treaties which have been ratified include means of halting illicit drug trafficking, protocols on energy, mining, trade, education and transport, and agreements on shared watercourses (RSA DFA, 2005:Internet source). Declarations have also been issued regarding landmines, firearms, and gender. Lastly, SADC has been lauded for successfully fostering a regional identity to a greater extent than its contemporaries on the continent (Hettne, 2001:94).

1.6.2.4 Weaknesses

SADC has some serious weaknesses to contend with, although this study only lists a few of these.[20] For example, the differing levels of experience between members, when combined with issues such as conflicts and natural disasters, result in an uneven track record for the successful attainment of the sectoral goals of the regional organisation. While the energy portfolio (managed by Angola) has flourished, increasing intra-state electricity trade by 15%, others have floundered (Lee, 2003:52). This approach has not been abandoned however, as it ensures that all member states are directly involved in programmes, providing incentives to maintain interest in the regional agenda. The institutional structure has also been inadequate for managing the resources of the region effectively (SADC, 2005:Internet source). This could be attributed to the lack of decision making power within agencies, which also reduces the scope of initiatives.

As with ECOWAS, SADC has had to contend with the drain on development and growth caused by conflict. Although the Organ on Politics, Defence and Security (OPDS) was integrated into the regional organisation in 2001, it has not been fully operationalised and SADC does not yet have the ability to collectively resolve conflicts. On the other hand, Angola and the Democratic Republic of the Congo have resolved the wars plaguing their people, and their economic contribution has been improving ever since (EIA, 2005b:Internet source).

As the economic grouping with the highest HIV and AIDS prevalence and death rates, SADC has a multitude of policy guidelines already in existence to combat the further

[20] For an overall assessment of SADC's progress, see le Pere & Tjonneland (2005). For more examples of SADC's weaknesses see Swatuk, Oden and Vale (2001) and Simon (1998).

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spread of the disease. However, the majority of these initiatives are run on a national, or even provincial scale, and are not often coordinated for maximum impact (le Pere & Tjonneland, 2005:15). This lack of coordination is shared by ECOWAS, who also struggles with a plethora of objectives and strategies across sectors (SADC, 2005:Internet source).

Further, both regional organisations rely excessively on external funding for their initiatives. Member states do not contribute adequate resources for programmes to be run effectively, nor do their resource inputs arrive within the given timeframes (SADC, 2005:Internet source). Thus, SADC's role as a facilitator, and it's aim to monitor programmes and provide assistance to member states, is hampered by its lack of "implementation capacity", brought about by the minimal contributions from member states (le Pere & Tjonneland, 2005:20).

1.7 CONCLUSION

By means of an introduction this chapter has provided a brief overview of the widespread ramifications of the HIV and AIDS pandemic in Africa. The severity of the current situation, together with contributing factors such as debt and underdevelopment has been outlined, clearly showing the need for collective action by developing states in formulating an effective and immediate response.

It is against this background that the purpose of this study is outlined, namely to compare and contrast the health policies of the regional groupings of ECOWAS and SADC, in particular their HIV and AIDS policies. These two organisations lend themselves to comparison since they share the same developmental and economic integration goals, have high prevalence rates of infectious diseases (such as HIV and AIDS, malaria, and tuberculosis), and consist of developing states with similar problems such as debt and poverty.

Useful comparison requires that indicators are established by means of which assessments can be made. The HIV and AIDS policies of ECOWAS and SADC will be compared in terms of the broad indicators identified in the relevant literature, namely education and awareness campaigns, prevention programmes, and treatment and care

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policies, and the avenues of funding being pursued. Specific attention will be paid to the incorporation of gender in all of these indicators, due to the fact that women are not only disproportionately affected by the HIV pandemic, but also because some aspects of the pandemic are specific to women.

This chapter concluded with a brief overview of the functioning as well as major achievements and failures of both ECOWAS and SADC. It has been shown that these organisations are similar in terms of organisational structures, have corresponding bodies for decision making, and have similar problems which may affect the implementation of their health policies such as limited resources and ineffective institutions. They do, however, differ in areas such as the approaches followed in solving certain issues, and the manner in which policies are implemented. Their level of commitment to gender issues is also vastly different, with SADC being slightly more articulate on women's issues (although by no means comprehensive in its approach).

Since the issue of HIV and AIDS forms part of the broader health policies of these organisations, and impacts directly on many other serious diseases on the continent such as malaria and tuberculosis, the next chapter initially focuses on a comparison of the general health policies of the two regional organisations, and then turns to their policies with regard to HIV and AIDS.

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CHAPTER 2: HEALTH POLICIES OF ECOWAS AND SADC

2.1 INTRODUCTION

The previous chapter highlighted the nature of the diseases and health problems facing the member states of ECOWAS and SADC. Particular attention is paid to the high death rate associated with HIV and AIDS, as well as other prominent infectious diseases such as malaria and tuberculosis. This dire health situation requires action by these two regional groupings, particularly since they have been established to promote economic development. As has been pointed out, diseases such as HIV and AIDS have a severe impact on economic development. These include a drastic reduction in economic growth, depletion of the productive workforce, and soaring health care costs for all the affected states.

This chapter provides a comparison of the health policies of ECOWAS and SADC. Although this study focuses on HIV and AIDS policies, these policies form an integral part of broader health policies, especially since AIDS deaths are not recorded as such. However, after a broad overview, specific attention is paid to HIV and AIDS in terms of the three indicators discussed in chapter one. Before this comparison, a brief discussion is provided on the meaning of public policy, and the purpose of health policy in particular. An introduction to antiretroviral treatment is also included, together with the complications brought about by Trade Related Intellectual Property Rights, which are an essential component of the HIV and AIDS policy debate. Important aspects which will be compared within the public health policies of ECOWAS and SADC in this chapter include the status of health policies, and HIV and AIDS policies, in these two regions. This encompasses the extent to which the severity of the health situation has been acknowledged, the policies which were introduced (including the ratification of health protocols by member states and their influence on shaping subsequent policies), and commitments made within statements by officials of the regional organisations regarding their response to the HIV and AIDS pandemic. The extent to which gender is incorporated into both the general health policy and the HIV and AIDS policies of the two regional organisations is a further aspect that is discussed in this chapter.

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2.2 PUBLIC POLICY, PUBLIC HEALTH CARE, AND PUBLIC HEALTH POLICY

Three concepts are discussed in this section. Firstly, the concept public policy, and the manner in which it is formulated. The core characteristics of what constitutes public health policy follows a brief conceptualisation of public health care, and the aspects which it should address. The concepts of public health policy and public health care are terms which are used throughout this study, and the universal requirements of public health care form the basis of the health policies of both ECOWAS and SADC, as will be shown below. Thus, the guidelines outlined within the theoretical discussion which follows informs the actions of both regional organisations in addressing health issues such as those of HIV and AIDS.

2.2.1 Public Policy

Public policy is a course of action undertaken by a government in order to achieve a specific goal (Anderson, 2000:4). It takes into account the context in which the policy will be implemented, and the range of actions needed to overcome impediments and capitalise on opportunities which exist in the environment. It is thus "purposive or goal-oriented action … designed to accomplish … definite results" (Anderson, 2000:5).

The formulation of public policy further "seeks to identify the most efficient alternative … that will yield the largest net social benefit for dealing with a current problem" (Anderson, 2000:2). The regional economic groupings generate both substantive and procedural policies. Substantive public policies provide specific actions for achieving policy goals, while procedural public policies are concerned with "specifying the processes and techniques that they can use in carrying out their programmes … and providing for controls over their operations" (Anderson, 2000:8). The policies generated by the regional economic groupings can be viewed as the broad approach being advocated by the bodies, as their implementation is performed by the individual member states and certain actions may face constraints imposed by bilateral and multilateral agreements made by the individual member nations with other parties. A public health policy therefore also implies a definite goal-oriented path of action. In the

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case of Africa, the policies of the two regional organisations should address the serious health issues such as HIV and AIDS, malaria and tuberculosis.

Further, the influence of the environment on the policies of a state is eloquently outlined by Anderson (2000:44), who argues that "policy making can not adequately be studied apart from the environment or context in which it occurs … [as the] environment both limits and directs what policy makers can effectively do". The policy environment is thus "that amorphous sphere where the boundaries between public and private interface to produce the societal variables that determine the need for (and indeed response to) policy" (Fourie, 2005:22). An understanding of the policy environment is therefore considered essential as the prevailing values and beliefs of the society in question "inform, guide, and constrain the actions of both decision makers and citizens" (Anderson, 2000:47). Of relevance to the discussion of the health policies of the two states being used as case studies, namely Nigeria and South Africa (see chapters four and five), are socio-economic factors such as the prevalence of poverty and illiteracy, the strength of their economies, the demographic features of their populations, and the prevalence of certain problems, which are all essential factors influencing the formulation of public policy.

The political environment in which public policy is formulated entails not only the form of government, but also the participation of citizens in the policy making process. Africa is considered a parochial society in that "citizens have little awareness of or orientation toward either the political system as a whole, the input process, the output process, or the citizen as a political participant [and citizens] expect nothing from the system" (Anderson, 2000:46). Thus, despite the prevalence of democratic systems of government within both regional economic groupings of ECOWAS and SADC, women especially are not influential in the policy making process, primarily as a result of the patriarchal nature of African society, and the resulting cultural and social norms which constrain their roles in the decision making process (Anderson, 2000:49).

The strength of a state's economy has obvious consequences for the formulation of policy, as without the resources to implement the programmes outlined in the policy, they remain words on paper. This is an especially crucial factor within developing states as the inability to effectively put policies into practice is sometimes viewed as

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bureaucratic bungling, or a state of disconnection between the government and the needs of people (Anderson, 2000:48). Over-dependence on a single sector (such as agriculture) would have dire economic consequences should the workforce be consistently less productive as a result of long absences from work due to illness, or be permanently depleted due to deaths. Further, population demographics are considered, such as the prevalence of illnesses amongst the most economically active population groups, which would be similarly detrimental to the long term economic growth of the state. The level of education (particularly noting literacy) attained by the average citizen also informs the policy environment in general, but is especially important within the context of HIV and AIDS as it has a direct bearing on the efficacy of education and awareness campaigns. Finally, the international agreements ratified by the state are an additional factor informing the policy formulation process, and must therefore also be included.

2.2.2 Public Health Care

Before expanding on the essential characteristics of public health policy, some attention should be paid to the concept of public health care. The accepted notion of what constitutes public health care was discussed at the International Conference on Public Health Care (PHC) in 1978, and the agreed principles which emerged included ensuring universal access, equity, community participation and inter-sectoral action (Chatora & Tumusime, 2004:296). In the context of the diseases being discussed, namely HIV and AIDS, malaria and tuberculosis, this "inter-sectoral action" would require coordinated action between different government ministries, the private sector, and community-based organisations.[21]

[21] This type of action is demonstrated by the East and Central African Global Competitiveness Hub (ECA HUB), which is dealing with the rapid increase of sex workers along major trade routes in Southern Africa by working at various levels, and in a range of sectors, to alleviate the problem (Bonnel, 2000:848). Firstly, a number of government ministries from various states worked together to decrease the delays at borders caused by unnecessary or poorly performed paperwork and shipment checks (ECA, 2005:Internet source). Secondly, CBOs such as Family Health International ran education and awareness programmes for sex workers and transport workers at border stations (FHI, 2005a:Internet source). Lastly, international public health NGOs and multinational corporations employing transport workers provided condoms to further aid in the prevention of sexually transmitted diseases (Phillips, 2004:Internet source).

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The 1978 International Conference on Public Health Care (PHC) further established that an "essential package of services" should be present in all public health care policies, incorporating:

- Education on prevalent health issues;
- Methods of prevention;
- Adequate nutrition and food supplies;
- Water and basic sanitation;
- Maternal and child health (family planning, etc);
- Immunisation for infectious diseases;
- Treatment for diseases;
- Provision of essential drugs (Chatora & Tumusime, 2004:296).

At the 1987 WHO Regional Committee Meeting in Bamako (Mali), the importance of these principles were re-emphasised and expanded to include co-financing measures to ensure sustainability (Chatora & Tumusime, 2004: 298). A 1999 review showed that while the effectiveness of this approach is sound, financial constraints, a lack of infrastructure and insufficient management capacity prevented the effective implementation of the principles.

2.2.3 Important Agreements in Health Care Policy Formulation

The United Nations also informs the formulation of public health policy in both regional organisations, primarily through the Joint and Co-Sponsored UN Programme on HIV and AIDS (UNAIDS), which was established in 1996 as a coordinating body for HIV and AIDS programmes within the UN system (UNAIDS, 2005a:Internet source).[22]

[22] HIV and AIDS projects had been overseen by the World Health Organisation (WHO) since 1986, but the scope of the pandemic necessitated the creation of a dedicated consortium of United Nations agencies. UNAIDS brought together ten existing agencies to address the problem of HIV and AIDS: the Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNPFA), United Nations Office on Drugs and Crime (UNODC), International Labour Organisation (ILO), United Nations Educational, Scientific and Cultural Organisation (UNESCO), World Health Organisation (WHO), and the World Bank.

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The first of two important influences on public health policies is the UNGASS Declaration. Convened in 2001, the UN General Assembly Special Session on HIV and AIDS (UNGASS) met with the objective of allowing the international community to set common goals for the fight against HIV and AIDS (UNAIDS, 2001:Internet source). This special session built on a number of previous agreements, including the Programme of Action of the International Conference on Population and Development (1999), the UN Millennium Declaration (2000), the World Summit for Social Development (2000), the Beijing Declaration and Platform for Action (2000), the Abuja Declaration and Framework for Action For the Fight Against HIV and AIDS, Tuberculosis and other related infectious diseases (2001), and the NEPAD Health Programme (2001). The member states of ECOWAS and SADC are signatories of these agreements, and compliance with the principles laid down in the resulting UNGASS agreement allows these states to meet both their obligations and development goals outlined in the above agreements, as well as new commitments which have since emerged.

The second influential agreement was reached in 2004 by UNAIDS, together with the World Bank, the US President's Emergency Plan For AIDS Relief (PEPFAR), and the UK Department for International Development (DfID). The aim was to create coordination and consolidation mechanisms within country-driven initiatives (USDS, 2005:11). These principles, dubbed the "*Three Ones*" are: "one agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate; and one agreed country-level monitoring and evaluation system" (UNAIDS, 2004b:Internet source). Both ECOWAS and SADC member states are signatories of the declarations containing these principles, and have begun to apply this policy tool to their public health strategies, as will be shown in the overviews of Nigeria and South Africa.

The concept of public policy therefore encapsulates not only the actual decisions made for addressing an issue, but also the series of subsequent resolutions designed to implement them, and the policy statements which formally express their content (Anderson, 2000:5). The expected outcomes of the actions (or inaction) are also

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included, regardless of whether the implementation is intended to be "limited, piecemeal, or sporadic" (Anderson, 2000:7).

These distinctions of what constitutes public policy are important in terms of acknowledging the legitimacy of the plethora of policies emerging from the two regional economic groupings. While the decision making organs of these bodies formulate many courses of action, their implementation is not necessarily carried out due to a range of factors including capability, funding and lack of infrastructure. This does not negate their validity however, as the bodies are recognised as authoritative and legitimate through their membership roster. This chapter is predominantly devoted to the courses of actions outlined within the health policies, and not whether implementation is necessarily carried out.

2.3 ANTIRETROVIRAL TREATMENT AND TRADE RELATED INTELLECTUAL PROPERTY RIGHTS

Before the discussion on the HIV and AIDS policies of ECOWAS and SADC commences, some attention must be paid to the issue of antiretroviral (ARV) treatment and the major issues affecting its effective use as part of the strategies of these two organisations, particularly Trade Related Intellectual Property Rights (TRIPS).

Antiretrovirals are specific medications taken by individuals who have been diagnosed with the HI-Virus. The "triple cocktail" improves life expectancy by suppressing or reducing the amount of HIV in the blood (Oakley & Sherman, 2004:353). With consistent treatment, HIV levels within the bloodstream become so miniscule that they can not be detected.[23] Providing drugs such as ARVs and other expensive, patent-protected medicines is thus a necessary reality which many states are forced to face as an increasing proportion of their population is fighting the effects of the disease. Leaders in both government and business are aware that the price of treating HIV infected individuals is far less than the costs they will incur if such treatment is not provided (Barron, 2002:12).

[23] In the three years following the introduction of this "triple cocktail" into the United States in 1995, AIDS deaths dropped by 70%.

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While these medicines are the most cost-effective solution in the long term, they must be available, accessible, affordable and properly used (World Bank, 1995:67). Successful ARV treatment therefore places further strain on infrastructure, by necessitating trained doctors to accurately gauge the most advantageous time to begin treatment, as well as being able to adjust the drug cocktail as needed; nurses to assist in a variety of tasks, especially educating patients on nutritional matters; advanced laboratories to perform monitoring tests; adequate counselling services; and sufficient funds to provide all of the above services and personnel (Barron, 2002:12).

Since 2002, developing states have needed to treat almost six million individuals with ARVs in order to ensure the health and productivity of their populations. However, of the 800 000 people taking ARVs in 2002, 500 000 resided in high-income states (WHO, 2004:Internet source). In a survey of 140 developing states, the World Bank (1995:68) reported that almost 70% of the population residing within the represented states did not have regular access to essential drugs in 1990. By 2002, less than one percent of HIV infected individuals in sub-Saharan Africa were receiving ARV treatment (Jones, 2004:386). The next section provides some explanation for this situation; the restrictions imposed by Trade-Related Intellectual Property Rights (TRIPS).

TRIPS provide the legal framework for the protection of intellectual property, which defends the advantage of a state or corporation when developing revolutionary innovations in various fields including military technology, production processes and pharmaceutical progressions (Levy, 2000:789). Under TRIPS, patents are protected for 20 years, allowing a corporation to gain profits by first selling the manufactured product, and then later the rights for another company to manufacture the product themselves. Article 28 of the TRIPS Agreement sets out the rights of patent owners which are: control over the manufacture, sale (including importing and exporting to and from other territories), and any other uses for the product; control over the use of the process used to acquire the product; and the right to transfer the patent to another party (Motjuwadi, 2000:31).

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The implementation of the TRIPS Agreement is felt disproportionately by developing states, who are subjected to "artificially high prices… imposed by the pharmaceutical industry and its patent protection" (Jones, 2004:386). This is reinforced by the World Bank (1995:67), which estimates that sub-Saharan African states import in excess of 90% of their pharmaceutical products, usually at inflated prices in comparison to the rest of the world. Developing states have argued that patent protection should not be extended to pharmaceuticals as they allow monopolies to develop which are detrimental to the health and welfare of their citizens (Motjuwadi, 2000:30). As a result of this opposition, a number of amendments were made to the agreement, the most important being Article 8, which allows for the alteration of patent laws as necessary to "protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development". The Article continues with the provision that the patent laws may also be amended if the patent holders abuse their rights or "resort to practices which unreasonably restrain trade or adversely affect the international transfer of technology" (WTO, 1994:Internet source). These amendments to patent laws may be made by states if they meet the conditions that include verified anti-competitive conduct, that the patented product is expected to be used for non-commercial purposes by the state (or by a third party selected by the state) or for use during times of urgency or national emergencies, and when it is determined to be in the public interest (Motjuwadi, 2000:35).

Developing states have been forced to find loopholes within the TRIPS Agreement in order to secure an affordable, sustainable drug supply for their people. For example, states may stipulate whether the patent protection of a product remains once it is placed in the market place (Motjuwadi, 2000:32). The principle of "exhaustion of rights" is notable in that it allows developing states to accept patented products from a third party, as well as enabling them to move the products to other states within their trading blocs, where they may be more expensive (Motjuwadi, 2000:32). It is however necessary that the patent holder has placed the product in all the markets involved. This practice is known as parallel importation, and is one of the strategies being pursued by the states in both ECOWAS and SADC as a means of reducing their health care expenditures.

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In a situation which constitutes a "national emergency", such as the HIV and AIDS pandemic, states may issue compulsory licenses allowing patented goods to be manufactured by a third party. This provides the state with cheaper drugs, as well as creating a more competitive environment for the original patented product, lowering the price of some drugs by up to 75% (Weismann, 1999:1). This practice is aided by the decision of developing states to protect the sale of the final product, but not the process used for attaining it. This allows generic products to reach the market place more rapidly (Motjuwadi, 2000:30). The state is still obligated to pay "reasonable royalties" to the patent holder on each item sold, although it is still comparatively cheaper than purchasing the drug from the patent holder.

Pharmaceutical companies argue that this is still not satisfactory, given the high costs of research and development of new drugs. Weismann (1999:2) contends that the use of compulsory licenses for the provision of essential medicines in Africa is not affecting the profit margins of large multinational pharmaceutical corporations as severely as they claim. On the contrary, royalty payments would be considerable as the sales of the drugs increase in a currently underdeveloped market, with developing states in Africa currently accounting for less than 2% of international sales.

Disregarding the moral argument for providing life saving drugs, the profit protection measures being pursued by the pharmaceutical conglomerates are rigorously supported by the Western governments who are heavily invested in the R & D processes used to obtain the drugs (Weismann, 1999:2). An example is that of AZT, a popular drug in treatments in Africa, funded by the US National Institute for Health (NIH), which is in turn supported by tax revenue, presenting a powerful incentive for Washington to ensure it recoups its costs. South Africa was placed on the "Special 301 Watch List" as a result of its government passing an Act allowing compulsory licenses and parallel importation for the provision of essential medicines (Weismann, 1999:2). Together with Argentina, Brazil, India and Thailand, South Africa faced the threat of trade sanctions and the repeal of certain trade benefits as a result of this type of legislation.

These threats by a powerful state such as the US slowed the adoption of these measures by other developing states. However, the passing of a resolution by the WHO in 1999 reiterated the legitimacy of the approach adopted by the developing countries, resulting

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in similar legislation being adopted throughout the developing world. The Doha Ministerial Declaration of 2001 has attempted to remedy the situation by allowing access to the life saving drugs needed by all people, although its effective implementation remains to be seen (WTO, 2004:Internet source).

2.4 ECOWAS

Before discussing the regional health policy of ECOWAS, focusing on the HIV and AIDS policy, a brief overview of the West African Health Organisation (WAHO) is required. This body serves as the official agency through which all health matters in the region are channelled, including the formulation of this particular health policy under scrutiny.

2.4.1 Organisational Structure of the West African Health Organisation (WAHO)

ECOWAS established the West African Health Organisation (WAHO) in 1987, with the acceptance of a protocol by all 15 member states (WAHO, 2005:Internet source). Considering the health problems facing the member states, it was viewed as a necessary first step to create several specialised agencies focused on a single sector.[24] The primary issue at the time was to merge the agendas of the sub-region's existing inter-governmental health organisations; the *Francophone Organisation de Coordination et de Coordination pour la Lutte Contre les Grandes Endemies* (OCCGE) and the Anglophone West African Health Community (WAHO). The policies and approaches of these two inter-governmental organisations were completed in 1998, with operations under the new WAHO beginning in 2000 (WAHO, 2003:16).

As the primary decision making body of ECOWAS, the Authority of Heads of State and Government is also in ultimate control of WAHO. Together with the Council of Ministers and an Assembly of Health Ministers, the general policy direction and

[24] Among these specialised ECOWAS agencies are the West African Monetary Agency (WAMA), created in 1992, the Organisation of Trade Unions of West Africa (OTUWA), established in 1984, and the ECOWAS Economic Monitoring Group (ECOMOG), established in 1978 and focusing mainly on peacekeeping activities.

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feasibility of programmes is decided (WAHO, 2003:16). However, WAHO is administratively and financially autonomous.

Responsibility for the organisation's programmes falls to the General Directorate of WAHO, under the leadership of its Director General, currently Dr. Kabba T. Joiner and WAHO Chairman Dr. Kwaku Afriyie, who is the Minister of Health for Ghana. Five areas of responsibility are demarcated within the General Directorate; human resource development, planning and technical assistance, primary health care and disease control, research and health information management, and administration and finance (WAHO, 2003:17).

The mission statement of the health agency seeks to coordinate regional health policies in order to create a standard approach across the grouping (WAHO, 2003:9). The efficient management and dissemination of health related information within ECOWAS is also considered a priority, especially in terms of the role it plays in ensuring that serious health problems are identified and addressed. This extends to the sharing of health resources between states, as well as a common commitment to ensure that community-based initiatives remain the focus of health policies. The core principle on which WAHO is based is to "enable rather than provide" (WAHO, 2003:8). For this reason WAHO does not aim to offer health services directly, but rather to strengthen the capacity of regional health providers. Thus, there is a strong focus on developing infrastructure, and investing in initiatives that are sustainable.

2.4.2 WAHO's Policy Document

The Five Year Strategic Plan (2003-2007) is the guiding document for WAHO policies (WAHO, 2003:2). It is the result of a collaborative effort which began in 2001, and involved WAHO, the ECOWAS Ministers of Health, and various international donors. The key partners are USAID and the Academy for Educational Development (AED), who assisted in narrowing down strategic objectives and clarifying priority programme areas. The health policy of WAHO is divided into four operational areas to assist in the attainment of these goals. These operational areas are: sub-regional health coordination, information management, health advocacy, and training and professional development (WAHO, 2003:8). Sub-regional health coordination is cited as a "precondition for

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sustainable developmental progress in West Africa" and is included as a key operational area in all ECOWAS documents and protocols (WAHO, 2003:10). Specific aims are mentioned, such as the recognition of medical practitioners across Anglophone and Francophone states, as well as addressing the "existing disparity among health standards, expertise and policies in West Africa [as a] significant but not insurmountable barrier to better overall health" (WAHO, 2003:14). Tying in with information management, this coordination is intended to ensure that medical breakthroughs and technical expertise will be more rapidly disseminated throughout member states. The information management arena also seeks to establish databases concerning essential drugs and their costs, lists of accredited health practitioners, and research findings (WAHO, 2003:21). Health advocacy aims to "promote awareness, dialogue, and legislative action among political decision makers in member states with regard to priority health issues", and includes aiding the launch of community level campaigns and care centres (WAHO, 2003:21). Lastly, training and professional development is concerned with the continuing education of health personnel, particularly sub-regional "training of trainers" (T-O-T) workshops.

Before addressing any of the eight priority programme interventions, it was decided that the institutional deficiencies within WAHO would first need to be attended to. Thus, a specialist team was assembled to meet objectives within five key sectors by the end of 2007, covering information management, capacity building, infrastructure development, political advocacy, and decentralisation (WAHO, 2003:4). The eight priority programme interventions are HIV/AIDS/STI/TB, the control of epidemics, child survival, malaria, nutrition, drugs and vaccines, prevention of blindness, and training. The function and activities of these priority areas are included in the assessment of indicators below.

Each priority area is further broken down into sets of activities, with the aim of expediting the progression of implementation. For example, within institutional development, activities include building training centres and diversifying the capacity of the existing centres (WAHO, 2003:24).

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The priority area is assigned a "task force" consisting of an ECOWAS Ministry of Health representative, a spokesperson for either a multinational, bilateral or international organisation, and a delegate from a training or research institution (WAHO, 2003:4). This team is responsible for overseeing the economic viability of programmes as well as supervising the effective implementation of initiatives.

2.4.3 Focus on HIV and AIDS within the Policy Document

The increasing prevalence of HIV and AIDS is described as a "critical issue" for West Africa, specifically with regard to human and economic development. The policy also notes the complications brought about by the "recent resurgence of tuberculosis, an opportunistic disease that now accounts for 40% of all HIV-related deaths in Africa" (WAHO, 2003:25). While recognising both the diversity and severity of health problems facing ECOWAS, WAHO emphasises that the regional approach being pursued is the only effective means of altering the current situation, stating that "success in lowering the rate of HIV transmission in Burkina Faso will prove sustainable only if HIV is also effectively contained in neighbouring Cote d'Ivoire and Togo" (WAHO, 2003:14). Further, access to treatment and drugs is extremely limited for the majority of West Africans, as is discussed later in this chapter.

The ability of West African states to curtail the rapid dispersion of serious epidemics is, by the admission of WAHO, severely lacking. The policy document states that, in order to remedy this situation, the sub-region "must develop a coordinated information system to predict outbreaks and disseminate relevant epidemiological data to member states" (WAHO, 2003:28). This "coordinated information system" will begin development during the four-year course of the programme of action outlined in the policy document, starting with the "historical mapping of epidemics", and the compilation of data on demographics, laboratory locations, and drug inventories (WAHO, 2003:28). WAHO will be responsible for the upkeep of the system as part of their "sub-regional information management role", although the financing of this project is dependant on the leaders of the member states, who are expected to contribute to a "solidarity fund" to enable the development of this early warning system. The policy document also reiterates the commitments made within the

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Ouagadougou Protocol of 1996, which called for the establishment of a national fund within each member state dedicated to the fighting of epidemics (WAHO, 2003:28).

According to an agreement on a control strategy for HIV and AIDS in West Africa, adopted in 2000, the economic grouping undertook to reform their respective health sectors to be able to play a central role in combating the pandemic, especially in terms of fostering a more comprehensive multi-sectoral approach for acquiring the necessary resources (ECOWAS, 2000:Internet source).[25] WAHO would assist in this process by harmonising national and regional health policies and enabling the pooling of resources to create a collective response for the region in dealing with HIV and AIDS (ECOWAS, 2005:Internet source). Member states pledged to undertake specific commitments, outlined in Article 1 of the agreement, including the creation of a political institution to ensure that programmatic actions are endowed with the necessary resources, and that they are properly implemented, as well as the protection of the rights of infected individuals (ECOWAS, 2000:Internet source).

A discussion of the policy on HIV and AIDS follows in the sections below. Based on the literature on HIV and AIDS, three broad issues are examined: education and awareness campaigns, prevention programmes, and treatment and care policies, which covers infrastructure, and drugs and services.

2.4.3.1 Education and awareness campaigns

As stated in chapter one, the literature highlights a number of issues for comparing the education and awareness components of health care and HIV and AIDS policies. These include the accurate conveyance of information about safe sexual practices, the importance of good nutrition, and the availability of essential services provided by health care facilities. Further, the social marketing of condoms (including female condoms) is essential for making their widespread use more culturally acceptable, and the emphasis placed on their provision is thus a crucial aspect of HIV and AIDS policies. The participation of employers in protecting the health of their workforce is considered, especially regarding high risk groups such as migratory workers. The

[25] The principles laid out in this document are incorporated into the current strategic framework, and can thus be included in the comparison.

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emphasis placed on the youth is inspected, as the indicators derived from the literature underline the importance of these aspects in HIV and AIDS education and awareness policies. Each of these issues is discussed under separate headings below. An additional section is included examining the focus on gender in various aspects of the HIV and AIDS policy of ECOWAS.

i) Safe sex, nutrition and health care services

The WAHO policy document does not directly state what type of information should be conveyed, or the manner in which this information should be relayed to the general population. The document merely states that "enhanced communication and information exchange between health ministries, colleges and universities, health NGOs and medical personnel will make the latest medical knowledge and best practices available to all member states" (WAHO, 2003:14). This suggests that ensuring that all health care personnel are aware of the latest studies on prevention and care is essential for providing accurate information to patients, although the use of the mass media is not directly mentioned at any point.

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The document also advises member states to establish "community level campaigns and care centres to address major public health concerns" (WAHO, 2003:21). This would imply that education and awareness drives will be performed by the community itself, although once again, no specific activities are recommended.

As malnutrition continues to contribute to death and illnesses in West Africa, particularly among children, the organisation has launched a focused nutrition programme. This initiative aims to address the lack of vitamin A, iodine and iron which leads to illnesses such as diarrhoea and respiratory infections (WAHO, 2003:32). Training, advocacy, and better communication between member states is again emphasised, as are public- and private- sector partnerships for fortifying food and assisting in its distribution (WAHO, 2003:32). Nutritional information drives are dealt with in more detail, although means of conveying this information to the general population is once again omitted.

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ii) Condom social marketing

The use of condoms is not specifically discussed within the policy document, although WAHO advocates the development of "culturally acceptable HIV and AIDS prevention and treatment policies" which allow for the participation of the community (ECOWAS, 2000:Internet source). While this vague wording allows member states greater leeway in formulating a response, it does not provide firm guidance for those countries struggling to create an effective strategy. Further, the emphasis placed by the literature on the provision and social marketing of condoms for both men and women is extensive. However, it is acknowledged within the literature in chapter one that there are significant cultural barriers to overcome within traditionally patriarchal African societies.[26]

There are some possible explanations for this omission. Firstly, the broadness of the guidelines may allow member states greater leeway in the implementation of their health policies, although considering the importance of condoms as preventative measures, this approach may not be justifiable, regardless of the prevailing cultural norms in the various member states. Secondly, a number of donor bodies attach conditions to their grants, such as specifying that abstinence programmes receive a certain percentage of the resources awarded to a state.[27] The lack of explicit policy guidelines within the documents of the regional organisation could therefore be construed as an effort not to alienate wealthy donors. Lastly, influential bodies such as the Catholic Church have publicly condemned the use of condoms, even issuing press statements proclaiming that their use "implies immoral sexual behaviour" and that abstinence and monogamy are the only means to prevent the spread of HIV (*LA Times*, 2005:Internet source). Such strongly worded statements carry influence with the many faith-based organisations which both provide aid and implement the programmes within communities, with little regard for the reality of the communities within these developing states who prescribe to very different social and cultural norms to those of Europe. Once again, this could be tied to ensuring that funding is not withdrawn due to moral or cultural differences between donors and recipient states.

[26] For example, see Elsey *et al* (2005), and Lowe Morna (2004).
[27] For example, PEPFAR (discussed in the following chapter) places such conditions on its aid.

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iii) Workplace interventions

Migratory population groups are one of the high risk groups of particular concern to ECOWAS as the borders between the member states divide tribes belonging to the same ethnic groups, and the poorly controlled stretches of these boundaries allow the seasonal migration of large numbers of people belonging to these tribes (Merid, 2003:5). The porous borders also encourage the movement of migratory workers seeking employment. High volumes of foot traffic, together with horses and trucks moving through these landlocked states, further increase the number of high risk populations. These migratory populations are therefore difficult to effectively educate about the disease, and their movements also make it tricky to gauge the efficacy of programmes. Targeted programmes were also launched focusing on the armed forces of member states, and on the workforce of selected industries. While these interventions are assisting high risk groups, the obligation of corporations to protect the health of their workforce is not yet formalised within the regional policy document, although some member states have begun to require this of the larger companies operating within their borders.[28]

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iv) Focus on youth participation

A critical issue emphasised in the policy document is the importance of youth centred campaigns (in line with the emphasis placed on the youth in the literature – see chapter one) due to the vulnerability of this high risk group, which is attributed to a "comparatively high level of sexual activity and a lack of information" (WAHO, 2003:26). Also noted within the policy document is the "failure of existing programmes to adequately address behaviour change among the youth of the sub-region [and the] infrequency with which young people in the sub-region access Voluntary Counselling and Testing (VCT) services" (WAHO, 2003:26). This statement stems from a directive

[28] A key aspect of the WAHO strategy to address this issue is the involvement of the Global Business Coalition on HIV/AIDS (GBC), whose efforts are directed towards protecting citizens in the formal sector (Bowen, 2005:Internet source). The approach of the coalition is briefly outlined further in this chapter. The focus on the private sector has arisen in part to overcome the perception that HIV and AIDS is not a serious threat to West African states. This impression is born out of the fact that infection and death rates are far lower than those in Eastern and Southern Africa, but the pandemic still poses a serious threat to their workforce. As a result, the various ECOWAS ministers are working with UNESCO to scale-up the response of the private sector through the implementation of more workplace programmes (Bowen, 2005:Internet source).

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issued within the 2000 HIV and AIDS control strategy, which states that the active participation of the community (particularly the youth) in the formulation and implementation of programmes aimed at lifestyle changes is essential for success (ECOWAS, 2000:Internet source). It is unclear why men are not expected to be as actively involved as women and the youth, as they play an influential role in increasing the vulnerability of women to infection, given the prevailing patriarchal nature of African society. As will be discussed in the section on gender below, it is also disconcerting that women and children are lumped together as high risk groups, despite their entirely different points of risk and diverse burdens. Further, the participation of the youth in the design of programmes is emphasised, although the involvement of women does not receive comparable attention.

The objective is thus to "facilitate the establishment of information-intensive, youth-focused VCT centres in ECOWAS Member States" (WAHO, 2003:26). It is proposed within the policy document that this can be achieved through participating in "political advocacy with governments and partners in member states to ensure the establishment of youth centred VCT services", ascertaining the training needs for staff at these centres (and providing this training), and assisting in the production of "fliers and other Information Education Campaign (IEC) materials for VCT centres".

2.4.3.2 Prevention programmes

As discussed in chapter one, the literature clearly outlines the integral elements of an effective prevention strategy, starting with scaling up the availability of and access to voluntary testing and counselling services. Tying in with this is the need to provide non-discriminatory access to vaccines, condoms, sterile injecting equipment, and drugs (including ARVs). Interventions for particularly high risk groups such as sex workers also constitute a focal point. The Prevention of Mother-to-Child Transmission (PMTCT), which is included in this programmatic area, will be discussed within the section on gender.

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i) Voluntary counselling and testing

The low rate of voluntary testing amongst the youth has been addressed above. The policy document does not acknowledge the lack of testing amongst the general population, most likely due to the prevailing social and cultural norms which are not conducive to openly declaring HIV status. The high unemployment and poverty rate could also be a contributing factor to the discrimination against workers who reveal their HIV positive status. However, apart from the danger of individuals spreading the disease further due to ignorance of their HIV status, the state is unable to effectively gauge the true extent of the pandemic, and plan accordingly for the necessary treatment and care of these individuals.

ii) The availability and accessibility of condoms and drugs (including ARVs)

The policy document does not contain any information about the provision of condoms, nor does the word "condom" appear in the document at all, as was discussed previously. The matter of ensuring access to drugs and consumables is complicated because of high costs, low availability, or a combination of both. The stated objective is to enable "at least 50% of PLWHAs and 80% of STI patients" to receive the necessary treatment (WAHO, 2003:26). However, the policy document is vague about how this goal is to be achieved, as is discussed in more depth in the section on treatment, which follows below.

iii) Interventions within the sex industry

No provision is made within the policy document for the high risk group of sex workers, which is a major concern considering the trade flows in the region, poverty, and the high volumes of migrant labourers (and refugees) moving between states. Firstly, as an expanding regional grouping made up of developing states, the trading between states both within and outside the grouping is increasing. This results in greater quantities of traffic between states, and an increase in the number of migrant workers, encouraging the growth of the sex industry along major routes. The accepted practice of sex with multiple partners, including commercial sex workers, heightens the HIV prevalence amongst both the migrant workers and commercial sex workers

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(*Toronto Globe and Mail*, 2006:Internet source).[29] Secondly, poverty (and unemployment) forces women especially to enter the "informal sector", including the sex industry, in order to ensure their survival. A similar situation confronts refugees fleeing conflicts in states such as Cote d'Ivoire, Liberia and Sierra Leone (see Nyikuli, 1999). A survey of Nigerian commercial sex workers (estimated to include some 80 000 women), revealed that 60% of these women were "unaware that condoms could lower the risk of HIV transmission" (*AFP*, 2001:Internet source). It is thus essential that sex workers are included in programmes aimed at preventing the spread of HIV, and the omission of this aspect from the policy document is a serious flaw.

2.4.3.3 Treatment infrastructure

The provision of treatment is a crucial component of the HIV and AIDS policy of ECOWAS, as without the necessary drugs and competent personnel to administer them, the workforce of member states will collapse. The policy document guidelines on treatment programmes are considered within two broad aspects identified within the literature (see chapter one); treatment infrastructure, and the attainment of the drugs (both in the long and short term). With regard to treatment infrastructure, the following aspects are addressed: strengthening of the infrastructures of member states in various sectors to ensure the effective delivery of essential services; the development of domestic industries (consistent with international law discussed above), and ways to increase the access of the general population to essential medicines. The manner in which to achieve improved access to home-based care for those sections of the population without adequate access to medical facilities is also discussed. The second issue of providing the drugs and services required for effective treatment is examined by evaluating the emphasis on increasing the number of health care workers and ensuring proper training, and providing psycho-social support and counselling. Also under consideration are methods of affordable drug procurement (focusing on long term sustainability), directives issued by the regional body about providing access to medication for sexually transmitted diseases (including ARVs), and ensuring that treatment for opportunistic infections is included in the policy document.

[29] A detailed case study of Nigerian migrant workers and their level of HIV and AIDS awareness was conducted by Oyadoke, Brieger, Adescope & Salami (2003), and shows that general knowledge about how the disease is contracted, and safe sexual practices, was very poor.

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i) *The expansion and strengthening of infrastructure*

As discussed in the literature in chapter one, the strengthening of infrastructure is a priority area as it directly affects the ability of the state to effectively deliver health care services. Apart from the numerous references by ECOWAS in its policy to expand and strengthen laboratories for quality control purposes, the discussions on the development of infrastructure remain focused on building the capacity of WAHO as an administrator, as opposed to providing guidelines to member states on strengthening their infrastructures (see section 2.1 of the WAHO policy document). This may be due to the vastly differing needs of the various member states, although some guidelines should be included.

ii) *Developing domestic industries for the provision of essential medicines*

The policy document states that WAHO will ascertain which countries have the "appropriate technology for local drug manufacture", and will then advocate for the "transfer of such technology to other parts of the sub-region" (WAHO, 2003:26). Despite the long term importance of the domestic manufacture of essential drugs, the policy document does not provide any more specific guidance on this issue. This could be due to the intensification of efforts to ensure that cheaper generic alternatives may be imported into the region, which are slowly starting to bear fruition across the continent (see for example Oakley & Sherman, 2004). It may also be an acknowledgement of the poor state of the infrastructure in member countries, which simply do not have the resources or experience to undertake such a mammoth task in the foreseeable future.

iii) *The provision of home-based care*

The provision of home-based care is not addressed within the ECOWAS policy document at all, even though this issue is mentioned within the literature discussed in chapter one. This omission may once again be due to a severe lack of resources and capacity (in terms of available personnel, equipment and funds), which has prompted the health agency to omit this service guideline from the policy document.

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2.4.3.4 Drugs and services required for effective treatment

As discussed above, the provision of essential drugs and the ability to maintain the skilled personnel necessary to administrate them, is examined in this section of the policy document analysis. As indicated in chapter one, the literature emphasises essential drugs as well as access to psycho-social support and counselling, means of ensuring affordable drug procurement, and supplying medication for sexually transmitted diseases and opportunistic infections.

i) Increasing the number of trained health care workers

The importance of properly equipping health personnel with the skills needed to deal with the issues facing the sub-region is emphasised throughout the policy document. It is noted that "health personnel are the most valuable inputs of health systems, and the quality of health personnel is directly determined by the quality of training that they receive (in both their degree programmes and their continuing professional development)" (WAHO, 2003:31). It is further stated that this training has been compromised by political and economic instability in the region. Additional factors which are hampering progress in the training arena include an increasing "brain drain" of qualified personnel leaving the region, and poor medical qualification recognition between states (WAHO, 2003:31). The acknowledgement of this serious issue in the policy document is especially noteworthy given the impact that it has on the effective implementation of the health policy as a whole.

ii) The provision of psycho-social support and counselling

Providing psycho-social support and counselling is emphasised within the literature due to the need to address the social and cultural taboos surrounding HIV and AIDS, and other STDs, and the stigma around people receiving treatment. It is also important in assisting infected and affected individuals in coping with the disease. Aside from the reference to increasing voluntary counselling and testing amongst the youth, discussed within the section on prevention campaigns, the document does not refer to providing counselling for the general population. This is problematic given the high number of child-headed households, and the issue of unknown HIV status together with the need

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to educate men about the implications of continuing high-risk behaviour (as mentioned previously). Secondly, women are in particular need of this service given their general lack of rights, and the disproportionate burden which the disease places on them (see Pearce, 2000 and Lowe Morna, 2004). However, there is no mention made within the policy document about providing voluntary counselling and testing services to either men or women.

iii) Identifying methods of affordable drug procurement

Given the high prevalence rates of HIV and AIDS, malaria and tuberculosis in West Africa, essential drugs and vaccines are in massive demand (WAHO, 2003:34). However, as stated before, accessibility is problematic due to exorbitant prices and poor continuous availability. The policy document states that "there is general agreement in political and health circles that all individuals in need should have access to quality drugs to treat diseases like malaria, tuberculosis, and HIV and AIDS, yet few tangible actions have been taken to make this principle a reality" (WAHO, 2003:34). This relates back to the discussion on TRIPS, and the restrictions placed by the manufacturers on the accessibility to essential drugs in poorer developing states such as those in ECOWAS (see Motjuwadi, 2000 and Weismann, 1999).

WAHO will thus facilitate discussions amongst the Heads of State and Government on means to improve the above situation, largely through assisting member states with the bulk purchasing of these essential drugs by building a database detailing the cost and availability of the drugs, serving in an advisory capacity in the purchasing process for vaccines and drugs, and aiding in price negotiations between member states and suppliers (WAHO, 2003:34). It is hoped that these actions will overcome the complications caused by "frequent shortages of essential generic drugs (EGD) and the high prices of those drugs relative to the purchasing power of West Africans" (WAHO, 2003:34).

WAHO has also committed to conducting an "assessment of the existing quality assurance/quality control (QA/QC) capacity in the sub-regional drug industry", as well as of the resources needed to increase this capacity, preparing "advocacy briefings for governments of member states", and compiling a "database of drug requirements (type

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and estimated quantity) in ECOWAS member states for a five-year period" (WAHO, 2003:26).

The policy document also states that "there is a severe shortage of documented information on the practice and effectiveness of traditional medicine in the sub-region" (WAHO, 2003:35). In order to raise both the awareness and use of traditional medicines, the organisation aims to conduct an inventory of the traditional medicines in use within the sub-region, research the usefulness and effectiveness of the drugs, and "assess the feasibility of regulating traditional medical practices" (WAHO, 2003:36). It is important to recognise the importance of this acknowledgement within the policy document, as the willingness and stated intention to explore traditional medicines is not readily found in the health policies of western governments. The ability to actively seek solutions tailored to the unique African context must therefore be commended.

iv) Access to medication for sexually transmitted diseases and opportunistic infections

The availability of medication for sexually transmitted diseases and opportunistic infections is a crucial aspect of the ECOWAS health policy. As has been pointed out in chapter one, deaths are not attributed to AIDS, but rather to the opportunistic infections and STDs which are able to take advantage of the weakened immune systems of infected individuals. It is stated within the policy document that treatment for sexually transmitted diseases should be made available to at least 80% of the patients requiring it (WAHO, 2003:26). It is the only reference in the document to sexually transmitted diseases (other than HIV and AIDS) and does not offer any further guidelines detailing what this treatment would entail or how member states should go about obtaining the stated goal. This indicates that a clear connection is not being made within the health policy between STDs and HIV and AIDS.

In terms of opportunistic infections, only malaria is dealt with in any detail. The policy document states that malaria infections continue to pose a serious health threat in the region; killing more than one million Africans each year, despite the WHO declaring it an eradicable disease (WAHO, 2003:27). Some of the difficulties discussed in the policy document include the resistance which patients are developing to anti-malarial

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drugs, and the growing ineffectiveness of insecticides against the disease-carrying mosquitoes. The document thus states that WAHO aims to "transform recent displays of political commitment (such as the Abuja Declaration) into concrete action by working in the domains of information transfer and training", going on to state that community participation is "implicit in the design of the programme" (WAHO, 2003:27). The conveyance of accurate information about the disease, as well as the drastic reduction of fees on anti-malarial drugs and bed-nets is emphasised, together with "harmonising treatment protocols, improving country-level competence and diversifying national programmes" (WAHO, 2003:27).[30]

2.4.4 Women and HIV and AIDS

There is an obvious lack of attention paid to women and gender within the policy document of the ECOWAS health agency. The only direct reference to women in the policy document concerns the higher rate of anaemia experienced by this sector of the population. Within the HIV and AIDS control strategy document mentioned previously, it is stated that West African states recognise that the "increasing spread of HIV and AIDS amongst women has brought on a massive increase in neonate infection through mother-child infection, and has also reduced or even reversed the improvement observed in child mortality rates" (ECOWAS, 2000:Internet source). It was thus decided that member states must "empower women to fight harmful traditional and cultural sexual practices which expose them to HIV and AIDS" (ECOWAS, 2000:Internet source). No further mention is made of the higher incidence of HIV and AIDS amongst women, nor how these women may be empowered to overcome this. Thus, there is little sign of gender mainstreaming in the policy document. This is in keeping with the general ECOWAS stance towards women in comparison to SADC (see chapter one).

[30] In terms of malaria, the agency has based its approach on the Abuja Declaration on Roll Back Malaria, signed in 2000. This agreement is a pledge by African Heads of State to commit to a regional plan of action which focuses on effective prevention and affordable treatment. However, the push for the reduction of tariffs on bed nets and anti-malarial drugs has only been partially implemented by certain states, and not addressed at all by others (WAHO, 2003:12).

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The Prevention of Mother-to-Child Transmission of HIV and AIDS (PMTCT) is one of the critical concerns regarding women which was raised in chapter one. Even this is not dealt with directly in the WAHO policy document. However, the issue of child survival, particularly the mortality rate for children in West Africa, is described as "particularly appalling, exceeding 20% in some countries" (WAHO, 2003:36). This is attributed to meagre immunisation coverage and a severe shortage of information to health care practitioners. WAHO has thus created the Child Survival Programme, which endeavours to rectify this situation through "promoting community Integrated Management of Childhood Illness (IMCI), increased immunisation coverage (including the introduction of new vaccines into immunisation programmes) and training in the area of peri-natal care" which will boost immunisation and vaccine coverage to 95% (WAHO, 2003:36). In addition, the establishment of a database for regional vaccine information, the mobilisation of funds for the purchase of these drugs, and the creation of better awareness around issues of child survival in the region are also to be pursued. While this will certainly improve general child survival, it is not nearly enough to overcome the disastrous rise in deaths which will occur should babies continue to be born with HIV infections.

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Thus, the WAHO document does not address crucial needs of women, perhaps because women did not have the opportunity for meaningful participation in the formulation of the policy guidelines. These needs include better access to voluntary testing and counselling services, the provision of condoms for either partner, focused education campaigns informing women of their basic rights, and provisions being made for PMTCT. The absence of policy guidelines on the needs outlined above leads to the conclusion that women are not playing a consequential role in the policy formulation process. The vague references made about the empowerment of women are thus little more than generic platitudes.

2.4.5 Summary of the ECOWAS Policy in terms of the Policy Indicators

The ECOWAS health policy, as formulated by WAHO, incorporates most of the indicators outlined in chapter one under the three broad issues. Although it is a largely superficial document providing little in the way of concrete guidelines to member states in applying the suggestions, it does have a number of positive aspects. It focuses on

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education and awareness campaigns, noting the value of community level campaigns and the improved exchange of information between ministries and member states. Education drives aimed particularly at the youth receive considerable attention, although the use of the mass media (emphasised in the literature) is not directly mentioned. While no formal document outlining the responsibilities of employers in protecting their workforce is referenced in the WAHO policy, the critical issue of corporate responsibility is addressed. Migrant workers are specifically mentioned, reflecting the emphasis placed on this high risk group in the literature. The importance of targeting the youth in education and awareness campaigns is strongly stressed, once again adhering to the indicators which illustrate the significance of this aspect of HIV and AIDS policy (see chapter one). Turning to treatment indicators, the development of domestic industries for the local manufacture of essential drugs is discussed, although no details are provided as to the proposed plan of action. However, the inclusion of this aspect shows that long term plans are being considered by the regional grouping. One of the most noteworthy aspects of the WAHO document is the discussion on the training and retention of health care personnel in the region, specifically noting means of reversing the "brain drain" being experienced by the region. In terms of developing means of affordable drug procurement, the WAHO policy mentions collective negotiation with pharmaceutical companies, and the scaling up of quality control procedures within the region, but provides few other details. The inclusion of traditional medicines as an integral part of treatment policies is also noteworthy, showing the tailoring of a unique African response being adapted from the indicators discussed in chapter one.

Little is said about the provision of voluntary counselling and testing services amongst the general population, and protecting sex workers in the region, and no mention is made about the provision of condoms. All three of the above issues are heavily emphasised within the literature referred to in chapter one. In terms of strengthening infrastructure, the only references are to laboratories and quality control measures, with no mention made of public health care structures such as hospitals, which are discussed in chapter one. Home-based care is not mentioned at all, although the literature does not accentuate this aspect of treatment as strongly as others. Psycho-social support and counselling for the general population is also not discussed in the ECOWAS policy document, although it is mentioned in relation to the youth. The connection between

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opportunistic infections, STDs and HIV and AIDS is also not acknowledged, despite heavy emphasis in the literature in chapter one, which demonstrates the necessity of recognising the manner in which the diseases impact on each other. The matter of drugs within the treatment policies is considered to some extent, but needs more detailed guidelines for member states, considering how crucial this issue is.

One of the major and most obvious deficiencies in the policy document is that gender is not mainstreamed in the ECOWAS health policy, nor in its policy on HIV and AIDS. The underlying causes for the vulnerability of women to infection which were identified in chapter one go unnoticed. Similarly, the treatment needs of women in terms of HIV and AIDS are not acknowledged, for example the necessity for increased PMTCT services. This general lack of gender awareness is indicative of the common ECOWAS stance discussed in the previous section.

On the whole, the ECOWAS policy on HIV and AIDS provides a number of general guidelines to issues that need to be addressed, as identified in the literature on HIV and AIDS. However, little direction is provided in terms of specific activities that could assist in the achievement of these goals. The following section will address the SADC health policy in comparison with the ECOWAS document discussed above. The approach will be similar, using the same indicators.

2.5 SADC

As in the case of ECOWAS discussed above, a brief overview of the SADC Social and Human Development Directorate, which serves as the body's health unit, will be conducted before commencing with the comparison of SADC's health policy.

2.5.1 Organisational Structure of the Social and Human Development Directorate

The health unit for SADC member states falls under the responsibility of the Social and Human Development Directorate, and is primarily concerned with the coordination of

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health policies and programmes within member states (SADC, 2005:Internet source).[31] The leaders of the SADC states have reiterated their commitment to the control and eradication of the three diseases causing the most damage in sub-Saharan Africa, namely HIV and AIDS, malaria, and tuberculosis. The burden which these diseases are placing on SADC states is clearly articulated within the policy documents, especially their impact on sustainable socio-economic development. The regional organisation estimates that should prevalence and death rates remain at their current levels, economic growth could be slowed by as much as 2.5% (SADC, 2005:Internet source). The dedication of the SADC member states is demonstrated through the signing of various treaties and declarations, such as the Millennium Development Goals (2000), the Abuja Declaration on HIV and AIDS (2001), and the New Partnership for Africa's Development (2001), which have also been signed by the ECOWAS member states, as pointed out above. These commitments were formalised within SADC in the Maseru Declaration which underlined the importance of prevention, care and treatment for the three primary killers in Africa (SADC, 2005:Internet source).

The SADC policy on health issues is structured in a similar manner to that of ECOWAS, in that the regional organisation serves as a facilitator and technical advisor rather than an implementing body. It is the responsibility of the member states to ensure that the policy is speedily and properly implemented. SADC does play a role in bringing strategic partners together, such as international donor agencies and other multilateral partners which may assist member states in the funding and effective implementation of programmatic actions, which is virtually identical to the actions stated in the ECOWAS policy document above.

The health "priority areas" identified within the ECOWAS policy document also appear within the SADC general health policy. However, as SADC has formulated a separate HIV and AIDS policy, this will be the document used in the comparison. It may be noted that the existence of a dedicated HIV and AIDS policy document shows that the disease seems to be receiving a higher profile within SADC than in ECOWAS.

[31] While WAHO is described as a "health agency" it is not an autonomous body, and is thus similar to the SADC Health Directorate in terms of its powers and scope of responsibility.

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2.5.2 HIV and AIDS Policy Document

The SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007) is the second policy document dedicated to HIV and AIDS released by the regional body, and outlines the HIV and AIDS policy guidelines to be pursued by all member states of the regional economic grouping. The document is an expansion of the previous HIV and AIDS document (SADC HIV and AIDS Strategic Framework and Programme of Action 2000-2004), and incorporates lessons learnt from the experience of its implementation. The two documents will be considered together as the SADC policy on HIV and AIDS.[32] Prevention and social mobilisation efforts remain at the forefront of SADC's HIV and AIDS strategy, aiming to change high risk behaviour across all population groups, and presenting comprehensive reproductive health services in the most accessible manner (SARPN, 2003:Internet source). Treatment and access plans are to be expanded, especially in terms of scaling up awareness amongst women and the youth. The Prevention of Mother-to-Child Transmission (PMTCT) is high on the priority list, with the target in this area stated as "ensuring that levels of uptake are sufficient to achieve the desired public health impact" (SARPN, 2003:Internet source). Included in this section of the framework are auxiliary matters such as nutritional education programmes and the use of locally manufactured foods for improving general health. All of the issues outlined above will be discussed in greater detail in the section comparing the indicators below.

Six areas of focus have been identified by SADC to ensure the achievement of these health policy goals. They are; "policy development and harmonisation, HIV and AIDS mainstreaming, capacity building, facilitation of the technical response, facilitation of the resource networks, and monitoring of the regional and global commitments" (SADC, 2004:4).

Policy decisions taken on a regional level are implemented through national agencies and initiatives, although the four SADC Directorates assist where needed and monitor progress and efficiency. These Directorates are Trade, Industry, Finance and Investment (TIFI); Infrastructure and Services (IS); Food, Agriculture and Natural

[32] The 2000 document is a short and fairly basic outline of the SADC HIV and AIDS policy, although it clearly articulates the general approach to be followed by the SADC member states.

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Resources (FANR); and Social and Human Development and Special Programme (SHDSP), which all play a role in the development of SADC's strategic framework for HIV and AIDS (SADC, 2000a:7; SADC, 2004:21).

Each Directorate is comprised of a number of sectors, which relate to bodies at the national level in member states (SADC, 2004:24). Data on the performance of programmes is collected by the national bodies, and fed back into the Directorates, which then collectively make decisions about how to adapt and maintain the initiatives (SADC, 2000a:2; SADC, 2004:25).

The main objectives outlined within the policy documents are very similar to those contained in the ECOWAS document, namely reducing the rate of HIV infections, particularly within the identified high risk groups, and minimising the socio-economic impact of the pandemic, as well as ensuring that regional, continental and global commitments regarding HIV and AIDS are met (SADC, 2000a:2). The SADC document adds that member states should also be aware of commitments aimed at guaranteeing that "gender is fully mainstreamed" into all policies, particularly HIV and AIDS (SADC, 2003:12).

SADC also commits to the "facilitating of a technical response", which entails establishing "mechanisms to facilitate regional technical discussions, develop regional guidelines and facilitate the sharing of best practices in the areas of HIV and AIDS mainstreaming, PMTCT, the support to orphans, home-based care, VCT, access to ARV treatment, the use of traditional medicines, [and] scaling up research and surveillance, taking into account anthropological and epidemiological factors" (SADC, 2000a:9; SADC, 2003:13). These aspects correlate very closely with the issues stipulated in the literature (chapter one) which require attention in the fight against HIV and AIDS (and which are used as indicators in this study to make comparison possible), indicating that SADC is incorporating the prevailing ideas on effective HIV and AIDS policies into their document.

In line with the general SADC policy on the equality of women (refer to discussion in chapter one), the regional body is intent on ensuring that gender issues are incorporated into both the HIV and AIDS strategic framework and the related initiatives being

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implemented in the region. The fulfilment of this mandate is the task of groups such as the Ad Hoc Expert Group on Gender. This collective was assembled after the Sixth Regional African Conference on Women met with representatives from government, civil society and various national and sub-regional NGOs involved with gender networking (UNECA, 2004:Internet source). This gender focus far exceeds that of ECOWAS (see above) and will be discussed further within the section on women and HIV and AIDS.

The next section examines the HIV and AIDS policy of SADC with regard to the same indicators applied to the ECOWAS document above. These indicators, introduced in chapter one, will once again be divided into issues related to education and awareness campaigns, prevention programmes, treatment infrastructure, and drugs and services required for effective treatment.

2.5.2.1 Education and awareness campaigns

This section compares the education and awareness campaign guidelines outlined in the SADC health policy document, using the same indicators applied to the ECOWAS document in the previous section. As discussed in chapter one, the indicators focus on the imparting of accurate information about safe sex, good nutrition, and an awareness of the essential services provided by health care facilities. Of particular importance is the social marketing of male and female condoms, in terms of ensuring that their use becomes socially and culturally acceptable. The involvement of employers in ensuring the good health of their workforce is considered essential according to the literature, as is the involvement of the youth in various aspects of policy formulation and implementation. The discussion below will also draw comparisons between the two documents, exploring the similarities and differences between the approaches being followed by these two regional organisations. Gender will once again be discussed in a separate section at the end of the comparison of indicators.

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i) Safe sex, nutrition and health care services

The SADC policy states its intention to scale up awareness about safe sex issues amongst women and the youth particularly, although it follows the same trend as ECOWAS in not providing details on the manner in which this can be achieved (SADC, 2000a:7; SADC, 2003:8). However, general education concerns and the manner in which HIV and AIDS affects the level of education in member states is acknowledged, with the policy stating that the "SADC Education Policy Support Initiative has supported studies on HIV and AIDS Education Policy … piloting the integration of HIV and AIDS [into education drives] … at three SADC centres" (SADC, 2000a:28; SADC, 2003:9). Education policies and their relationship with HIV and AIDS are not addressed in the WAHO document. While the importance of nutritional education programmes is discussed, ECOWAS expands on the role of nutrition to a far greater extent than SADC does. However, as mentioned above, SADC mentions the use of locally manufactured foods for assisting member states in drives aimed at improving the general health of the population, which is not noted within the ECOWAS policy document.

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Consistent with the ECOWAS focus on better information exchange between ministries and member states, SADC has also established a data management programme to aid various aspects of policy formulation and implementation, including improving education drives to ensure the effectiveness of health service marketing. This data consolidation will create a network of national AIDS councils, assisting member states with inter-country initiatives (such as cross-border initiatives), coordinating regional donors and training programmes, and developing a regional data bank to manage all this information (SADC, 2000a:21; SADC, 2003:13).

ii) Condom social marketing

The importance of condom social marketing is strongly stressed in the literature (see chapter one), but this crucial aspect is not addressed within the 2003 SADC document at all, although the 2000 SADC document makes a few fleeting references. It is stated that "the early HIV and AIDS response was mainly centred around raising awareness through … communication for behaviour change [such as] condom promotion"

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(SADC, 2000a:7). It may be inferred that the reasons behind the omission in the 2003 document are the same which are assumed to hold for ECOWAS, namely the desire not to alienate donors with policies which are at odds with their doctrines, and the plethora of faith-based organisations operating within the region (see corresponding ECOWAS indicator above). However, considering both the strong emphasis placed by the literature on the social marketing of condoms, and SADC's substantially higher prevalence rate, these explanations seem inadequate.

iii) Workplace interventions

SADC has established a *Code on HIV and AIDS and Employment*, which presents employers with guidelines for protecting their workforce in accordance with directives from international labour organisations and the WHO (SADC, 2000a:17; SADC, 2003:13). The formal inclusion of this code within the policy document is in contrast with the ECOWAS document, which mentions the possible value such measures may have, but does not expand on these benefits to the extent which the SADC document does, such as sustaining productive capacity and reducing poverty, which can be expected to increase when the primary breadwinner dies (SADC, 2003:5). The Code requires that the number of workplace programmes be increased, including impact studies, legal stipulations in contracts and terms of employment, as well as worker education campaigns (SADC, 2003:30). These projects are usually run in partnership with corporations operating within the state, and generally include the families of employees and in some instances the local community living around the business premises of the corporation. The involvement of corporations in HIV and AIDS programmatic actions is used within ECOWAS member states as well, and will be discussed further in the following chapter (see section on the private sector and corporate social responsibility).

High risk groups such as migratory workers are targeted more specifically within the SADC policy document than in the ECOWAS document. SADC also specifies a wider range of vulnerable groups, including long distance truck drivers and commercial sex workers, and discusses the intervention actions in greater detail (SADC, 2000a:34; SADC, 2003:9). For example, a large number of individuals in SADC member states are involved in the transport industry, a group which is considered at high-risk for

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infection. As the efficiency of this industry is essential to the continued development of the region, a pilot programme was initiated by SADC in the Beira Corridor to establish the best means of protecting transport workers from HIV and AIDS (SADC, 2004:32). The success of the project has led to the expansion of the initiative, and it is expected to be implemented in the Tazara, Nacala, Maputo, North-South, Trans-Kalahari, Walvis Bay, Trans-Caprivi, and Lobito Corridors (SADC, 2004:32). This initiative is not limited to truck drivers, and includes rail, air and maritime workers. This again demonstrates the greater attention to detail within the SADC documents in comparison to the ECOWAS policy, which only acknowledges the high risk of transport workers, and does not elaborate on any initiatives which may assist their protection from HIV and AIDS. The protection of sex workers is also addressed directly, as this particular industry ties in with the transport workers' prevention and treatment programmes.

iv) Focus on youth participation

The SADC policy, like the ECOWAS document, emphasises the high risk of the youth, as well as the vulnerability of children and orphans. Member states are instructed to ensure that "social support, such as shelter, schooling, nutrition, health and social services" are provided for orphans and other vulnerable children, in an effort to minimise the socio-economic impact on this severely affected group (SADC, 2000a:13; SADC, 2003:8). Furthermore, SADC member states must reduce the HIV prevalence amongst the youth by 25%, according to both the SADC policy document, and commitments made under the UNGASS Declaration. SADC also states that the youth should be further protected from HIV through the "provision of educational and employment opportunities, and by the fostering of positive cultural values" (SADC, 2003:22). This statement is an extension of the goal to overcome stigma, discrimination and alienation through education as "culture has a key role to play in the development of positive attitudes towards HIV and AIDS infected and affected individuals" (SADC 2000a:11). While the ECOWAS document also emphasises the participation of the youth, the SADC policy document, as pointed out above, provides more details of the types of activities in which member states are expected to engage with this high risk group.

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2.5.2.2 Prevention programmes

Prevention campaigns incorporate a number of essential indicators identified in the literature in chapter one. Critical issues to be addressed include ensuring the availability of voluntary testing and counselling, the provision of non-discriminatory access to vaccines, condoms, sterile injecting equipment, and drugs (including ARVs), and interventions for commercial sex workers. Following the format established in the previous section, the provision of PMTCT will be considered in the section on gender, although it is discussed together with the above mentioned prevention indicators in the literature in chapter one.

i) Voluntary counselling and testing

While the 2003 SADC policy document mentions VCT, it is not expansive on the manner in which member states can achieve greater access to voluntary testing and counselling services, and simply states that "standards in VCT were developed … to guide member states in implementing VCT programmes" (SADC, 2003:10). These standards are not included in the document, although it should be noted that VCT is not addressed in the 2000 SADC document at all. While ECOWAS mentions the youth in connection with VCT, both policy documents are vague on how these services can be scaled up, or provided at all. The concerns raised during the discussion of the ECOWAS policy document hold true for SADC as well; failure to utilise VCT services could be as a result of the continuing stigma around the disease, and discrimination against individuals who are identified as HIV positive. The non-committal response on the issue of VCT by both regional organisations results in a skewed picture of the true extent of the pandemic, and will make gauging the effectiveness of HIV and AIDS policies very difficult.

ii) The availability and accessibility of condoms and drugs (including ARVs)

As with the ECOWAS policy document, no information about the provision of condoms is available in the SADC policy document of 2003, nor does the word "condom" appear in the 2003 document. SADC mirrors the ECOWAS edicts of facilitating the bulk purchasing of ARVs, and improving the quality of drugs in the

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region through harmonising the regulatory requirements across member states (SADC, 2000a:20; SADC, 2005:Internet source). As with ECOWAS, the statements are vague, with little detail on how these intended activities will be implemented. For example, SADC indicates that it will assist member states in "facilitating access for the citizens of the region to such medicines and related substances when they need them", but provides no further information (SADC, 2005:Internet source). As has been repeatedly pointed out, both within the ECOWAS policy discussion and the social marketing of condoms above (see sections on education and awareness campaigns), the provision of condoms is integral to a successful prevention campaign, and the failure of both regional organisations to acknowledge this in their policy documents could be ascribed to the prevailing cultural and moral norms of foreign donors such as PEPFAR and faith-based organisations (see discussion within ECOWAS education and awareness campaigns).

iii) Interventions within the sex industry

The needs of other vulnerable and high risk groups such as commercial sex workers are considered within the SADC policy document to a far greater extent than in the ECOWAS policy. For example, the road transport sector is specifically mentioned, particularly the distance truck drivers and commercial sex workers which work along the major travel routes (SADC, 2000a:11; SADC, 2003:9). Member states are advised to undertake "HIV and AIDS information, education and communication activities targeting truck drivers, railway workers and commercial sex workers" and the Beira Corridor Project is specifically mentioned as an example (SADC, 2003:9).

As the push for trade sees more traffic between states, a higher number of sex workers are earning a living along major trade routes. This paradox is highlighted by Bonnel (2000:848) who notes that while economic development is crucial for containing the disease and improving infrastructure, it can have the converse effect by encouraging widespread labour migration, which in turn promotes risky sexual behaviour. It is estimated that up to 40% of new infections in sub-Saharan Africa are amongst transport

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and sex workers, and the HIV and AIDS strategy is therefore focused on this high risk population group (Phillips, 2004:Internet source).[33]

The SADC guidelines are innovative, and relatively simple and inexpensive to implement, and are based on Uganda's phenomenally successful "ABC" programme, promoting abstinence, being faithful, and condom usage (Phillips, 2004:Internet source).[34] The emphasis is thus on prevention through education, and on state intervention to remove the circumstances that encourage the growth of the sex industry. For example, long waiting times at borders to check paperwork and shipments lead to delays of up to five days, luring sex workers into the vicinity. Construction sites and weigh stations experience similar delays, and these identified hotspots are being targeted for a pilot programme aimed at reducing the risk to these workers. The importance of specifically targeting these high risk groups is recognized by the World Bank, which has allocated US$500 million for these programmes under the second MAP initiative (Merid, 2003:10).

2.5.2.3 Treatment infrastructure

The treatment infrastructure of states is considered vital in the literature, as was shown in chapter one, and considers issues such the strengthening of the health care infrastructure, the development of domestic industries for the local manufacture of essential drugs, and the scaling up of home-based care. The section below will examine the guidelines provided by SADC, and how these compare with those suggested in the ECOWAS policy document.

i) The expansion and strengthening of infrastructure

The SADC policy states that the regional body will provide guidance to member states in "developing and implementing comprehensive programmes of care, support and treatment, including addressing resource constraints such as a poor health care

[33] An illustration of the urgency required in disseminating information to sex workers is provided by the *Toronto Globe and Mail* (2006:Internet source), which reports that approximately 80% of the commercial sex workers operating along the "trucking corridor" through Kenya and Uganda are HIV positive.

[34] An example of how these guidelines are implemented can be seen in the ECA Hub's programmes.

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infrastructure and issues of stigma and discrimination" (SADC, 2000a:19; SADC, 2003:8). The body is also committed to "strengthening the regional quality control infrastructure, including the sharing of relevant information" (SADC, 2005:Internet source). Although no details are provided on the guidelines, the intention to establish these programmes and policies is clearly stated, which is not the case with the WAHO document as that document only discusses the scaling up of laboratories and quality control measures.

ii) Developing domestic industries for the provision of essential medicines

SADC has stated its intention to assist member states in the local manufacture of generic drugs for use within the region, committing itself to encouraging the "development of the regional capacity for pharmaceutical manufacturing as well as for conducting research into pharmaceuticals that are relevant to local health problems, including traditional medicines" (SADC, 2005:Internet source). There is an expansion on this activity, involving the "effective exchange of information among the region's pharmaceutical management systems" (SADC, 2005:Internet source). Both regional organisations have shown their proclivity towards the local production of drugs within one of their member states, although neither has provided any guidance to member states as to how this could be achieved.

iii) The provision of home-based care

The treatment and care framework provided in the SADC strategic framework is centred around strengthening the public health care and home-based care infrastructures in member states through the use of more advanced technologies. The increase of testing and counselling to ascertain the level of need is included in the SADC strategy. The SADC policy also mentions the training of more health care practitioners to assist in the home-based treatment and care of HIV infected and affected individuals (SADC, 2000a:24; SARPN, 2003:Internet source). This aspect receives far more attention within the SADC policy document than it does from ECOWAS, which does not mention it at all. This could be an acknowledgment by ECOWAS of the limited resources of member states, or a display of optimism by SADC that member states may

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begin laying the groundwork for home-based care and scaling it up as funds become available.

2.5.2.4 Drugs and services required for effective treatment

The indicators identified for ensuring that drugs and services are effectively addressed within HIV and AIDS policies (also used with regard to ECOWAS) begin with the personnel who administer the treatment. Health care personnel are essential in the implementation of treatment policies, and the literature is expansive on the importance of increasing the number of individuals with proper training (see chapter one). Secondly, psycho-social counselling and support for individuals affected and infected by HIV and AIDS is discussed, followed by an examination of identified methods of affordable drug procurement. Lastly, and most importantly (according to the literature), is the acknowledgement of the relationship between HIV and AIDS, STDs and opportunistic infections.

i) Increasing the number of trained health care workers

The SADC policy document discusses the importance of addressing "human resource needs in all sectors in the context of HIV and AIDS" and "sustaining human capital" (SADC, 2000a:23; SADC, 2003:12). While the policy focuses mainly on general education matters, it does state that SADC will contribute to "developing competent professional pharmaceutical as well as support personnel through training in medicines supply management" (SADC, 2005:Internet source). Thus, while SADC acknowledges specific types of health care personnel, ECOWAS focuses only on the general training of health care workers. However, the ECOWAS document elaborates more on what needs to be achieved in terms of health care personnel training and retention, including means of reversing the "brain drain".

ii) The provision of psycho-social support and counselling

Given the stigma associated with HIV and AIDS (particularly regarding the high risk behaviour of men), and the increase in child-headed households (see discussion above in the relevant section on ECOWAS), the provision of psycho-social support and

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counselling is a crucial aspect of the HIV and AIDS policy. The SADC policy states that it has released regional guidelines and "best practice" reports providing guidance about the provision of psycho-social support and counselling, although no details are provided (SADC, 2003:13).[35] While this is an improvement on the ECOWAS policy document, which does not discuss this issue with reference to the general population at all, neither policy addresses issues such child-headed households or the necessity to create awareness amongst men about their high risk behaviour.

iii) Identifying methods of affordable drug procurement

The importance of ensuring affordable drugs for the individuals infected with HIV and AIDS is, as has been pointed out, strongly emphasised in the literature as one of the most essential components of health policies. Obstacles such as exorbitant prices and the interrupted supply of medicines are also acknowledged, as was demonstrated within the ECOWAS discussion above. SADC undertakes to provide "principles to guide negotiations with the pharmaceutical industry on medicines, including antiretroviral medicines for the treatment of HIV and AIDS", which must then be developed further by the health sectors of member states (SADC, 2000a:23; SADC, 2003:9). The statements on developing the domestic manufacturing capabilities of the region with regard to pharmaceuticals discussed above is also relevant here, as it would greatly improve the long term access to drugs for citizens in the region. The content of the SADC policy with regard to pharmaceuticals is basically identical to that of ECOWAS in that both policy documents state a commitment to play an advocatory and advisory role on behalf of member states, but do not provide any details of proposed actions. While the advice being offered by the regional bodies will certainly aid member states in their negotiations with the pharmaceutical companies, a greater level of detail and involvement may be more appropriate given the severity of the HIV and AIDS pandemic.

[35] It should be pointed out that psycho-social support and counselling is not addressed in the 2000 SADC policy document at all, and thus the lack of detail regarding "best practice" guidelines in the 2003 document is not surprising.

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iv) Access to medication for sexually transmitted diseases and opportunistic infections

The relationship between opportunistic infections, STDs, and HIV and AIDS has been pointed out in the literature in chapter one, and expanded on in the discussion of the ECOWAS policy above. The core concern is that HIV and AIDS deaths are predominantly attributed to opportunistic infections (such as STDs, TB or pneumonia), and the treatment of these infections are thus a crucial aspect of HIV and AIDS policies, especially in conjunction with ARV treatment. SADC states its intention to develop protocols on care and treatment, specifically noting the use of antiretrovirals (SADC, 2000a:23; SADC, 2003:12). The policy documents also mention nutritional therapies and the use of traditional herbs in treatment, as well as the establishment of guidelines for use throughout the region during clinical trials. Lastly, the SADC policy declares that it will assist member states in securing the "bulk procurement of drugs and medical supplies for HIV and AIDS" (SADC, 2000a:23; SADC, 2003:12). As stated in the previous indicator, SADC appears to be acting in an advisory capacity only.

Contrary to the ECOWAS document, SADC clearly articulates the connection between STDs, opportunistic infections, and HIV and AIDS, as advised by the literature (see chapter one).The link between HIV and AIDS and opportunistic infections such as tuberculosis and malaria is acknowledged by the following statement: "Many countries are now grappling with the intensifying impact of mature HIV and AIDS epidemics, and the related epidemic of tuberculosis, that together are reversing the hard won development gains of the past 50 years" (SADC, 2000a:4; SADC, 2003:2). Furthermore, SADC also recognises the value of incorporating traditional medicines into their health policy. While traditional medicines are not stressed within the literature, their inclusion in the policy documents of both SADC and ECOWAS shows initiative on behalf of the regional organisations to ensure an HIV and AIDS response that is adapted to the African context.

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2.5.3 Women and HIV and AIDS

SADC's stance on gender equality and women's rights far exceeds that of ECOWAS in general, and it is particularly noticeable within the context of the health policy documents. Within the guiding principles outlined in the policy document, it is stated that member states must "ensure gender mainstreaming into all policies and programmes being undertaken in relation to HIV and AIDS" (SADC, 2003:11). This stems from the statement made by SADC that "the majority of people living with HIV and AIDS in the region are women and that the social and economic status of women increases their vulnerability to HIV and AIDS. This principle acknowledges that the relationships between men and women are integral to the development of an effective response to the epidemic" (SADC, 2003:11).

This is reiterated by the statement that "the SADC response is based on the understanding that HIV and AIDS impact differently on women and men, are multi-sectoral and multi-dimensional, and that effective and relevant policies and programmes need to be developed in collaboration with partners at the national and regional level" (SADC, 2003:11). The policy notes the role of women in both society and the economy, and the detrimental influence of HIV and AIDS on their participation. Further, there is an acknowledgement that "due to the disadvantages suffered by women, illiteracy rates are generally higher among women than men, and this has implications on the range of communication strategies that can be used to deliver information to the population, especially women" (SADC, 2000a:6).

This is followed by the assertion that "women account for an overwhelming share of agricultural labour, are responsible for the upbringing and socialisation of children, including the passing on of essential skills to the next generation. As the majority of people living with HIV and AIDS in the SADC region are women, many of the activities being undertaken by women are threatened by the epidemic, and the consequences for society are extremely serious" (SADC, 2000a:17; SADC, 2003:18). However, no details are provided about programmes which may counteract this.

Lastly, the policy document states that there is a higher rate of school dropouts amongst girls as a result of HIV and AIDS, and that "women, particularly the girl-child and

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elderly women, disproportionately bear the brunt of the epidemic with increased workloads especially in the provision of care and support with decreasing resources" (SADC, 2000a:4; SADC, 2003:5). The conclusion is thus drawn in the policy document that "gender will be mainstreamed into all activities, and programmes will be developed with regional partners to reduce the vulnerability of women to HIV and AIDS through policies and programmes that increase the socio-economic status of women" (SADC, 2003:21). It is clear from these statements that the SADC policy document is far more gender sensitive than that of ECOWAS, clearly articulating the added burden on women created by HIV and AIDS.

The awareness of SADC about the need for women specific programmes is reflected in the importance placed on PMTCT within the policy document, which acknowledges that very little groundwork has been done in this regard. The body undertakes to "establish mechanisms to facilitate regional technical discussions, develop regional guidelines and facilitate the sharing of best practices in the areas of PMTCT" (SADC, 2000a:23; SADC, 2003:13). While this is still a relatively vague statement, it is far more explicit than anything written within the ECOWAS document about this critical issue.

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2.5.4 Summary of the SADC Policy in terms of Policy Indicators

The SADC policy documents address more of the indicators discussed in chapter one than the ECOWAS document, and generally elaborate more on how to achieve the stated goals. Within education and awareness campaigns, references are made about the effect which HIV and AIDS has on education, which does not appear in the ECOWAS document. While nutritional information drives are discussed in both policies, the use of local produce to further the goal of eradicating malnutrition is only mentioned in the SADC policy. The SADC policy, unlike the ECOWAS document, takes a strong stance on workplace programmes, specifically referring to the *Code on HIV and AIDS and Employment*, which outlines the regional grouping's views on employer participation in HIV and AIDS prevention and care.

In accordance with the literature (see chapter one), both documents include migratory populations as a high risk group, although SADC expands its mandate in this regard by

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including long distance truck drivers, air, rail and maritime workers, and commercial sex workers. The provisions made by SADC with regard to sex worker interventions far exceed those of ECOWAS, whose policy document does not mention any activities for this indicator emphasised in the literature. SADC proposes various actions, specifically mentioning the Beira Corridor Project and programmes at construction sites and weigh stations from where the sex workers operate. The vulnerability of the youth to HIV and AIDS is addressed by both ECOWAS and SADC, although the latter provides more details about proposed activities, such as targeted employment programmes.

The strengthening of health care infrastructure is discussed in greater detail in the SADC documents, as ECOWAS only addresses the scaling up of laboratories and quality control measures. While home-based care is not stressed within the literature, the SADC policy provides some guidance to member states regarding the training of personnel to deliver these services, while ECOWAS ignores this issue completely. As mentioned within the discussion of this indicator above, this may be due to the acknowledgement of the severely limited resources of ECOWAS member states. However, SADC states are equally poor and may be demonstrating some optimism that they may secure funding for the costly enterprise of providing home-based care.

Turning to the drugs and services needed for effective treatment, the first indicators based on the literature (see chapter one) advise that the number of trained health care workers should be increased. SADC states its commitment to maintaining the human capital in the region, and specifically notes the need to train more pharmaceutical professionals. ECOWAS pays more attention to the training of general health care personnel, and means of reversing the “brain drain”; an issue which SADC does not address directly. The correlation between HIV and AIDS, and opportunistic infections and STDs, is acknowledged by SADC, in contrast to the ECOWAS policy which does not address the issue at all. The SADC document also contains suggested activities for treating these opportunistic infections, such as the bulk procurement of the necessary medication and the use of traditional medicines. While the ECOWAS document also refers to the use of traditional medicines in HIV and AIDS treatment policies (see relevant section above), these allusions are not made within the context of STDs or opportunistic infections.

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Despite a strong emphasis in the literature on the provision of condoms, no attention is paid in the latter SADC policy to the use of condoms as a preventative measure. As discussed in the sections on prevention in both the ECOWAS and SADC analysis, this could be attributed to the moral and cultural values of donor bodies, although the prevalence rates in SADC particularly put strain on this justification of the omission. SADC also does not address the provision of VCT, and as pointed out in the discussion of the ECOWAS policy, this is problematic given the high incidence of child-headed households brought about by HIV and AIDS, and the urgent need to address high risk behaviour amongst men particularly.

Lastly, in terms of gender, the SADC policy document acknowledges the influential and disproportionate impact of HIV and AIDS on women, as well as the subordinate status of women which impacts directly on containing the spread of the disease. This position is consistent with the discussion in chapter one of SADC's generally superior commitment to gender issues in comparison with ECOWAS, with a greater degree of understanding reflected within the policy documents of the regional body, including this health policy. Thus, SADC shows a greater commitment on paper to addressing the effects of the disease with regard to women.

Based on the HIV and AIDS literature, the SADC policy document largely reflects the most important aspects which should be incorporated into a health policy document. The ECOWAS policy in comparison is a far more superficial document, lacking the necessary level of elaboration.

2.6 CONCLUSION

Within the parameters set by the public policy and health policy discussion, and the indicators developed from the literature in chapter one, this chapter has outlined and compared the health policies of ECOWAS and SADC. It has been shown that both regional organisations follow a multi-sectoral approach, utilising similar central decision making bodies which seek to coordinate the health policies of their member states. Both are also structured in a similar manner when considering the division of responsibilities within the health structures. The decision by ECOWAS to assign the

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responsibility of dealing with the pandemic to a dedicated body, namely WAHO, has allowed for the synchronisation of the health policies in the region. SADC has opted to make policy decisions at a multilateral level within the regional meetings, forming Directorates to assist in the implementation of the programmes at the national level within member states. However, the sheer volume of initiatives being run in the region lends itself to some duplication. The policy documents of ECOWAS and SADC acknowledge a range of health issues affecting their region, particularly tuberculosis and malaria, and their commitment to curbing HIV and AIDS is displayed through the signing of documents such as the UNGASS Declaration and the Millennium Development Goals.

Neither ECOWAS nor SADC is involved with the implementation of the guidelines for the region, which falls to the member states themselves. However, both bodies aim to enable member states to achieve effective strategy implementation by playing an advisory role with development partners, as was discussed within the treatment indicators, where both organisations stated their willingness to be involved in negotiations with the pharmaceutical companies.

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Using the indicators explored in chapter one, it becomes apparent that while both regional groupings have made efforts to combat the pandemic, SADC has the more comprehensive policy of the two, especially in terms of workplace interventions (particularly for sex workers) and in the provision of home-based care. However, ECOWAS has shown greater strides in the policy in terms of health care personnel training. Furthermore, awareness of gender issues is hardly acknowledged by ECOWAS, while SADC shows a clear grasp of the disproportionate effect of the pandemic on this vulnerable, high risk sector of the population, with special reference to PMTCT. Both regional organisations emphasise the exploration of traditional medicines within the context of HIV and AIDS. Both policy documents contain a strong emphasis on the youth, but are equally vague on the means by which member states can accomplish the stated goals of reducing the HIV prevalence rate and affecting behavioural changes. Despite the emphasis on the use of condoms within the literature on HIV and AIDS, neither the ECOWAS nor the SADC policy documents mention condom provision or VCT services for the general population, which are also identified in the literature. The omission of these aspects may be explained by the

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moral and cultural values of donors, but as was stated, the prevalence rates of HIV and AIDS within both regional groupings raises questions about the validity of this rationalisation.

The vague references in both policy documents, with regard to infrastructure development, affordable drug procurement, condom use and VCT services (amongst others), have both positive and negative implications for the formulation of health policies in their respective member states. On the one hand, the broad guidelines allow member states greater leeway in devising a tailored response to the disease, taking varied local contexts into consideration. On the other hand, given the magnitude of the pandemic and the limited resources of these states, firmer guidance from their respective regional organisations would not go amiss.

The next chapter examines the policies of ECOWAS and SADC regarding the funding for the programmes being administered by the regional bodies. This entails a discussion of the various multilateral and bilateral partners involved, particularly NGOs and international bodies such as the UN and World Bank. The role of member states in the funding of regional activities is also examined.

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CHAPTER 3: FUNDING OF HIV AND AIDS POLICIES OF ECOWAS AND SADC

3.1 INTRODUCTION

> *"The AIDS pandemic-unexpected, unexplained, unspeakably cruel-presents us with a tragedy we can barely comprehend, let alone manage ... AIDS leaves poor societies poorer still, and thus even more vulnerable to infection. It brings in its wake discrimination, prejudice, and often violations of human rights. It is taking away not only Africa's present, but also its future. ... The challenge can not be met without resources. But donors can and must do more than that. They must adopt policies and priorities that meet the needs of the countries most affected. And they must raise awareness in their own countries that AIDS is not over. That AIDS is far more than a medical problem, that AIDS is a threat to an entire generation-indeed, a threat to human civilization as a whole."* - Kofi Annan, UN Secretary-General (quoted by Collins, 2001:Internet source).

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The previous chapter outlined the policy guidelines provided by ECOWAS and SADC on the actions to be undertaken within the member states of the regional organisations. Using indicators based on the literature, a broad range of activities relating to education, awareness and prevention campaigns emerged, and a number of treatment programme objectives were identified.

The literature on public policy emphasises the establishment of the financial implications of the policies during the formulation process (see Anderson, 2000). In particular, it highlights the long term cost benefits of prevention and treatment (see Bonnel, 2000; Bowen, 2005; Phillips, 2004). The statements made by both ECOWAS and SADC in their respective policy documents as to how member states could secure the funding necessary for effective implementation are therefore of the utmost importance.

This chapter examines the guidelines provided by the regional organisations on how these programmes are to be funded. These guidelines incorporate contributions from both the member states of the regional organisations and from a variety of donors, both

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bilateral and multilateral. The recommendations in the policies provide an indication of the role which ECOWAS and SADC play in the crucial area of securing funding for the implementation of programmes within member states. As will be made apparent, this role does not necessarily involve funding the implementation of HIV and AIDS programmes from regional coffers, but rather advocating means of maximising donor contributions, or functioning in an advisory capacity.

The examination of budgetary allocations and the mechanisms for funding to be used by member states is useful as it provides a clearer gauge of the priority placed on certain actions (such as an emphasis on prevention programmes), as well as supplying a better representation of how the regional organisations and their member states plan to fund the implementation of their policies. It is also key to assessing the sustainability of the programmes (Hickey, 2005:4). This view is expanded upon in a report by UNAIDS (2005b:9), which states that "understanding the flow of financial resources – from funding source to actual expenditure- is an essential part of monitoring and evaluating the response to the AIDS pandemic. Identifying the source of funds, be they from a range of international sources or available domestically, allows us to assess the shared responsibility for funding across stakeholders, partners and affected persons. Expenditure can give an indication of efficiency, equity and sustainability of programmes" (UNAIDS, 2005b:9).

Further, with the decline in life expectancy in developing states (after decades of improvement), the WHO argues that the "way a health system is financed is a key determinant of population health and well-being" (WHO, 2006b:Internet source). The public health care expenditure of these developing states is further described as "insufficient to ensure equitable access to basic and essential health services and interventions … because people can not afford to pay or because governments can not afford to provide them" (WHO, 2006b:Internet source). According to the UNGASS Agreement (see chapter one), developing states should be dedicating 15% of their annual budgets to overcoming HIV and AIDS, and the need to adequately address these funding issues is reiterated when considering that only 8% of people residing in Africa requiring ARV treatment by the end of 2004 were receiving it (WHO, 2004:Internet

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source).[36] This is reflected in the allocation of funds between interventions, which shows that until 2003 a minuscule proportion of the budget of developing African states was spent on treatment programmes; the focus was on management and prevention activities (see Figure 3.1 below). This shortfall can be squarely attributed to the lack of resources and infrastructure. However, this split focus is being addressed within the policy documents of both ECOWAS and SADC (as will be shown). While prevention activities still dominate the strategies outlined in both documents, treatment programmes are receiving more attention, as was illustrated in chapter two. This acknowledgment of the disproportionate emphasis on prevention activities to the detriment of treatment programmes is also reflected in the changes made to the health policies of member states, as will be shown in the case studies of Nigeria and South Africa.

Furthermore, based on the current rate of infection, revised estimates have been calculated for low and middle income states. In order to achieve effective care and treatment programmes, US$14.9 billion will be required annually from 2006. By 2008, this rises to US$22 billion (UNAIDS, 2005a:Internet source). This is broken down into "US$11.4 billion for prevention, US$5.3 billion for care and treatment, US$2.7 billion for orphan support, US$1.8 billion for programme costs and 0.9% for human resources" (UNAIDS, 2005a:Internet source). Of these funds, an estimated 55% will be spent in sub-Saharan Africa. Even with international donor assistance, these targets are unlikely to be met; by 2004, only US$6.1 billion in AIDS funding reached developing states, which is far below the calculated necessary minimum (UNAIDS, 2005a:Internet source). It is also important to note that these cost projections do not take the cost of developing infrastructures or expanding health services into account.

[36] For a comparison of ARV treatment received in other regions of the world, see Appendix 3.1.

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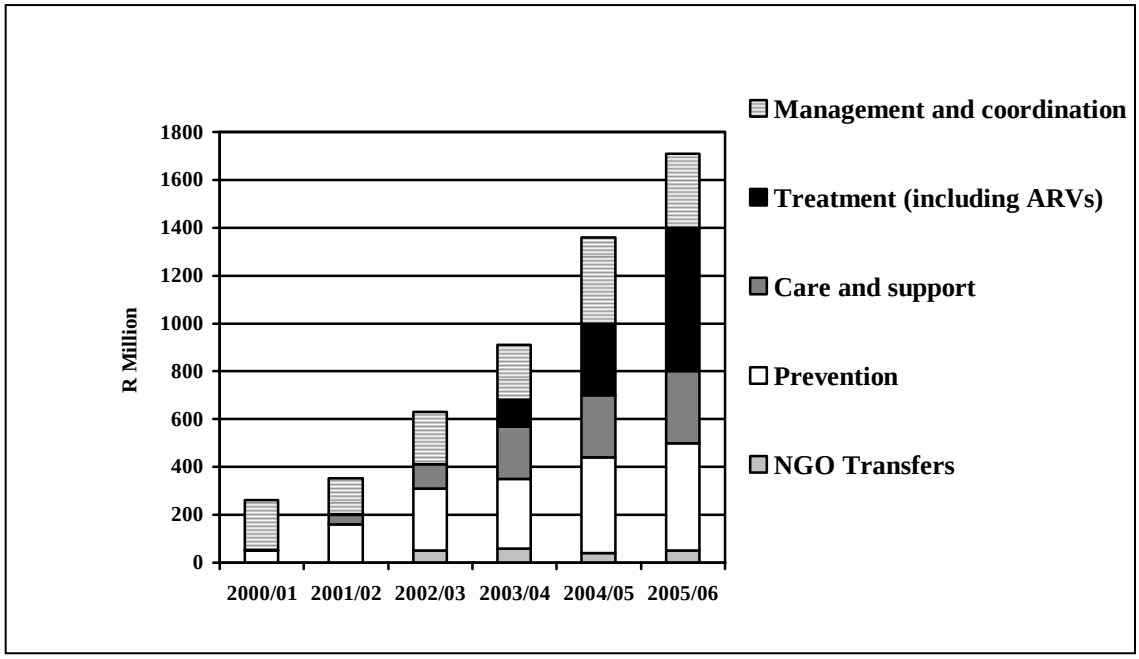
Figure 3.1: Allocation of Funds between Interventions in Africa



(Adapted from Hickey, 2005:17).

Thus, this chapter will examine the extent to which ECOWAS and SADC participate in directly or indirectly contributing to the funding of the programmes being implemented in the region. This will be done by first comparing the recommendations for funding within the health policies of these two organisations (including how these resources are currently being spent), and the future funding initiatives identified within the documents. Next, partnerships which are coordinated by the regional organisations of ECOWAS and SADC are considered, as it will be shown that member states do not have the resources to implement the recommended HIV and AIDS programmes with the limited funds at their disposal. The involvement of partners such as the ECA Hub and the like are thus a critical consideration in this discussion. Lastly, the contributions of bilateral and multilateral partners are included, as these actors supply a significant portion of the capital needed to implement policies within both the region, and member states specifically. Community-based organisations (CBOs) and the private sector are also taken into account, in an effort to provide a more complete picture of the funding mechanisms advocated by the regional organisations of ECOWAS and SADC.

As indicated in chapter one, funding will be examined according to two broad aspects, namely; funding received from member states of the regional organisations, and money (and other aid) obtained through donor partners such as USAID, the UN, and the like.

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Individual state contributions to the regional organisations, as well as health expenditure relative to GDP and infected population statistics are considered first. Next, an overview of the donor bodies is provided, followed by a comparison of the aid received by member states from these bodies, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), USAID and the World Bank. This comparison is broken down in terms of allocation by state, and regional grouping, as well as noting the express purpose for certain grants.[37] Funding from NGOs will also be included as this source of revenue is a significant enabling factor for many programmatic actions of the regional organisations.

Some mention must also be made of debt relief for the purposes of funding AIDS programmes. The crippling effect of high debts in African states, introduced in chapter one, is considered by donors in the granting of aid. Conditions may be attached to the debt relief received by states, such as the stipulation that the money must be directed towards dealing with HIV and AIDS. Thus, while some aid may not necessarily be directed at HIV and AIDS, it provides the recipient states with the resources they need to implement more sustainable policies for dealing with the pandemic, such as the development of infrastructure for essential service delivery.

The most prominent example of this is the Heavily Indebted Poor Country Initiative (HIPC), through which recipient states are reallocating the resources made available by debt relief programmes to address HIV and AIDS more effectively (UNAIDS, 2005a:Internet source). The scope of this relief was expanded by almost US$55 billion at the latest G8 Summit in Gleneagles, Scotland in 2005, although a number of contentious conditions were attached (Bretton Woods Project, 2005:Internet source). Conditions linked to liberalisation and privatisation have been included since the inception of the project, and were criticised for delaying the relief urgently needed by target states. A number of new conditions were added at this latest summit, aimed at curbing corruption, poverty, and the misuse of aid (Bretton Woods Project, 2005:Internet source). Furthermore, no substantial new money is being given for this new round of debt relief, with some G8 members insisting that the World Bank uses its

[37] While recent grants are included, all comparisons (unless otherwise indicated) are based on the 2002 fiscal year as it is the latest complete information available.

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own resources to fund the new concessions. This could then result in cuts in other crucial programmes.

3.2 ECOWAS FUNDING GUIDELINES

The member states of both ECOWAS and SADC pay membership fees which are calculated individually according to a range of factors, primarily based on their GDP. However, these funds are chiefly used for the administrative functions of the regional institutions, and are not intended for the implementation of programmes. The administrative budget of the organisation covers personnel and operating costs, and provides for institutional development such as the strengthening of infrastructure and political advocacy (WAHO, 2003:38). The policy document describes the budget as "sizeable", although it is also expected to extend to the creation and expansion of the "technological capacity necessary to act as the hub of sub-regional health information" (WAHO, 2003:38). It is envisaged that the efficient management of the region's information will improve the effectiveness of WAHO, and that there will be "substantial returns on its technology-related expenditures in the form of positive health impact and visible integration of health in the sub-region" (WAHO, 2003:38).

It is stated that certain programmes are jointly funded by ECOWAS and WAHO partners, with a specified percentage (not indicated within the policy document) to be granted from ECOWAS funds (WAHO, 2003:38). However, the ECOWAS Secretariat has been unable to supply its full share of resources pledged to WAHO, limiting the ability of WAHO to effectively implement its mandate, and specific programmes which are to receive these funds are not identified. Further, as member fees are earmarked primarily towards administrative duties, the majority of these funds are drawn from donor grants, which are discussed later in this chapter. International partners thus provide the bulk of the remaining funds as part of WAHO's strategy to secure sustainable alternatives to the support of the ECOWAS Secretariat.

Within the WAHO Strategic Plan document, funding is allocated for each major priority intervention area, with further breakdowns for specific activities within some of these categories. The administrative budget allotments for institutional development activities are: information management (US$3.97 million), capacity building (US$475

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000), political advocacy (US$140 000), and infrastructure development (US$1.33 million). The budget allocated by WAHO to address HIV/AIDS/STI/TB is US$3.5 million (17.7% of the total budget), while drugs and vaccines were allocated US$1.85 million (WAHO, 2003:35). Comparative to the other priority areas, malaria received US$1.18 million (5.9%), the control of epidemics received US$325 000 (1.6%), the prevention of blindness was allocated US$2.88 million (14.5%), training costs were estimated at US$1.6 million (8.2%), nutrition costs were placed at US$1 million (5.1%), and child survival was given US$1.52 million (7.6%), with the total budget coming in at US$19.783 million (WAHO, 2003:23). However, as stated above, this money is not distributed to member states; it is for the administration and coordination of regional programmes, not for policy implementation, and these funds are intended to be sufficient for overseeing the administration necessary at the regional level for the duration of the policy (2003-2007).

ECOWAS is not forthcoming in its policy document on specific partnerships with donors which are underway in the region, neither does the policy document discuss particular cross-border initiatives, although a number of such initiatives are active within the region.[38]

Thus, the ECOWAS strategy is to provide administrative assistance to regional programmes, and to support member states in negotiations with donor bodies. However, the onus remains on member states to secure the necessary funding for programme implementation.

3.3 SADC FUNDING GUIDELINES

SADC's financial structure is identical to that of ECOWAS, in that both regional bodies receive dues from member states which are used predominantly to deal with administrative functions and coordination. However, the SADC policy document does state that "the budget for other regional activities to be implemented by member states will be developed at a later stage. Resource mobilisation will, therefore, be a primary activity at the Secretariat" (SADC, 2003:15). In other words, at the moment, SADC

[38] One such programme is the Action for West Africa Region (AWARE HIV/AIDS), which focuses on sex workers, migrant workers and truck drivers. For more information see PSI (2005:Internet source).

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member states do not receive funding for their HIV and AIDS programmes from the regional body either. It should be noted that the SADC HIV and AIDS Strategic Framework is more forthcoming about both the manner in which programmes in member states could be funded, as well as providing more details about the regional funding mechanisms with which the body is directly involved.

The budget outlined within the policy document for the coordination of activities at the Secretariat level is about US$10.5 million over a period of four years (2003-2007). The breakdown for the SADC Secretariat structures is as follows; Department of Strategic Planning, Gender and Policy Harmonisation (25%), Directorate for Social and Human Development and Special Programmes (26%), Directorate for Trade, Industry, Finance and Investment (14%), Directorate for Infrastructure and Services (16%), Directorate for Food, Agriculture and Natural Resources (16%), Organ on Politics, Defence and Security (4%) (SADC, 2003:15).

The budget for the span of the strategic framework totals US$22.77 million, and runs for the same period of four years (2003-2007). The funds are divided among six areas, with the bulk of funds (48.3%) going towards the scaling up of cross-border initiatives (US$11 million), followed by the monitoring and evaluation of global and regional commitments (US$3.44 million or 15%), capacity building and HIV and AIDS mainstreaming (US$3.32 million or 14.9%), facilitation of technical responses, resource networks, collaboration and coordination (US$2.82 million or 12.4%), policy development and harmonisation (US$1.97 million or 8.6%), and the SADC Secretariat HIV and AIDS Workplace Programme (US$220 000 or 1%) (SADC, 2004:5). It should be pointed out that not only are specific concessions made for regional cross-border initiatives, but also that the administration of these programmes receives the highest allotment of funding. This is a stark contrast to the vague descriptions within the ECOWAS policy document.

SADC acknowledges the limitations that a severe lack of resources places on the development and scaling-up of policy programmes, reiterating the need to secure new sources of sustainable funding (SADC, 2003:15). As with ECOWAS, SADC member states retain the responsibility for formulating and implementing their HIV and AIDS policies according to the programmes of the regional organisations. However, as

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pointed out above, without the necessary funds or the prospect of sufficient funds, the drafting of policy programmes on HIV and AIDS would be a futile exercise. SADC has noted that the SADC Strategic Framework serves as a complementary tool to the multi-sectoral response of member states to the pandemic, but added that "taking forward the operationalisation of the revised SADC Framework on HIV and AIDS will ultimately depend on the mobilisation of resources" and that "resources will always be a constraint on what can be achieved, but financial and human resources are increasingly becoming available to the region in support of its response to HIV and AIDS. Many bilateral donors are increasing their funding for HIV and AIDS in recognition of the magnitude of the challenges confronting the countries of the region" (SADC, 2003:15).

In terms of resources for women-specific programmes, only SADC makes provisions within the policy document. The Department of Strategic Planning, Gender and Policy Harmonisation is specifically mentioned in terms of resource mobilisation, particularly the role this department is expected to play in "identifying and mapping potential resources and the future funding plans of donors" (SADC, 2003:15). The international aid being mobilised for women-specific programmes is largely being devoted to education campaigns, increasing access to antiretroviral treatment, and general economic development, with special attention being focused on gender equality. This commitment to highlighting women's issues can be seen in the 2004 launch of the Global Coalition on Women and AIDS by UNAIDS, which is involved in advocacy programmes in the many states in which UNAIDS is active, including both ECOWAS and SADC member states (UNAIDS, 2005a:Internet source). However, it should be reiterated that only SADC makes direct mention of funding for women-focused activities within the policy document. This continues the trend established within the policy analysis in the previous chapter, with ECOWAS trailing behind the progress made by SADC in terms of gender mainstreaming.

SADC indicates within the policy document that it intends to establish a Regional Fund which will assist in securing funding for both the regional and national programmes being run within the area (SADC, 2003:15). This fund will receive predetermined annual amounts from member states, and "additional resources will be raised from the

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private sector both in the region and globally. International cooperating partners will also be requested to contribute to the Fund" (SADC, 2003:16).[39]

Within the regional organisation, over US$20 million was raised for HIV and AIDS interventions, with its disbursement spread over three years ending in 2006 (SADC, 2003:10). The SADC Department for International Development secured US$12 million for a multi-country health intervention focusing on Botswana, Lesotho, Namibia and Swaziland. The European Union has provided over US$8 million to "support the implementation of the regional multi-sectoral response" (SADC, 2003:10). While similar cross-border initiatives are in operation within ECOWAS, they are not discussed within the WAHO policy document, and can therefore not be included in this study.

The bulk of the funding for HIV and AIDS programmes in SADC is drawn from donors such as the "World Bank's MAP Programme, the US President's Emergency Plan for African Relief (PEPFAR) … and the Global Fund for AIDS, TB and Malaria", as well as the HIPC, and Official Development Assistance (SADC, 2003:8; SARPN, 2003:Internet source). Further, assistance has been provided to some members of SADC through a range of other bilateral and multilateral partners (SADC, 2003:8). Other stakeholders contributing to the running of the programmes include civil society organisations, the private sector, organised labour and businesses, which provide both financial and technical assistance. While these resources are predominantly aimed at supporting national programmes, the "possibility exists to access more of these [funds] by regional organisations such as SADC" (SADC, 2003:15).

The manner in which SADC partner, the ECA HUB, operates is indicative of the approach to be followed by member states. [40] As the Trade Hub, like member states, does not have the resources to effectively implement a regional strategy on its own, it

[39] While the SADC policy document was published in 2003, this Regional Fund is not yet operational.

[40] The East and Central African Global Competitiveness Hub (ECA Hub) is a trade organisation which aims to stimulate growth in the region to increase competitiveness in the regional and global trading market (Phillips, 2004:Internet source). Membership of this economic grouping includes both COMESA and SADC member countries, making it one of the most comprehensive HIV and AIDS initiatives within sub-Saharan Africa in terms of membership. The ECA Hub is placing a spotlight on the role of trade in poverty reduction, which is cited as a primary concern in the battle against HIV and AIDS (ECA, 2005:Internet source).

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has passed this responsibility to its primary partner; Family Health International (FHI). This well established international public health NGO is involved in research, education and a variety of health care services (FHI, 2005a:Internet source). Working together with client states, in-country and international NGOs, Multi-National Corporations (MNCs), as well as a variety of donor partners, Family Health International provides programmes to overcome specific obstacles such as those faced by transport and sex workers. Another collaboration with the ECA Hub is operated through the African Growth and Opportunities Act (AGOA), which is seeking means to develop and maintain trade related HIV and AIDS projects. One example of this approach is the export of handicrafts created by HIV positive workers (Phillips, 2004:Internet source). These efforts to increase the cooperation of corporate, union and professional partners in creating and maintaining effective workplace programmes for both the prevention and treatment of workers is reflective of the approach being pursued by the African region as a whole (Phillips, 2004:Internet source). The ECA Hub relies on the current donor programmes such as those of USAID to meet the challenges facing the region, although the responsibility for the success of the ECA Hub HIV and AIDS strategy remains with Family Health International (Phillips, 2004:Internet source).

Before attention is turned to the contributions of bilateral and multilateral donors, the International Partnership Against AIDS in Africa (IPAA) should be discussed. Although it falls under the management of UNAIDS, it is predominantly organised by regional African organisations, and will be examined below.

3.4 INTERNATIONAL PARTNERSHIP AGAINST AIDS IN AFRICA (IPAA)

A coalition of African governments, the United Nations, donors, and the private, labour and community sectors have united to form the IPAA, to examine the effectiveness of existing HIV and AIDS programmes and the manner in which they are funded (UNAIDS, 2005a:Internet source). During the 1999 OAU Summit in Algiers in July, 20 African states pledged their support for the partnership, signing a Cooperation Agreement with UNAIDS three months later (Collins, 2001:Internet source). Finance and planning ministers provided their endorsement for the partnership during the 1999

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annual meeting of the Economic Commission for Africa in Addis Ababa (Collins, 2001:Internet source). Participation has swelled to 40 states in various stages of HIV and AIDS policy implementation (UNAIDS, 2005a:Internet source). ECOWAS and SADC have both declared their allegiance to the IPAA (Collins, 2001:Internet source).[41]

The private sector, encompassing multinational corporations, pharmaceutical companies and trade union associations, are also participating in the IPAA initiative in educational, financial and technical programmes in an effort to minimise the impact of the disease on employees and members, as it impacts their businesses directly (Collins, 2001:Internet source).

UNAIDS serves as the IPAA's secretariat, and apart from acting as a coordinating body, aims to encourage social and political mobilisation on a previously unimagined scale. The partnership seeks to identify gaps in current national programmes, assign clear responsibility for objectives, and ensure that the necessary resources are made available for the effective implementation of these strategies (Collins, 2001:Internet source). It further endeavours to eliminate duplication, replicate successful programmes, and promote "a linked response among sub-regional, regional and international resources and initiatives" (Collins, 2001:Internet source).

The IPAA aims to allow a greater percentage of national resources to be used in the fight against HIV and AIDS by taking advantage of the debt relief offered by the enhanced Highly Indebted Poor Countries (HIPC) initiative (Collins, 2001:Internet source). Expanding the technical capacity of the region is also identified as a priority, together with the scaling-up of advocacy programmes. The results of the IPAA's strategy can be seen in the actions of the Malawi government, who pledged US$100 million in March 2000 towards the implementation of their national HIV and AIDS programme, a much higher sum than most African states had previously allotted to combating HIV and AIDS (Collins, 2001:Internet source). The IPAA is also the

[41] Regional economic development organisations and political bodies which have declared their allegiance to the IPAA include the African Development Bank (ADB), the Economic Community of Central African States (ECCAS), COMESA and the East African Community (Collins, 2001:Internet source).

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administrator for the Multi-Country AIDS Programme for Africa (MAP), which is managed by the World Bank, and is discussed below (UNAIDS, 2005a:Internet source).

3.5 MULTILATERAL AND BILATERAL DONOR BODIES

As the discussion above shows, the ability of ECOWAS and SADC to provide funding to member states for the implementation of HIV and AIDS programmes is very limited. Thus it is important to discuss the bodies which make up this shortfall, as it has a direct bearing on the comparison of the health policies of the two regional organisations in that without the availability of sufficient funding, the proposed programmes would not be feasible. The contribution of these actors will be made more apparent in the case studies in the following chapter. This section will look at the bodies dealing primarily with HIV and AIDS within the UN, followed by a discussion of the other major donor bodies involved with ECOWAS and SADC states, including USAID and PEPFAR.

3.5.1 UNAIDS

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A unified budget and work plan covers HIV and AIDS programmes at the regional level, but does not reflect all the country-level initiatives with which the body is involved. This unified budget is divided into three components. The first refers to the "regular budget or general resources of the co-sponsors for HIV and AIDS-related activities" (namely the ten UN bodies comprising UNAIDS). The second component deals with funds raised by the secretariat for specific programmes, and the third budget component conveys information about "supplemental" funds elicited by other agencies or involved parties (UNAIDS, 2005a:Internet source).

The consortium of UNAIDS agencies below presented a budget of US$818.1 million during the 2004-2005 fiscal year, to be used for the running of HIV and AIDS programmes at the country-level. The highest spender was UNICEF (US$280 million), followed by the World Bank (US$200 million), UNDP (US$120 million), WHO (US$98 million), UNFPA (US$75.6 million), UNESCO (US$18 million), ILO (US$14 million), with the UNODC spending the least at US$12.5 million (UNAIDS, 2005a:Internet source).

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The distribution of the above resources between regions reflects the severity of sub-Saharan Africa's needs, with this area receiving 43% of the total funds, followed by Asia (28%), Latin America and the Caribbean (17%), Eastern Europe (9%), with North Africa and the Near East receiving the least (1%). These funds are provided by, amongst other parties, 32 donor states. Ten states endow the body with 85% of its working budget, namely Belgium, Canada, Denmark, Finland, Japan, the Netherlands, Norway, Sweden, the UK, and the USA (UNAIDS, 2005a:Internet source).

3.5.2 Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

The establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was precipitated by UN Secretary-General Kofi Annan at the 2001 Organisation of African Unity Summit in Abuja (UN, 2001:Internet source). The appeal for the Fund stemmed from commitments made during 2000 at the Okinawa Summit of G8 states, which was devoted to developing "new financial mechanisms for increasing the flow of resources to developing countries" which would "focus on HIV and AIDS, tuberculosis and malaria, would promote an integrated approach to the three diseases, and would be geared at strengthening and expanding existing development processes rather than designing new projects" (UN, 2001:Internet source).

This public-private partnership became operational in 2002, and is an independent body which works closely with the range of agencies falling under the umbrella of the UNAIDS consortium (UNAIDS, 2005a:Internet source). These include representatives from the WHO and the WB, with the WB serving as the trustee (GFATM, 2005:Internet source). The GFATM is a financing body made up of governments, affected communities, civil society, and the private sector, and does not implement any programmes, but coordinates multilateral and bilateral initiatives around the world concerned with development and health issues (GFATM, 2005:Internet source). All ECOWAS states (with the exception of Cape Verde) and all SADC states (with the exception of Mauritius) have received grants from the Global Fund.

The Global Fund places an emphasis on local ownership, ensuring that the national governments of host states retain control of the funded programmes (GFATM, 2005:Internet source). This is done through Country Coordinating Mechanisms

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(CCMs) which bring together the various partners at the country-level, who then submit grant proposals and monitor their implementation (UNAIDS, 2005a:Internet source). Thus, governments, civil society organisations, and all other involved parties demonstrate where the financing gaps are in current HIV and AIDS, TB and malaria programmes, and, based on the evidence, funds are allocated over two years, with the full duration of the grant running for an average of five years (GFATM, 2005:Internet source). For example, Nigeria received US$180 million to scale up the national HIV and AIDS treatment and care programme, and South Africa was granted US$66 million to expand an HIV and AIDS initiative in the Western Cape (GFATM, 2005:Internet source). All disbursements are awarded in this way, through a series of five rounds which began in April 2002.[42]

The Secretariat of the Global Fund has decreed that 60% of aid granted should be devoted to HIV and AIDS programmes. Viewing the breakdown of aid disbursements by disease (Table 3.1 below) shows that HIV and AIDS activities receive the bulk of the body's resources (OECD, 2004:Internet source). It should also be noted that the particular afflictions of each region are taken into account in the disbursement of funds; ECOWAS has a higher malaria prevalence rate (13.09%) than SADC, and thus applies more of its funds towards programmes addressing this problem. SADC clearly receives the bulk of HIV and AIDS targeted funds, as its member states have a proportionately higher average prevalence rate of 18.05% (see Table 3.1 below). This needs-based assessment carries through to general disbursements too, with sub-Saharan Africa receiving in excess of 55% of the Global Fund's total resources since the inception of the body.

[42] The funds awarded to each ECOWAS and SADC state over these five rounds, as well as the programmes towards which the resources went, can be viewed in Appendix 3.2.

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Table 3.1: Summary of Global Fund Aid Disbursements

	ROUND 1 April 2002	**ROUND 2** Jan 2003	**ROUND 3** Oct 2003	**ROUND 4** June 2004	**ROUND 5** Sept 2005
Distribution by Region (% of Total)					
Sub Saharan Africa	55%	64%	59%	64%	74%
Asia, Middle East, North Africa	27%	16%	20%	23%	17%
Latin America, Caribbean, Eastern Europe	18%	20%	21%	13%	9%
Distribution to Regional Groupings					
ECOWAS	13%	15%	9%	1%	28%
SADC	70%	36%	47%	4%	24%
Percentage spent on HIV/AIDS					
Africa (Total)	79%	61%	73%	6%	57%
ECOWAS	89%	68%	36%	44%	7%
SADC	86%	77%	73%	77%	64%
Percentage spent on TB					
Africa (Total)	10%	7%	4%	0.3%	20%
ECOWAS	-	2%	12%	8%	27%
SADC	9%	2%	1%	2%	26%
Percentage spent on Malaria					
Africa (Total)	11%	33%	23%	4%	23%
ECOWAS	8%	32%	52%	54%	3%
SADC	15%	16%	26%	21%	10%

(Own calculations based on GFATM (2005:Internet source). A breakdown of monetary contributions from the Global Fund to ECOWAS and SADC member states is included in Appendix 3.2).

The overall expenditure targets for HIV and AIDS, malaria and tuberculosis can be broken down by the activities or actions for which they are used, namely drugs and commodities (49%), human resources and training (20%), physical infrastructure (13%), monitoring and evaluation (6%), administration (7%), and other miscellaneous expenses (6%) (GFATM, 2005:Internet source).

In its first year, the Global Fund received US$400 million from France, the UK, and the US, and from non-state contributors such as Credit Suisse and the International Olympic Committee (UN, 2001:Internet source). In the subsequent years, more than US$47 billion has been committed from various donors, which will be submitted until the end of 2008. It is estimated that the first two rounds of grants will total US$1.5 billion, providing assistance to approximately 154 programmes in 93 countries. The US is the most generous contributor to the Fund, accounting for approximately one third of the Fund's resources in 2004 (USDS, 2005:82). While the US pledged US$550 billion for the fiscal year 2004, it was able to appropriate only US$430 million due to the current US laws which restrict its share of contributions to the Global Fund to one third

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of the total contributions made by other donors (UNAIDS, 2005a:Internet source).[43] Together with contributions from private entities such as the Bill and Melinda Gates Foundation, the Global Fund has significant resources at its disposal, and serves as one the primary sources of funding for member states of the regional organisations of ECOWAS and SADC.

As stated previously, the Global Fund does not create or implement programmes, but provides the resources necessary for the effective operation of initiatives. The programmes currently being supported range from the national health policies of states, to specific initiatives targeting certain groups or activities, such as condom social marketing amongst the youth. The funds are disbursed in the same way within all of the regions in which the Global Fund is active (including sub-Saharan Africa), and are divided between a variety of actors as follows: government (51%), NGOs and CBOs (25%), PLWHA, TB and Malaria (4%), academic institutions (5%), faith-based organisations (5%), the private sector (5%), with approximately 5% going to other miscellaneous entities (GFATM, 2005:Internet source).

The allocation of specified funds to these different actors is in sync with the multi-sectoral approach advocated by both ECOWAS and SADC (see chapter two). Further, by dividing the funds at this level, member states can easily demonstrate their adherence to this guideline handed down by their regional organisations, as well as being spared the administrative costs of determining which CBOs, faith-based organisations and the like should receive support.

[43] Other contributors include the EU (US$402 million), Italy (US$215 million), France (US$184 million), Japan (US$160 million), the UK(US$118 million), Germany (US$62 million), the Netherlands (US$52 million), Canada (US$50 million), and non-state actors such as the Bill and Melinda Gates Foundation (US$100 million), which contribute significant sums to the Fund (GFATM, 2005:Internet source). The Organisation for Economic Co-operation and Development (OECD) also contributes funds from its members, totalling US$844 million, a summary of which can be seen in Appendix 3.3 (OECD, 2004:Internet source).

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3.5.3 Multi-Country HIV and AIDS Programme for Africa (MAP)

The Multi-Country HIV/AID Programme for Africa (MAP), run by the World Bank, provides substantial zero-interest loans in support of country-level, sub-regional and cross-border initiatives (UNAIDS, 2005a:Internet source). Launched in 2002, US$500 million was initially committed to assist primarily in the scaling-up of the HIV and AIDS programmes in developing states, particularly in Africa (UNAIDS, 2005a:Internet source).

To date, the World Bank has provided US$1 billion in loans to sub-Saharan HIV and AIDS programmes (UNAIDS, 2005a:Internet source). Three regional initiatives have received assistance, and 28 states in Africa have garnered significant assistance from the MAP programme (World Bank, 2004:Internet source).

Table 3.2: Distribution of MAP Funds in ECOWAS and SADC

Country	Approval Date	Total Credit (US$ Millions)
Regional Initiatives		
Regional Capacity Building Network for HIV/AIDS Prevention, Care and Treatment (ARCAN)	June 2004	10.0
Regional HIV/AIDS Treatment Acceleration Project	June 2004	59.8
ECOWAS		
Benin	January 2002	23.0
Burkina Faso	July 2001	22.0
Cape Verde	March 2002	9.0
Gambia	January 2001	15.0
Guinea	December 2002	20.3
Guinea-Bissau	June 2004	7.0
Mali	June 2004	25.5
Niger	April 2003	25.0
Nigeria	July 2001	90.3
Senegal	February 2002	30.0
Sierra Leone	March 2002	15.0
SADC		
DRC	April 2004	102.0
Madagascar	December 2001	20.0
Malawi	August 2003	35.0
Mozambique	March 2003	55.0
Tanzania	July 2003	70.0
Zambia	December 2002	42.0
	ECOWAS TOTAL	**282.1***
	SADC TOTAL	**324***
	AFRICA TOTAL	**1088.2**

* Excludes Regional Grants
(Table adapted from figure "Projects Lending Portfolio", World Bank, 2004:Internet source).

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The participating ECOWAS and SADC states account for 62% of the programme's recipients, with SADC states receiving 30% of the disbursed funds. This calculation is based on the assistance received by 11 ECOWAS states (including Benin, Nigeria, and Sierra Leone), and the 6 SADC states (including Mozambique and Tanzania), as shown in Table 3.2 above. One example of a regional initiative receiving assistance is the Abidjan-Lagos Transport Corridor Project, mentioned in chapter two, which was allotted a grant in July 2003 (World Bank, 2003:Internet source).

3.5.4 United States Agency for International Development (USAID)

The United States Agency for International Development (USAID) is a federal government agency, which serves as the principle organ for humanitarian assistance from the US (USAID, 2006:Internet source). President Bush's Emergency Plan for AIDS Relief (PEPFAR), discussed in the next section, falls within the USAID mandate, although the agency also provides assistance independently from that programme.

As Table 3.3 below shows, the agency has provided almost US$1 million to ECOWAS states (including Liberia, Nigeria and Senegal) for HIV and AIDS programmes in the period between 2002 and 2005 (USAID, 2006:Internet source). More than U$1.6 million was awarded to SADC states such as Madagascar, South Africa, and Zimbabwe during the same time span (USAID, 2006:Internet source). As with the disbursements from other donor bodies, SADC states consistently receive higher grants, presumably due to their proportionately higher prevalence rates of diseases such as HIV and AIDS. Since 2002, SADC states have received an average of US$42 288, as opposed to the US$32 698 granted to ECOWAS states (USAID, 2006:Internet source). Considering individual state grants, Nigeria receives the most funding of the ECOWAS states (approximately 29%), while South Africa receives only the third highest amount of funding amongst SADC states (13%), behind both Angola (16%) and Mozambique (14%), although neither of these two states has comparatively higher HIV and AIDS prevalence rates.[44]

[44] USAID grants are awarded on the strength of proposals received from member states, taking into account the HIV prevalence rates and level of good governance present in the state. However, USAID states its preference for awarding grants to NGOs, CBOs and faith-based organisations as opposed to governmental structures due to their higher effectiveness in service delivery (USAID, 2006:Internet source).

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Table 3.3: USAID Funding 2002-2005

State	Total Programme Funds (2002) US$	Total Programme Funds (2003) US$	Total Programme Funds (2004) US$	Total Programme Funds (2005) US$
ECOWAS				
Benin	21 090	20 583	18 288	19 319
Guinea	29 610	33 636	26 112	21 543
Liberia	12 118	28 489	12 938	27 542
Mali	37 531	40 812	38 596	34 767
Nigeria	66 534	75 146	61 122	64 314
Senegal	30 745	32 327	27 106	31 421
Sierra Leone	41 834	35 187	13 223	13 604
TOTAL	239 462	266 180	197 385	212 510
AVERAGE	34 209	38 026	28 198	30359
			TOTAL (2002-2005)	**915 537**
SADC				
Angola	89 182	120 660	37 502	24 175
DR Congo	44 543	75 622	54 036	32 449
Madagascar	29 768	31 178	25 790	34 023
Malawi	43 567	30 931	34 494	37 695
Mozambique	58 416	67 584	58 816	56 850
Namibia	10 733	13 652	7 786	8 708
South Africa	58 308	62 958	53 994	51 800
Tanzania	20 635	61 144	34 013	26 988
Zambia	54 382	54 230	47 877	48 127
Zimbabwe	40 484	18 892	14 828	14 615
TOTAL	450 018	536 851	369 226	335 430
AVERAGE	45 002	53 685	36 923	33 543
			TOTAL (2002-2005)	**1 691 525**

(USAID, 2006:Internet source).

3.5.5 President Bush's Emergency Plan for AIDS Relief (PEPFAR)

President Bush's Emergency Plan for AIDS Relief (PEPFAR), initiated in 2003, is a "global initiative to combat the HIV and AIDS epidemic" (AVERT, 2006:Internet source). The PEPFAR strategy is spread over five years, with US$816 million being spent in the fifteen "focus" states in 2004 (USDS, 2005:14). These target states, eight of which belong to either ECOWAS or SADC, will receive US$9 billion in new funding in order to scale up prevention, treatment and care programmes (UNAIDS, 2005a:Internet source).[45] An additional US$5 billion is spent in support of ongoing bilateral programmes, and US$1 billion is given to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

[45] The target states are: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

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The US Congress has decreed how these funds should be spent, earmarking 55% for the treatment of people with HIV and AIDS, further stipulating that of this amount, a minimum of 75% should go towards the purchase and distribution of ARVs (AVERT, 2006:Internet source). Palliative care receives 15% of the total PEPFAR budget, followed by 10% for orphans and vulnerable children. A minimum of 50% of the 10% is to be awarded to NGOs, including faith-based organisations, both of which should be operating primarily at the community level. One of the most contentious provisions made by Congress is in the awarding of 20% of the budget towards the prevention of HIV and AIDS. The body stated that not less than 33% of this amount must be spent on "abstinence until marriage programmes" (AVERT, 2006:Internet source).[46]

PEPFAR's prevention strategy includes affecting behavioural change through counselling and peer outreach, reducing high risk behaviour through community and workplace interventions, promoting voluntary testing, supporting substance abuse treatment for HIV positive addicts, and focusing on the health of sex workers (USDS, 2005:20). The prevention strategy also includes testing, treatment, the provision of condoms, and advocating "correct and consistent condom use" (USDS, 2005:20). The prevention strategy further aims to utilise the media to present targeted messages to high risk population groups, and finding means of dealing with sexual exploitation and coercion, especially rape (USDS, 2005:20).

The Prevention of Mother-to-Child Transmission (PMTCT) received a massive boost from PEPFAR, who estimated that less than 4% of expectant mothers in the focus states previously had access to the life saving drugs (USDS, 2005:25). While all these services are provided for all citizens in need, the US Department of Defence has included a targeted programme for the armed services of these focus nations, as soldiers are both at high risk of becoming infected, and also threaten to infect others. High infection rates in the armed forces threaten the security and stability of both the state and the region, thus prompting the spotlight on this particular group (USDS, 2005:83). This type of focused intervention assists the involved ECOWAS and SADC states to scale up their protection of vulnerable groups (such as soldiers). The general strategy

[46] This is an unrealistic inclusion in the African context, given entrenched cultural practices such as polygamy, the high rates of violence against women (particularly rape), and a range of other issues which will be highlighted in the policy environment discussions in the following chapters.

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points of the donor body are emphasised within both the indicators discussed in chapter one, and in the policy documents of both groupings, allowing the assistance to be closely aligned with the national strategies of target states. Further, the assistance of donors such as PEPFAR allows for a more rapid response than the limited budgets of these states would ordinarily permit.

It is also worth noting the strong gender emphasis in the programme. In its first annual report to the US Congress, PEPFAR recognised the "social inequalities between women and men, [which] in conjunction with harmful gender-based cultural norms and practices perpetuate women's vulnerability to HIV" (USDS, 2005:61). The report placed a strong emphasis on continuing the promotion of abstinence programmes in the focus states to overcome this issue, although economic empowerment, greater access to medical care, and the reduction of violence and coercion were also mentioned. The inclusion of gender within PEPFAR's mandate illustrates that the donor body is taking the patriarchal African context into account, which is important in terms of ensuring that sponsored interventions are relevant, implementable, and effective.

3.6 COMMUNITY-BASED ORGANISATIONS (CBOS)

The multi-sectoral approach advocated by both ECOWAS and SADC within their respective policy documents clearly states the need for the involvement of partners such as Community-Based Organisations (CBOs). CBOs are crucial in the effective and sustainable implementation of HIV and AIDS policies. The ability to take the local context into account, especially in terms of the cultural and religious views of the targeted community, is arguably the decisive factor in successfully maintaining the numerous programmes being put into action in developing states (World Bank, 1995:121).

Further advantages and necessary knowledge are provided by encouraging community participation, which are outlined by the World Bank (1995: 210);

> *"Placing greater decision making in the hands of community representatives tends to be associated with more rapid and comprehensive identification of health needs and expectations; more reliable identification of the poorest households in the*

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community; unbureaucratic employment of local or community staff; greater flexibility in executing activities outside normal work hours (for example, nights, weekends); use of non-conventional and creative methods to promote education and information (for example, theatre, animation, dances); and practical development of technologies that can be adapted to local conditions".

One of the largest and most prominent bodies fulfilling this role is the Africa Council of AIDS Support Organisation (AfriCASO). AfriCASO brings together NGOs and CBOs in the sub-Saharan African region, allowing a higher quality information exchange and thereby providing a more effective policy-influencing platform (Collins, 2001:Internet source). This body works closely with UNAIDS, particularly the IPAA, with the aim of increasing the capacity and efficacy of regional networks. AfriCASO, together with the hundreds of CBOs operating throughout the two regional economic groupings in various capacities, provide some of the essential components for progressing the development of health care systems in the region.

Initially, they ensure that health care providers are held more accountable to the communities which they serve (World Bank, 1995:210). The ability to bring the health needs of local citizens to the attention of service providers and administrative liaisons fosters a crucial sense of ownership, which is necessary for both effective implementation and sustainability. Eventually, as these aspects develop, a trust is slowly built which then increases the social capital of the state, as citizens begin to feel the effects of the policies working to improve their lives. The accumulation of social capital by the state is essential in ensuring stability and security in the region, not only to avoid the obvious negative consequences of conflict, but also to reduce the high infection rate associated with it, as is being experienced in states such as the Democratic Republic of the Congo.

CBOs are also involved in a range of activities beyond facilitating the implementation and monitoring of state HIV and AIDS programmes. They actively participate in the procurement of funds from various donors, and the involvement of CBOs in the policy formulation process is essential in ensuring that programmes are properly directed to

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areas of need (Eldis, 2004:Internet source). The work of groups such as the Treatment Action Campaign of South Africa shows the influence of CBOs in securing access to antiretroviral medication, and other parties from both economic groupings play a similarly active role in protecting the interests of infected and affected citizens.

The phenomenal growth rate of community-based organisations shows that the need for this type of intervention activity is imperative for the success of the ongoing fight against HIV and AIDS. The Southern African Network of AIDS Service Organisations (SANASO) has released statistics which show as many as 346 CBOs, NGOs and faith-based organisations focused on the pandemic operating within a single state (SANASO, 2002:Internet source). While CBOs in general are discussed within the policy documents of ECOWAS and SADC in terms of both policy formulation and implementation, the exact figures of their monetary contributions to the fight against AIDS are not reported in this study as the sheer number of involved bodies (and the complicated network of partnerships between them) would make it problematic to accurately state their inputs.

3.7 THE PRIVATE SECTOR AND CORPORATE SOCIAL RESPONSIBILITY

The involvement of the private sector and the issue of corporate social responsibility is another key component of the multi-sectoral approach being pursued by both ECOWAS and SADC, as these regional economic groupings aim to utilise the considerable resources of corporations operating within the member states. This involves not only the capability of the corporations to provide financial assistance to state programmes, but also their ability to administer a range of workplace programmes to which the state does not necessarily need to contribute at all. While ECOWAS does not explicitly outline its stance on the responsibility carried by employers with regard to workplace interventions (see chapter two), it is a member of the IPAA which clearly states the rights of workers and the accountability of corporations in securing these rights. SADC, on the other hand, plainly states the obligations of corporations towards employees within its borders, not only within the policy document but also in multiple references to an auxiliary document devoted entirely to this issue. SADC is also a member of the IPAA (see section 3.4).

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Multi-national corporations are natural targets in today's globalised world due to their increasing power, not only in states in which they operate but also on the world stage (Winston, 2002:71). Their influence in policy formulation within a range of bodies increases as they amass experience in implementing their own workplace programmes, resulting in better policies emerging from these various forums.

Corporate social responsibility has grown not only from the acknowledgment of the vast resources that corporations have at their command, but also as a result of the corporations themselves acknowledging that certain issues, such as HIV and AIDS, affect their profitability directly. As it is becoming advantageous for corporations to be perceived as contributors to the communities in which they operate, as well as being necessary to maintain productivity, more and more multinational enterprises are instigating their own HIV and AIDS programmes for workers and their families (Collins, 2001:Internet source).

Most of the endeavours of MNCs to protect their workforce are voluntary, and are considered equal parts "ethical obligations" and "paying attention to the 'triple bottom line' – the financial account, the environmental account, and the social account" (Winston, 2002:71). However, some corporate obligations are enforced through the legal system of the host state, such as not allowing forced testing or protecting workers from being dismissed due to their HIV status. Thus corporations must take measures to care for their workforce if they wish to maintain their profitability.

One of the largest groups performing this task is the Global Business Coalition on HIV and AIDS (GBC), which boasts a membership of the most powerful multinational corporations operating around the globe (GBC, 2005:Internet source). Led by Sir Mark Moody-Stuart, chairman of Anglo-American Plc, the body works at the local, national and international level to assist member companies in devising and implementing HIV and AIDS workplace strategies (GBC, 2005:Internet source). The GBC has also enlisted the help of various international organisations. Examples of the group's activities include "Secure the Future", which received US$100 million from Bristol-Myers, Eskom's policies which provide employees with a range of AIDS related medical benefits through its funded medical clinics, and Rio Tinto who provide condoms and counselling to employees and their communities, as does Chevron Oil

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(Collins, 2001:Internet source). Another example is the large intervention effort which is occurring as the result of a public-private partnership between the Botswana Government, the Bill and Melinda Gates Foundation and pharmaceutical giant Merck. Each entity put US$50 million into an HIV and AIDS treatment and prevention fund, with Merck providing the medication needed (Wilson, 2005:6).

This type of collaboration is especially prevalent within the key industries of most states, especially agriculture (see chapter two). Agriculture remains one of the key sectors for developing African states, and the decline in labour availability and the resulting decrease in productivity caused by HIV and AIDS is a major obstacle for SADC states in particular. In Zimbabwe, household harvests for maize, cotton and sunflower dropped by more than 50%, a sizeable hit for commercial crops (SADC, 2004:24). A priority has therefore been placed on developing a strategy to counteract the effects of HIV and AIDS on this particular sector.

The involvement of trade unions has also been a contributing factor in the success of SADC HIV and AIDS projects. The Organisation of African Trade Union Unity has developed a Health Safety and Environmental Programme (HSEP) to provide guidelines for the continent's trade unions to protect the rights of members (Collins, 2001:Internet source). For example, the Congress of South African Trade Unions (COSATU), together with the Federation of Unions of South Africa (FEDUSA) and the National Council of Trade Unions (NACTU) have drawn up a guide for shop stewards, detailing the legal rights of employees and providing information on HIV and AIDS awareness and education drives (Collins, 2001:Internet source). These projects tie in with the "corporate social responsibility" workplace programmes mentioned above.

The East and Central African Global Competitiveness Hub (ECA Hub), discussed earlier within regional partnerships, is playing an important role in the SADC policy in terms of addressing high risk groups such as sex workers and distance truck drivers, by bringing governments, donors and other participants together in order to gain greater understanding of the interlocking roles of trade, investment (and disinvestment), and HIV and AIDS. While it is considered a SADC initiative (see section 3.3), the active involvement of corporations requires it to be mentioned within this discussion as well.

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3.8 SUMMARY OF DONOR AID CONTRIBUTIONS

The heavy dependence of states in both regional organisations on foreign donor assistance may prove problematic in the long run. The WHO argues that while the latest swell in the number of donors and international agencies has assisted in the significant increase in resources for certain health interventions and programmes over the next few years, the question is raised of how this level of expenditure could be sustained thereafter (WHO, 2006b:Internet source). Furthermore, while NGOs have been assisting states in the provision of welfare services for decades, there seems to be a shift as they are now viewed as the "preferred channel for service provision in deliberate substitution for the state" (Hulme & Edwards, 1997:6).

A summary of the health care expenditure of states and the grants received is included in Table 3.4 below.[47] Despite the low percentage of GDP spent on health care, in relation to the commitments made in the Abuja and UNGASS Declarations, developing states are spending significant amounts on protecting the health of their citizens. Nigeria was the highest public health spender in ECOWAS (US$2.04 billion), followed by Cote d'Ivoire (US$725 million) and Senegal (US$255 million), although Nigeria's comparatively larger population must also be taken into account (calculations based on WHO, 2006a:Internet source). It should also be pointed out that these three states report the highest number of HIV infected individuals, and produce the largest GDP.

Within SADC, South Africa was the state with the largest health budget at US$9.06 billion, followed by Zimbabwe (US$705 million), and Angola (US$560 million), although once again, population size and prevalence rates should be noted (calculations based on WHO, 2006a:Internet source). While South Africa is contending with the highest number of HIV positive individuals, it also reports the highest GDP of all the SADC states, and can therefore afford to spend more on health care. Further, while Angola is the third highest health care spender, the state has the second highest annual GDP, but only the tenth highest prevalence rate. Thus while a clear spending pattern emerges in ECOWAS between prevalence, GDP and health care expenditure, the same does not hold true for SADC.

[47] Although the statistics are for 2002, it gives a good comparative idea on money spent in the region.

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When considering the additional contributions of the plethora of CBOs, grass-roots organisations, faith-based organisations, corporations and other NGOs, it is apparent that developing states are receiving significant assistance with the financing of their health care policies, thereby bringing their annual expenditure closer to the 15% advocated by both ECOWAS and SADC.

Table 3.4: Summary of Health Care Expenditure and Donor Funding

State	GDP (US$) 2002[1]	Public Health Expenditure 2002[2]	GFATM (US$) 2002[3]	MAP (US$) 2002[4]	USAID (US$) 2002[5]
ECOWAS					
Benin	2 700 000 000	126 900 000	2 973 150	23 000 000	21 090
Burkina Faso	3 100 000 000	133 300 000	-	22 000 000	-
Cape Verde	600 000 000	30 000 000	-	9 000 000	-
Cote d'Ivoire	11 700 000 000	725 400 000	-	-	-
Gambia	400 000 000	29 200 000	-	15 000 000	-
Guinea	3 200 000 000	185 600 000	-	20 300 000	29 610
Guinea-Bissau	200 000 000	12 600 000	-	(7 000 000)	-
Liberia	-	-	-	-	12 118
Mali	3 400 000 000	153 000 000	2 592 316	(25 500 000)	37 531
Niger	2 200 000 000	88 000 000	-	(25 500 000)	-
Nigeria	43 500 000 000	2 044 500 000	70 891 576	90 300 000	66 534
Senegal	5 000 000 000	255 000 000	15 999 999	30 000 000	30 745
Sierra Leone	800 000 000	23 200 000	-	15 000 000	41 834
Togo	1 400 000 000	147 000 000	-	-	-
TOTAL	78 200 000 000	3 953 700 000	92 457 041	224 600 000	239 462
AVERAGE	6 020 000 000	304 130 769	23 114 260	28 100 000	34 209
SADC					
Angola	11 200 000 000	560 000 000	-	-	89 182
Botswana	5 300 000 000	318 000 000	-	-	-
DR Congo	5 700 000 000	228 000 000	-	(102 000 000)	44 543
Lesotho	700 000 000	43 400 000	-	-	-
Madagascar	4 400 000 000	92 400 000	2 000 063	20 000 000	29 768
Malawi	1 900 000 000	186 200 000	178 614 264	(35 000 000)	43 567
Mauritius	4 500 000 000	157 500 000	-	-	-
Mozambique	3 600 000 000	208 800 000	-	(55 000 000)	58 416
Namibia	2 900 000 000	194 300 000	-	-	10 733
South Africa	104 200 000 000	9 065 400 000	92 194 683	-	58 308
Swaziland	1 200 000 000	72 000 000	-	-	-
Tanzania	9 400 000 000	460 600 000	26 380 796	(70 000 000)	20 635
Zambia	3 700 000 000	214 600 000	179 458 056	42 000 000	54 832
Zimbabwe	8 300 000 000	705 500 000	22 977 500		40 484
TOTAL	167 000 000 000	12 506 700 000	501 625 362	62 000 000	450 018
AVERAGE	11 930 000 000	893 335 714	83 604 227	31 000 000	45 002

[1]UNDP, 2004:Internet source; [2] Own calculations based on WHO, 2006a:Internet source; [3]GFATM, 2005:Internet source (maximum approved); [4]World Bank, 2004:Internet source (Includes funds approved in 2001); [5]USAlD, 2006:Internet source.

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Nevertheless, while current estimations of necessary resources for dealing effectively with the HIV and AIDS pandemic are not being met, UNAIDS projections for the next two years show that dramatic strides in resource mobilisation must be made. Table 3.5 below shows projected costs for the crucial scaling-up of existing programmes covering prevention and treatment costs, amongst other expenditures. The figures reflect that prevention programmes remain the focus, constituting 54% of the total projected budget, and demanding an annual rise of almost US$2 billion, almost double that required for treatment and care (UNAIDS, 2005b:Internet source). Treatment and care is expected to claim 22% of the total HIV and AIDS budget, representing US$12.3 billion over just two years. The increase of orphans and vulnerable children is considered within this budget, with US$6.4 billion required to assist this group.

Table 3.5: UNAIDS Projected HIV and AIDS Resource Needs

US$ Billion	2006	2007	2008	Total (2006-2008)	% of Total Budget
Prevention	8.4	10.0	11.4	29.8	54%
Treatment and care	3.0	4.0	5.3	12.3	22%
OVC	1.6	2.1	2.7	6.4	12%
Programme Costs	1.5	1.4	1.8	4.6	8%
Human Resources	0.4	0.6	0.9	1.9	4%
TOTAL	14.9	18.1	22.1	55.1	100%

(UNAIDS, 2005b:Internet source).

3.9 CONCLUSION

This chapter examined the guidelines provided by ECOWAS and SADC to their member states regarding the funding of HIV and AIDS programmes. It has been shown that the contributions made by member states are almost exclusively used for administrative purposes by the regional bodies, and that adequate financial assistance must be secured elsewhere if the policy guidelines set by ECOWAS and SADC are to be implemented by member states instead of remaining policies on paper. ECOWAS has set aside US$3.5 million for HIV and AIDS programme administration, although if the funds for malaria, the control of epidemics and vaccine and drug development are included, the total rises to US$7 million. SADC provides a more detailed breakdown of how the US$22.77 million allocated to HIV and AIDS is to be spent, for example setting aside US$11 million for the scaling up of cross border initiatives.

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While ECOWAS and SADC have both formed partnerships to address the HIV and AIDS pandemic within their particular regions (for example, see section on IPAA above), the onus remains on member states to secure the resources necessary to implement their national HIV and AIDS policies. The bulk of the funding for HIV and AIDS programmes, both regionally and nationally, is therefore derived from foreign donors. It is necessary to clarify that as the regional organisations can not fund these initiatives themselves, alternative funding has had to be secured. The policy documents of both ECOWAS and SADC indicate that the donors discussed above are to be pursued for this purpose, with SADC mentioning some of these donors by name in the policy document.

The significant resources at the disposal of these bilateral and multilateral donor entities can potentially allow member states to implement the crucial HIV and AIDS policies at a faster rate, as well as enabling the necessary scaling up of existing programmes, which would not have been possible with their own meagre resources. Both ECOWAS and SADC receive noteworthy concessions from the bilateral and multilateral donors discussed in section 3.5 and illustrated in Table 3.4. The resources received from these entities are targeted at activities such as education and awareness campaigns, as well as prevention measures, which tie in closely with the policy objectives of ECOWAS and SADC (see chapter two). For example, the Global Fund provides grants to specific programmatic actions, such as the scaling up of treatment programmes within a specific province in a state (see Appendix 3.2 for detailed examples). PEPFAR allocates grants according to very similar guidelines to those within the policy documents of ECOWAS and SADC, earmarking 55% of total aid disbursements for treatment programmes (of which 75% is dedicated to the provision of ARV treatment), and setting aside 20% of the budget for prevention strategies (see section 3.5.5). Thus, the aid received from the above entities complements the regional and national HIV and AIDS policies, as it is designated towards the same goals as those stipulated by ECOWAS and SADC.

The mandatory assistance of corporations in protecting the workforce has also been shown to be a strategy advocated by both bodies, stretching the budget of member states further. While the actual contributions of CBOs and the many NGOs operating within both ECOWAS and SADC are not specifically stated, the impact of their involvement in the funding of HIV and AIDS programmes can not be discounted. It

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should be noted that while ECOWAS has a number of workplace programmes in effect, only SADC has formalised the responsibilities of corporations operating within member states (see chapter two).

The following two chapters are devoted to the ascertaining the extent to which the policy guidelines of the two regional organisations are reflected in the respective HIV and AIDS policies of the two case studies, namely Nigeria and South Africa.

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CHAPTER 4: NIGERIA'S HIV AND AIDS POLICY

4.1 INTRODUCTION

The manner in which the HIV and AIDS pandemic is being addressed within the regional economic groupings of ECOWAS and SADC has become clearer through the comparison of their respective health policies in chapter two. A number of common threads have emerged in terms of the indicators which are addressed within the education and awareness campaigns, prevention drives, and treatment and care programmes. Stark differences have also come to light, particularly in the realm of gender awareness.

This chapter will apply the same indicators used to compare the regional health policies, to ascertain the extent to which the guidelines provided by the regional organisations are applied to the national health policies of member states. As discussed in chapter one, the strongest states in each grouping will be used as case studies, namely Nigeria within ECOWAS, and South Africa in SADC. As these two states are considered the most powerful within their respective groupings, the extent to which they adhere to the framework provided by the regional organisations could be indicative of both the feasibility of proposed actions and the practicality of the guidelines offered by their respective regional organisations. Whether the two states reflect the same strengths and weaknesses in their respective policy documents may be suggestive of the leadership role played by ECOWAS and SADC in their respective regions.

This chapter will first provide an overview of Nigeria in terms of the environment which policy makers need to take into consideration when formulating a policy on HIV and AIDS. As pointed out in chapter one, no policy is made in a vacuum, and a number of important realities need to be considered in the formulation of policies (referred to as the "policy environment" by Anderson). This will be followed by an analysis of the HIV and AIDS policy of the state, using the indicators developed from the literature on HIV and AIDS in chapter one. The prominence of gender within the formulation of policy and subsequent actions will be addressed in a separate section, as was done in

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chapter two. Finally, the funding protocols discussed in the previous chapter will be examined within the Nigerian context. The same format will be applied to the HIV and AIDS policy of South Africa in the following chapter.

4.2 NIGERIA

The political, economic, social, and cultural environment of a state influences the policies which a state can realistically formulate and implement (see chapter two), and can provide some insight into why certain guidelines provided by the regional body are adopted, adapted, or disregarded. This is especially true of HIV and AIDS policies, as these policies are centred around generating behavioural changes that may be in conflict with the prevailing beliefs and values of society, which are discussed below. Thus, there are a range of factors which constitute the political, economic and social environment in which policies are formulated, and a brief discussion is necessary to place the Nigerian health policy into context. The issues highlighted below represent some of the most important factors to be taken under consideration in the formulation of the policy.

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4.2.1 Nigerian Policy Environment

The federation of Nigeria, uniting 400 ethnic nationalities in 36 semi-autonomous states, is considered the dominant state within ECOWAS, as was shown in chapter one. As Nigeria also reports the highest prevalence rate for both HIV and AIDS and tuberculosis, with almost 6.8 million HIV positive individuals, and 717 630 tuberculosis cases, it is an apt case study to ascertain the usefulness of the guidelines provided by ECOWAS in the formulation of an effective HIV and AIDS strategy.

4.2.1.1 Health care infrastructure, demography, and socio-cultural values

Firstly, the formulation and implementation of a health policy requires a consideration of its health care infrastructure, which, in the case of Nigeria, is considered weak and poorly managed;

> *"The state of health care in Nigeria is to say the least, uninspiring. From the avalanche of fake drugs to the moribund health care infrastructure and*

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> *the constant work stoppages by resident doctors, the health care system is in tatters. It is even worse in the rural areas where doctors and nurses are scarce"* (Akukwe, 2001:Internet source).

Any health policy needs to acknowledge the lack of a physical infrastructure and skilled staff to administer the health programme. Without this, the HIV and AIDS pandemic will not be slowed. For example, proper blood management is essential for ensuring that preventable infections are avoided. It is estimated that improperly screened blood products are used in 60% of blood transfusions in Nigeria (Akukwe, 2001:Internet source). Poor knowledge about the disease is rampant among medical personnel, with 60% believing that isolation of HIV positive patients is necessary to prevent new infections (Pennington, 2006:Internet source). Hospitals will also not acknowledge AIDS-related illnesses as the cause of death on death certificates, and this stigma is reflected in the obituary notices from families which state the patient died after a "brief illness" (Akukwe, 2001:Internet source).

The demography of Nigeria provides a further backdrop for the formulation of any HIV and AIDS policy. The massive size of the population presents challenges of its own, more so when considering the wide array of cultural and religious population groups. Muslims constitute approximately 50% of the Nigerian population, followed by Christians (40%), with a multitude of indigenous beliefs making up the remaining 10% (Pennington, 2006:Internet source). Conflicts between Muslims in the north of the state and Christians in the south persist as they compete for political power, and it is estimated that more than 10 000 people have died in ethnic and religious clashes since 1999 (*BBC*, 2003:Internet source).[48] This combination of religious and indigenous groups have entrenched intricate ancestral belief systems which govern Nigeria's diverse population and some of these beliefs, such as the importance attached to fertility, have set back the effectiveness of family planning programmes (Obono, 2003:103). It is suggested that this is due to a "religious belief system and an accompanying social structure that have accorded both spiritual and economic rewards"

[48] Much of this conflict stems from the inability to reconcile Nigerian law with the more conservative beliefs set forth by Sharia law, which is upheld in the northern Muslim states. For example, under Sharia law adulterers are stoned, a practice which is not supported by the Nigerian constitution (*BBC*, 2003:Internet source). The military remains divided by ethnic loyalties, which further fuels conflict (Tsai, 2002:32).

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to the notion that many children (and in some cultures, many wives) are indicative of great prosperity (Obono, 2003:103). This issue is expanded by Pennington (2006:Internet source), who states that widespread polygamy, the absence of legislation regarding the minimum legal age for marriage, and other "harmful marriage practices" are increasing the susceptibility of women and girls to HIV infection. In addition to a lower social standing restricting the ability of women to negotiate safer sex and condom use, female circumcision remains a common cultural rite in many areas of Nigeria, with as many as 60% of Nigerian women undergoing the process (Pennington, 2006:Internet source). This heightens the risk of infection due to the use of unsterilised equipment during the procedure.

These cultural and social restrictions placed on women are not unique to Nigeria, but are reflective of the traditionally patriarchal nature of African society which constrains their roles in the decision making process (Anderson, 2000:49). Women constitute 49.4% of the Nigerian population, yet they hold less than 5% of the parliamentary positions available, which is the lowest of all the ECOWAS states.[49] While women in Nigeria have the highest literacy rate in comparison to the other ECOWAS states (59.4%), male literacy is much higher at 74.4%, which would have some consequences on the effectiveness of education and awareness campaigns as it limits the media and methods which can be used to convey HIV and AIDS information. This could arguably already be reflected in the higher HIV prevalence rate of women, who account for 58% of HIV infections, the highest rate of all women in ECOWAS (UNDP, 2004:Internet source). In general, the needs of women are not addressed, as is evidenced by the statistic that 90% of HIV positive children contracted the virus from their mothers (Pennington, 2006:Internet source). Further, the youth are a particularly high-risk group in need of proper health education and support, as they account for approximately 45% of the Nigerian population, and it is estimated that more than 60% of new HIV infections occur in the 15-25 year age group (Pennington, 2006:Internet source; UNDP, 2004:Internet source). These cultural and religious differences, together with the inequality of women and vulnerability of the youth, impact on the belief systems of the population, influencing the communication and treatment strategies which can be undertaken by the state.

[49] Guinea has the highest representation of women in parliament (19.3%), followed by Senegal (19.2%) and Sierra Leone (14.5%) (UNDP, 2004:Internet source).

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4.2.1.2 Socio-economic factors

Socio-economic factors such as poverty, illiteracy, and lack of communication infrastructure, further impact on HIV and AIDS policies, particularly with regard to the type of communications strategies which can be pursued by the state, as well as the type of treatment which citizens can afford. The literacy rate for Nigeria is 66.8%, with less than 20% of the population owning a radio receiver (UU, 2004a:Internet source). However, this should be contrasted with the other forms of mass communication available: less than 6% of Nigerians own a television, and fewer than 2% regularly buy a newspaper. The latter can therefore not be utilised as the primary method of communicating information to the general public, as the majority of people clearly do not have access to the medium.

High levels of unemployment are reported for Nigeria, exacerbating the extreme poverty in a state where almost 91% of the population is living on less than US$2 a day (UNDP, 2004:Internet source). This situation is not unique to Nigeria, but has been aggravated by issues such as decades of oppressive military rule, widespread corruption, and continuing religious conflicts. This level of poverty thus limits the treatment options available to Nigerians, and places a greater burden on the state to provide comprehensive health care solutions.

4.2.1.3 Economic problems

After gaining independence from Britain in 1960, a coup in 1966 left the state under military control until 1999, when the first civilian-run democratic elections were held (*BBC*, 2003:Internet source). This period of military governance has left some lingering effects, starting with the enormous debt inherited from the regime of General Abacha, whose government is estimated to have depleted the national treasury store by more than US$43 billion (Tsai, 2002:32).[50] Nigeria is the sixth largest exporter of oil, producing 4.5 percent of the world's oil (Tsai, 2002:32), and this oil revenue constitutes the bulk of Nigeria's GDP, bringing in more than US$40 billion a year (*Guardian*, 2005:Internet source). Despite this income, Nigeria remains more than

[50] Nigeria's debt stood at US$34.9 billion in 2003, the highest of all ECOWAS states. Cote d'Ivoire had the second highest debt at US$12.1 billion, followed by Senegal at US$4.4 billion (see chapter one).

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US$39 billion in debt. Exacerbating Nigeria's problems is its status as the second most corrupt state in the world, and the continuing practice of overspending in the military, placed at more than US$430 million in 2002 – the highest allocation for any item on the budget (Tsai, 2002:32). Corrupt soldiers and officials continue pilfering oil supplies; a common practice during the military regimes which preceded democracy in the state, and one which is yet to be addressed and halted (*Guardian*, 2005:Internet source). The mismanagement of oil resources, coupled with debt and corruption, has dire consequences for the economic future of the state, and by extension the resources available for programme implementation.[51]

4.2.1.4 HIV and AIDS agreements

The international and regional agreements ratified by the state are an additional factor informing the policy formulation process (as discussed in chapter two), and include the Abuja Declaration and the UNGASS Declaration of Commitment on AIDS, of which all ECOWAS states are signatories (Nigeria NSF, 2005:9). The application of the *"Three Ones"* at a state level is also specifically emphasised within the policy document, namely that the "Nigerian response will promote the recognition of only one coordinating agency for HIV and AIDS at the federal, state and local levels [which are] the NACA, SACA and LACA respectively" (Nigeria NSF, 2005:21).[52]

[51] Nigerian Finance Minister Ngozi Okonjo-Iweala (a former Vice President of the World Bank, and the first female finance minister in the world), has already begun a severe crackdown on corruption within the government since her appointment in 2003 (*Guardian*, 2005:Internet source). Both the President of the Senate and the Speaker of the House of Representatives were fired following forgery and perjury convictions (Tsai, 2002:32).

[52] The Presidential AIDS Council (PAC) is the overriding body for all HIV and AIDS matters, assuming responsibility for the direction of the national response, and working with the National Action Committee on AIDS (NACA). NACA assists in overseeing the implementation of the policy, together with "self coordinating entities" such as the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), civil society organisations on AIDS (CISHAN), the private sector, donor groups, and the UN system (Nigeria NSF, 2005:10). SACA is the State Action Committee on AIDS, LACA is the Local Action Committee on AIDS.

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4.2.2 The Nigerian HIV and AIDS Policy

The current HIV and AIDS policy document of Nigeria emerged from a three year interim policy entitled the HIV and AIDS Emergency Action Plan (HEAP 2001-2003), which outlined the intended multi-sectoral approach (Nigeria NSF, 2005:3). The primary aims of HEAP were to create "an enabling environment for interventions and control of the epidemic", as well as to provide specific HIV and AIDS prevention measures. The slow acquisition of resources for HEAP's implementation led to its mandate being extended to the end of 2004, enabling the current strategic framework to come into effect in 2005. Overall, the Nigerian Strategic Framework (NSF) is a fairly eloquent 100 page document, providing an overview of the HIV and AIDS institutional framework, government, administration and coordinating structures, involved stakeholders, as well as a synopsis of opportunities and challenges. The programmes outlined in the policy will be discussed in greater detail in the following sections.

The broad policy statement made within the health document regarding HIV and AIDS is that;

> *"The delivery of an effective, comprehensive HIV and AIDS prevention and continuum of care programme in Nigeria is necessary to reverse the rampages of the epidemic in the country. The obstacles to this include: weak health systems, inadequate access to prevention commodities and care services, inadequate or weak psycho-social/welfare system and poverty, among others. Thus, the NSF will implement strategies that strive to surmount these obstacles, thereby averting millions of needless deaths, while progressively directing the nation towards attaining the desired objective in line with the Millennium Development Goals"* (Nigeria NSF, 2005:24).

Other issues which are highlighted include legal reforms (especially as they relate to gender-sensitivity), ethical matters arising from clinical trials and drug testing, and addressing the "constraints against successful implementation of HIV and AIDS interventions [which] need to be removed through legal reforms" (Nigeria NSF, 2005:27). As with the ECOWAS policy document, the NSF identifies areas which are

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to receive priority attention, such as education and awareness about the disease, better treatment programmes, and a strong youth focus.

4.2.2.1 Education and awareness campaigns

Retaining the indicators applied to the ECOWAS policy document in chapter two, education and awareness campaigns are compared in terms of the dispersal of information about safe sexual practices, good nutrition, and raising awareness of the services offered by health care facilities. Secondly, the emphasis placed on the social marketing of condoms is considered, including references to female condom use. Further, the importance of programmes within the workplace which protect employees from the contraction of HIV and AIDS is examined. The level of youth participation and protection is crucial to halting the spread of the pandemic, and is thus scrutinised as well. Adhering to the format of chapter two, gender will be considered in a separate section. The purpose of this analysis is to ascertain whether the Nigerian policy document adheres to the guidelines provided by ECOWAS, as this will be a reflection of the practicality of the proposed actions and the leadership role played by the regional body to its member states. This comparison will also reflect whether the same strengths and weaknesses are present in both documents.

i) Safe sex, nutrition and health care services

The Nigerian policy document is fairly eloquent regarding education and awareness campaigns, stating that the overriding objective is to have "95% of the general population make the appropriate behavioural changes (safe sex, abstinence etc) through social mobilisation and greater access to information by 2009" (Nigeria NSF, 2005:22). Specific activities are outlined within the document to achieve this goal, including the utilisation of mass and news media, community outreach programmes, programmes targeted specifically at the youth, and the scaling up of initiatives making "innovative use of telecommunications and information technology" (Nigeria NSF, 2005:22). Further reference is made to the provision of "strategic directions for audience segmentation and targeting, and message development" (Nigeria NSF, 2005:22). This level of elaboration far exceeds the vague wording within the ECOWAS policy document, with an acknowledgement of high risk groups such as women and health

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workers, and a discussion of definite actions which are to be undertaken to meet the targets set out. For instance, the inclusion of communications content which promotes "abstinence, partner reduction, delay of sexual debut, mutual fidelity, condom use, blood safety and universal precautions", none of which are discussed within the ECOWAS policy (Nigeria NSF, 2005:23). The range of activities indicates that the broad cultural spectrum of Nigerian society is being carefully considered, and the clear inclusion of the social marketing of condom use is particularly noteworthy considering the conspicuous absence in the ECOWAS policy document.[53] In addressing the issue of education and awareness campaigns, possible innovations for future communication campaigns are also included, such as the statement that "sub-strategies will also include the design and implementation of … information dissemination through telephone hotline, text messages (SMS), HIV and AIDS-related websites such as NACA, e-forum and development partner sites" (Nigeria NSF, 2005:23).

The ECOWAS policy document advises the operation of campaigns at the community level, as well as the development of care centres (WAHO, 2003:21), a guideline which Nigeria meets satisfactorily. This commitment to involving the community in the successful implementation of HIV and AIDS programmes is shown in the Nigerian policy document through the pledge to remove "socio-cultural, informational and systemic barriers to community-based responses" (Nigeria NSF, 2005:17), and the promotion of "BCC [behavioural change campaigns] through community outreaches" (Nigeria NSF, 2005:22).

The statement that the "community has a responsibility to promote target-specific, culturally-sensitive and innovative approaches…" (Nigeria NSF, 2005:24) further entrenches Nigeria's commitment to a community-based response. There are also numerous references to building the capacity of communities and CBOs to fulfil these tasks. The ECOWAS document is also fairly expansive on the importance of overcoming malnutrition, and in this regard Nigeria has also complied, with a primary health care programme devoted to proper nutrition, especially noting the needs of vulnerable groups such as orphans and vulnerable children (OVC), people affected by

[53] The continuous inclusion of condoms (and condom social marketing) is noteworthy given the complex beliefs of not only the 400 ethnic groups within Nigeria, but also the staunchly conservative views of both the Christians in the south and the Muslims in the north (see preceding section on the policy environment in Nigeria).

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HIV and AIDS (PABA), and people living with HIV and AIDS (PLWHAs) (Nigeria NSF, 2005:24).

Lastly, the ECOWAS document stresses the establishment and maintenance of knowledge databases, noting the importance of "enhanced communication and information exchange" (WAHO, 2003:14). The NSF acknowledges the importance of this aspect in the implementation of education and communication campaigns, and expands on the original mandate somewhat. The alterations introduced include the conducting of "gender disaggregated research of the impact of HIV and AIDS on key sectors", and the promotion of "ethical issues in research and ensuring community participation" (Nigeria NSF, 2005:27). Continued and expanded research in a variety of areas, with partners such as international development organisations, academic institutions, corporations and government ministries, is also discussed in some detail. The statement on disaggregated gender research will be discussed in more detail within the section on women and HIV and AIDS that follows.

ii) Condom social marketing

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The social marketing and provision of condoms is clearly discussed within the policy document, as has been pointed out above. In addition to the aforementioned statement, there are also references to the development of a strategy to "improve access and utilisation of condoms" (Nigeria NSF, 2005:23). Both the general population and the youth are specifically mentioned, showing initiative on the part of the Nigerian Government in expanding on the lax guidelines contained within the ECOWAS policy document. This is not to say that the possible explanations given in chapter two for the omission of condom provision in the ECOWAS document do not also apply to the Nigerian context. The cultural and social constrictions discussed earlier in this chapter (see section on policy environment above) hamper the drive to encourage condom use, and it is reported that as few as 24% of Nigerian women (aged 15-24) used condoms during their last high risk sexual encounter, and that only 46% of men used condoms (UNDP, 2004:Internet source). However, as the use of condoms remains one of the most effective and affordable prevention methods, the Nigerian Government would be remiss if it was not included in the policy document. It appears that in an effort to appease both religious groups and donor bodies, complementary policies promoting

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abstinence, fidelity and delay of sexual debut are mentioned in conjunction with condom use.

iii) Workplace interventions

The protection of the workforce is crucial given the level of poverty and underdevelopment in the state. The importance of involving the corporations operating within the state in these programmes is underlined in the ECOWAS policy document, particularly with reference to migrant labour and selected industries such as agriculture and health care services (see chapter two). The Nigerian policy document is fairly expansive, stating that in addition to the protection of health workers, there must be a concerted scaling up of all workplace interventions, continuing with the statement that "while the workplace policy is expected to impact all sectors, the critical socio-economic sectors targeted by this objective are agriculture and rural development, education, transport, extractive industries, insurance and tourism. In each sector, both the public and private sectors are included, integrating gender as a cross-cutting factor" (Nigeria NSF, 2005:25). The policy document also indicates that the development and implementation of these workplace HIV and AIDS programmes are the responsibility of the actors within each sector. A further sub-objective states that strategies should be developed which encourage "95% of groups with special needs make the appropriate behavioural changes (safe sex, abstinence etc) through social mobilisation by 2009" (Nigeria NSF, 2005:26). These include prison inmates, sex workers, uniformed persons, transport and migrant workers, intravenous drug users, substance abusers, persons engaged in same sex practices, physically and mentally challenged persons, trafficked persons and internally displaced people (see Objective 5 of the Nigerian policy document). The NSF thus exceeds the limited guidelines provided by the ECOWAS document, which mentions only migratory workers, the armed forces, and the workforce of selected industries which are not identified.

iv) Focus on youth participation

The importance of protecting the youth has received considerable attention in the policy document of ECOWAS (see chapter two), and has been emphasised continually in the literature (see chapter one). There are a variety of reasons for this, notwithstanding the

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higher risk of infection facing this target group, starting with the need to ensure that a productive workforce is assured for the economic future of the state. As was illustrated in the discussion regarding Nigeria's policy environment (see preceding section), it is not only the prevention of infection amongst the youth which requires attention, as children are also forced to miss school in order to care for infected relatives and tend to crops when the family structure becomes disrupted due to deaths. As discussed within the policy environment section, proper health education and support are therefore crucial for the youth, as they constitute almost half of the Nigerian population, and represent more than 60% of new HIV infections. The policy document continually mentions the youth, committing itself to scaling up existing initiatives such as "youth-friendly centres, AIDS information centres, youth-focused television programmes, adverts (billboards), musical concerts, sporting events, family life education and the National Youth Service Corps (NYSC) and National Youth Network on HIV and AIDS (NYNetHA)" (Nigeria NSF, 2005:23). Although the ECOWAS policy stresses the importance of youth-centred campaigns and the involvement of this high risk group, the detail within Nigeria's policy document far exceeds that of the regional body as it discusses specific actions to be taken to achieve these goals.

4.2.2.2 Prevention programmes

Education and awareness campaigns are considered the first line of defence against new infections, but are closely linked with prevention programmes to ensure an effective response against the pandemic. As pointed out in chapter two, the ECOWAS policy document does not provide adequate guidance with regard to prevention campaigns which are focused on the expansion of VCT, providing access for the general population to vaccines, condoms, sterile injecting equipment, and drugs (including ARVs), and scaling up PMTCT. The priority placed on sex worker interventions is also considered.

The general prevention objective within the policy document is to "increase access to comprehensive gender-sensitive prevention, care, treatment and support services for the general population, PLWHAs and PABAs, including OVC by 50% in 2009, and to mitigate the HIV and AIDS impact on the health sector" (Nigeria NSF, 2005:23). This goal is similar to that proposed within the ECOWAS document, apart from the

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inclusion of OVCs, which is neglected by the regional body's policy. This section will examine each of these indicators with regard to the similarities and differences between the ECOWAS policy and the adherence of the Nigerian policy to the guidelines provided by the regional body.

i) Voluntary counselling and testing

The provision of VCT services for the general population is discussed within the policy document, which is an improvement on the regional document as the ECOWAS policy does not discuss this vital issue at all. The statement that Nigeria will "expand access to gender-focused VCT services, including access to youth friendly VCT" shows some expansion on the ECOWAS document in that the ECOWAS policy only mentions the youth specifically, neglecting women altogether in this regard (Nigeria NSF, 2005:24). The implication of the regional body not emphasising VCT to the extent advocated within the literature is primarily one of logistical planning; without accurate data regarding the true prevalence rate, sufficient provision can not be made for treatment and care programmes. At the social level, the continuing stigmatisation around the use of VCT services does allow the necessary behavioural changes to become common practice, perpetuating the cycle of ignorance and infection.

ii) The availability and accessibility of condoms and drugs (including ARVs)

The Nigerian policy document is surprisingly concise about condoms (as mentioned above within education and awareness campaigns), given the poor precedent set by the ECOWAS framework. The Nigerian document states that a "condom policy and strategy to improve access and utilisation of condoms" will be developed (Nigeria NSF, 2005:23). The same commitment is made regarding the non-discriminatory access to ARVs, and the maintenance of an uninterrupted supply of essential drugs. There is a reference to an ARV treatment programme initiated in 2001, which aimed to equip 25 clinics to treat 10 000 adults and 5 000 HIV positive children (Nigeria NSF, 2005:10). By the Nigerian Government's own admission, the roll out was slow and unsustainable due to the high cost of the drugs. Subsequently, some relief has been provided through the support of GFATM, MAP and PEPFAR, who are working with the state and approximately 300 CBOs, in order to resume the functioning of this initiative.

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However, the procurement of more affordable drugs is not discussed within the Nigerian document, neither are quality control measures. Both of these issues are emphasised in the ECOWAS policy (see chapter two), with statements that the importance of establishing a "bulk purchasing mechanism" is a "top priority" (WAHO, 2003:26).[54] This is of great concern when considering that 60-70% of all drugs in Nigeria are "counterfeit or contain only a fraction of the declared strength" (Pearce, 2000:263). However, the Nigerian document also mentions issues such as the accessibility to safe blood and the proper management of medical waste and infection control, which are discussed in the literature on HIV and AIDS as supplementary issues that need attention. While these matters may not be heavily emphasised, they contribute to the elimination of avoidable infections (for example through using infected blood during transfusions), and as they are not discussed at all in the ECOWAS document, it is worth noting that the Nigerian policy is paying attention to the small details that may make a difference.

iii) Interventions within the sex industry

The Nigerian policy document does not discuss sex worker interventions in great depth. This high risk group is merely mentioned as a target group along with a number of other vulnerable parties. While this is an improvement on the total lack of attention paid to sex workers within the ECOWAS framework, it is not in keeping with the status of Nigeria as a major trade hub. As discussed in chapter two, the prevalence of HIV infections amongst long distance truck drivers, railway workers and migrant labourers, places sex workers along commercial routes at great risk, and should therefore be addressed in more detail. When considering that less than half of the female population of Nigeria (aged 15 and older) is formally employed, and that more than 90% of the population is living on less than US$2 a day, the potential earnings of sex workers would prove tempting. This is reflected by the more than one million sex workers estimated to be operating in Nigeria, despite it being illegal (Pennington, 2006:Internet

[54] Since the implementation of the policy began, the Archy Pharmaceuticals Company, funded by US-based Nigerian expatriates, has begun constructing a manufacturing plant in Nigeria, which will enable the state to produce its own generic ARV drugs (*BBC*, 2005:Internet source). The long term goal is to export these medicines to other states within the region. As this is not discussed in the policy document, it is not included within the comparison.

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source). Thus, it is essential that more attention is paid to this high risk group, both within the Nigerian and ECOWAS policy documents.

4.2.2.3 Treatment infrastructure

The importance of efficient infrastructure in all sectors is emphasised in the ECOWAS policy document (see chapter two), as it is essential for ensuring effective policy implementation. The measures outlined within the NSF policy document to strengthen and expand its infrastructure are thus the first topic examined in this section. The development of domestic industries is a crucial consideration in the formulation of long term plans for treatment programmes, although constraints such as insufficient resources and the influence of international laws such as TRIPS on Nigeria's policy must be considered in conjunction with this indicator. Lastly, although the issue of home-based care is not mentioned in the ECOWAS policy document at all, it is one of the aspects emphasised in the literature (see chapter one), and used as an indicator for comparison in this study. It is therefore included in this discussion of the treatment infrastructure of the Nigerian policy document.

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i) The expansion and strengthening of infrastructure

While the ECOWAS policy document does not provide much guidance on how member states could go about improving their health care infrastructures, this issue nevertheless receives some attention (see section 2.1 of the WAHO policy document). The Nigerian policy document, on the other hand, is slightly more forthcoming in outlining steps to scale up the capacity and efficiency of their health care institutions in order to properly implement policies and "enhance efficient and sustainable logistics systems for improved access to health commodities for HIV and AIDS-related services" (Nigeria NSF, 2005:24). However, the maintenance and skills development of health care personnel are not discussed in detail, although the shocking state of Nigeria's health care infrastructure (see policy environment section above) demonstrates the urgent need to address this issue. While the policy document is not expansive on activities which may assist in achieving the goal of a stronger health care system, the expected benefits which the state could derive from strengthening the health care infrastructure are articulated in statements such as the ability of "health

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sector institutions, systems and personnel to plan and manage a well coordinated and adequately resourced health sector response to HIV and AIDS at all levels" (Nigeria NSF, 2005:24).

ii) Developing domestic industries for the provision of essential medicines

The Nigerian policy document does not provide much detail on the development of domestic drug manufacture, apart from declaring that the state will "promote the development, acquisition and utilisation of new HIV and AIDS technologies" and that "operation research will be promoted … through the setting up of research grants by government, corporations and international development organisations" (Nigeria NSF, 2005:27). This is in keeping with the bland guidelines of the ECOWAS document, which merely notes that countries that have the "appropriate technology for local drug manufacture" should pursue its development (WAHO, 2003:26). The Nigerian document also holds that the expansion of national research and manufacturing capabilities are a medium to long term goal, which might explain the lack of expansion on the topic within this strategic framework, given the country's status as a least developed state without the infrastructure or resources to support such an undertaking (see policy environment section above).

iii) The provision of home-based care

While the ECOWAS document does not address this issue at all, the Nigerian policy is to "define, promote and implement gender-sensitive community- and home-based care services" (Nigeria NSF, 2005:24). This declaration is not followed by a detailed breakdown of activities aimed at achieving this goal, but its inclusion once again shows that Nigeria is willing to go beyond the basic recommendations of the ECOWAS document. It could again be surmised that the lack of adequately trained staff and the resources needed to provide home-based care in needy communities are the reason why more specific actions are not included.

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4.2.2.4 Drugs and services required for effective treatment

The ECOWAS policy document established the importance of trained health care workers in the successful implementation of ARV and other drug treatment programmes. However, the ECOWAS document does not discuss psycho-social support and counselling for the general population, nor does it acknowledge the correlation between HIV and AIDS and opportunistic infections, or the need to provide treatment for opportunistic infections related to HIV and AIDS. Both the provision of counselling and the issue of opportunistic infections are stressed within the literature (see chapter one), and it is thus important to consider the Nigerian response in the light of the absence of guidelines from ECOWAS.

i) Increasing the number of trained health care workers

The ECOWAS policy document stresses the importance of properly trained health care workers (see chapter two), including statements that "health care personnel are the most valuable inputs of health systems" (WAHO, 2003:31). However, apart from the prior references (see education and awareness campaigns) to increase the education of health workers about the means of HIV infection, the Nigerian policy document does not really address this issue. It does state that it intends to boost the "capacity of health sector institutions, systems and personnel to plan and manage a well coordinated and adequately resourced health sector response" (Nigeria NSF, 2005:24). This proclamation falls far short of the emphasis placed on training health care personnel by the ECOWAS document. The NSF also does not address the "brain drain" issue which is identified by the regional organisation as a major concern, and which is being experienced by Nigeria. Years of conflict and instability have prompted professionals to leave the country. There are currently an estimated 27 physicians per 100,000 people, and this shortfall is unlikely to be made up from within the current residents of the state, with only 29% of the population attaining secondary school education, and less than 4% of tertiary students pursuing scientific degrees (UNDP, 2004:Internet source). Thus, developing the skills of existing personnel and preventing the migration of these skills should receive greater priority within the Nigerian policy document.

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ii) The provision of psycho-social support and counselling

An important aspect as shown in previous chapters in terms of the literature on HIV and AIDS is the provision of psycho-social support and counselling. The NSF has a much stronger statement on the access of individuals to psycho-social support and counselling than ECOWAS, which only refers to voluntary counselling for the youth. The NSF declares that it will "strengthen socio-economic, nutritional and psycho-social support programmes at all levels for vulnerable groups, including OVC, PABA and PLWHAs" (Nigeria NSF, 2005:24). While a more detailed breakdown of activities is not included, the inclusion of this statement acknowledges the indicator, which the regional body failed to do. The implications of limited resources and poor infrastructure once again come into play (see preceding sections), as the regional body could arguably be focusing the attention of member states on more important issues that need to be addressed in the fight against HIV and AIDS.

iii) Identifying methods of affordable drug procurement

A crucial aspect in the long term sustainability of treatment programmes is the pursuit of affordable drugs, especially given the high prevalence rates which indicate that HIV and AIDS will remain an issue for the foreseeable future. The importance of this issue has been argued by the ECOWAS policy document (see chapter two), yet new sources of affordable drugs are not discussed within the Nigerian policy document, apart from stressing the need to ensure that a sustainable and affordable source of drugs is maintained (Nigeria NSF, 2005:24). No mention is made of either bulk purchasing or the use of generic medications, which are also mentioned in the ECOWAS policy document (see corresponding indicator in chapter two). The more immediate issue is the fact that quality control measures are not discussed (as in the case of section 2.8 of the WAHO policy), despite the high incidence of fake and substandard medications entering Nigeria, as was discussed earlier in this chapter. While Nigeria may not have the infrastructure, resources, or skilled personnel needed to begin manufacturing these essential drugs locally, the policy document should stipulate the long term plans of the state regarding drug procurement.

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iv) Access to medication for sexually transmitted diseases and opportunistic infections

Although the ECOWAS policy document does not acknowledge the link between HIV and AIDS and opportunistic infections, it is reiterated numerous times in the literature (see chapter one). This is important in terms of ensuring that infected persons receive the correct treatment, especially in states such as Nigeria which have a high TB, malaria and HIV and AIDS prevalence rate (see policy environment discussion). Despite the lack of guidance from the regional body, the link between HIV and AIDS and opportunistic illnesses and STDs is acknowledged within the Nigerian policy document. The goal is to scale up the access, quality, and affordability of STIs and reproductive health services, and to promote "access to treatment of opportunistic infections, including tuberculosis and malaria" (Nigeria NSF, 2005:24). The document further states that it will "promote joint programming between HIV and AIDS, TB, RH [Reproductive Health], STIs, as well as linkages between sectors and levels of health care delivery" (Nigeria NSF, 2005:24). This reflects an awareness of the interrelation between these diseases, and the steps being taken to ensure that treatment programmes are amended accordingly.

The ECOWAS document stresses the importance of including traditional medicines in the treatment programmes of member states, and once again Nigeria's policy reflects the application of these guidelines. The involvement of traditional organisations is also mentioned, as is "collaboration with traditional healers" and the provision of training for traditional health care practitioners (Nigeria NSF, 2005:58). This is an essential inclusion given the diverse ethnic groupings present in Nigeria, as discussed above.

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4.2.3 Women and HIV and AIDS

The cultural, social and economic factors affecting the position of women in Nigerian society (and their resulting susceptibility and vulnerability to HIV infection) were outlined at the beginning of this chapter. Briefly; women have poor representation within decision making structures, lower education levels, literacy rates and earning power, and are subjugated to inferior positions through both religious and ethnic practices (including female circumcision and polygamy). The combined effects of these practices can arguably be related to the higher HIV prevalence rate in women, primarily affecting their ability to negotiate safer sex and condom use.

The NSF pays a significant amount of attention to gender-related matters, especially in comparison with the paltry references contained within the ECOWAS policy document. The Nigerian policy document repeatedly states that programmes should be "gender-sensitive and responsive", for example when discussing prevention, care, treatment and support initiatives and non-health sectoral responses (Nigeria NSF, 2005:20). Within workplace responses (see earlier section on education and awareness campaigns) women are specifically referenced, with the Nigerian policy document stating that the integration of "gender as a cross-cutting factor" is a priority (Nigeria NSF, 2005:25).

The policy further aims to "create an enabling social, legal, and policy environment by a 50% increase in the number of reviewed and operational gender-sensitive and human rights-friendly policies, legislations, and the enforcement of laws that protect the rights of the general population, particularly PLWHAs, by the year 2009" (Nigeria NSF, 2005:21). In addition, within the previous section on education and awareness campaigns, the NSF referred to the conducting of "gender disaggregated research of the impact of HIV and AIDS on key sectors" (Nigeria NSF, 2005:27).

While the use of the word "gender-sensitive" is often meaningless when used within policy documents as the concept is not always understood, the NSF document implies through the manner in which these issues are addressed that the concept is grasped, especially in that it recognises that the underlying power relations which are responsible for women's particular vulnerability to HIV and AIDS need to be addressed for momentous changes to occur.

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The NSF also contemplates the manner in which the policy can be advanced in terms of legislation which "supports safer sex practice, reduces stigma, promotes positive living and the rights of women and the general population, particularly PLWHAs" (Nigeria NSF, 2005:27). The listed strategies to attain this goal are:

- The creation of an "enabling policy environment for an effective and gender-sensitive national HIV and AIDS response";
- The removal of "impediments to the attainment of an enabling legal environment";
- The construction of a "gender-sensitive and human rights friendly environment for the effective management of HIV and AIDS responses" (Nigeria NSF, 2005:27).

It is envisaged that this will promote "an engendered and vibrant multi-sectoral response that will mitigate the impact of HIV and AIDS in the country" through activities such as "free education to OVCs, institutions such as NDE and NAPEP for the provision of capacity building (jobs, skills, training) for older OVCs and female headed households, and poverty reduction initiatives [which] will be scaled up to reduce vulnerability" (Nigeria NSF, 2005:25). Women are also specifically referenced within the context of workplace interventions, and are identified as one of the vulnerable groups which must be provided with economic empowerment (Nigeria NSF, 2005:25). In more practical terms, the Nigerian policy document also states the intention to regularly monitor "facilities promoting and dispensing female condoms" in terms of increasing the number of condom outlets and dispensing points, as well as recording the number of condoms which are dispensed (Nigeria NSF, 2005:70).

The improvement of logistical management to ensure the uninterrupted supply of PMTCT drugs is described as a priority, as it is a "means of markedly reducing the number of children born infected from birth" (Nigeria NSF, 2005:24). Included in this section of the policy document is a commitment to address the "specific cultural challenges that fuel stigma and discrimination", particularly towards women (Nigeria NSF, 2005:24). Psycho-social support programmes and welfare initiatives catering for women are also included. The policy expresses hope that "the detailed attention paid to

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the interplay between gender and HIV" and the "specific attention and focus on women, youth and specific groups" will result in a drastically reduced infection rate, which will in turn facilitate increased access to treatment. The stated goal is to treat 250 000 PLWHAs by 2006, expanding to all infected citizens by 2009 (Nigeria NSF, 2005:3).

The references to women and their differing needs, within almost every objective in the policy, shows initiative on the part of Nigeria to ensure that gender is addressed despite the utter lack of guidance from the regional organisation. As pointed out previously, the particular legal and social contexts with which women must contend, and which increase their vulnerability to HIV infection, are not mentioned in the ECOWAS document. The absence of guidelines regarding the assistance which member states could offer female or child headed households is also a serious omission from the ECOWAS policy document.

4.2.4 Funding

In the previous chapter, the limited ability of ECOWAS to assist in the funding of the HIV and AIDS programmes of member states was outlined, and the role of the regional organisation as a guiding body was reiterated. The result was a strong emphasis on securing donor funding, with the primary donors involved in the funding of programmes within the region identified and discussed. Adhering to the same indicators used within the previous chapter to compare the means of funding HIV and AIDS policies, two broad categories will be applied. Firstly, the state's own contribution to public health care will be examined, followed by an overview of external contributors such as bilateral and multilateral donors.

4.2.4.1 State expenditure

According to commitments made in the Abuja Declaration of 2001, participating African states (including Nigeria and South Africa) pledged to allocate a minimum of 15% of their annual national budgets to the fight against HIV and AIDS (UNAIDS, 2001:Internet source). In addition, the UNGASS Agreement stated that an amount of US$7 billion to US$10 billion should be dedicated to overcoming HIV and AIDS,

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revealing the dire financial situation of these states (UNAIDS, 2001:Internet source).[55] However, as pointed out previously, the health care expenditure of most developing states is currently far below these guidelines, as within ECOWAS none of the member states has devoted 15% of their annual budgets towards health care in general, with Gambia spending the highest amount on health care at 12%. Comparatively, within SADC member states, only the DRC and Mozambique meet the Abuja target, spending 17.8% and 19.9% respectively.

While Nigeria is far below this target at 3.3%, the state spent more than US$2 billion on public health care in 2002, almost four times that of the second highest spender in ECOWAS, Cote d'Ivoire, which spent US$725 million during the same period (see chapter three). Further, examining the health expenditure of the ECOWAS member states, it emerges that while public health expenditure falls far short of both needed levels and those recommended by Abuja and UNGASS, it is increasing.[56] In keeping with this trend, Nigeria's public health expenditure increased from 0.8% in 2001 to 4.7% in 2002. It is also important to note the correlation between HIV prevalence and public health care expenditure. Generally, the states with the lowest prevalence rates spend the most on public health care.

However, it is clear that the demands placed on the state far exceed the capabilities of its budget, with private health expenditure soaring. Nigeria's private health care expenditure constitutes 74.4% of the total expenditure on health, and this appears to be a trend within most ECOWAS states, as Togo (89.2%) and Guinea (84.5%) reflect the same range of figures. Within this bleak context, the Nigerian policy document provides a detailed breakdown of each objective, the activities to be pursued for its attainment, and the intended means of funding each of these activities (see Annexure of the Nigerian policy document). However, budgeted amounts are not included, and the percentage which the Nigerian Government will be spending in relation to donors is not clear.

[55] Comparatively, developed countries were asked to commit 0.7% of their annual GDP to assist in overcoming the pandemic, due to their grossly lower prevalence rates (UNAIDS, 2001:Internet source).

[56] On average, public health expenditure doubled from 2001 to 2002, with Togo showing a dramatic increase from 1.4% to 10.5% (UNDP, 2004:Internet source; WHO, 2006a:Internet source). For a comparison of the health care expenditure across ECOWAS member states, see Appendix 4.1.

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With the well-documented link between poverty and disease already established, it is apparent that the state requires some assistance in funding the implementation of its HIV and AIDS programmes. The following section considers the provisions made within the policy document regarding donor aid, and briefly looks at contributions made by donor bodies such as UNAIDS, PEPFAR and others.

4.2.4.2 Donor contributions

The coordination of donor funds falls under the responsibility of the National Action Committee on AIDS (NACA) and the State Action Committee on AIDS (SACA) at the respective federal and state levels, and all resources are directed exclusively to programmes contained within the NSF (Nigeria NSF, 2005:22). Due to the extensive resources required to effectively implement the programme, the policy document states that "the fully costed NSF will be used for a massive resource mobilisation exercise … using innovative approaches like the expansion of the World Bank MAP project to all states, the establishment of state level HIV and AIDS Funds, and support for state proposals to the Global Fund" (Nigeria NSF, 2005:22). There are also commitments by the state to award performance-based grants to the provinces within Nigeria which properly and effectively implement the priorities identified within the NSF, although this process is not expanded upon within the document.

The participation and support of community- and faith-based organisations is advocated within the ECOWAS policy document as part of the multi-sectoral approach aimed at combating HIV and AIDS (see chapter two). In line with this, the NSF reflects on the importance of community- and faith-based organisations, referring to their role in the implementation of HIV and AIDS programmes throughout the document (see section 1.4 of the Nigerian policy document). However, the sheer number of involved entities makes it unfeasible to include them in this study. Similarly, the assistance of the private sector is also addressed within the NSF, which states that this segment of society "will be challenged to embrace corporate social responsibility in providing support to the NSF priorities" (Nigeria NSF, 2005:22). The document also states that incentives such as tax relief will be provided to corporations participating in the funding of HIV and AIDS activities, and that the state, together with partners such as the various AIDS agencies and civil society, "will intensify and widen foreign bilateral relations to bring

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new donors into the external resource pool for the HIV and AIDS response" (Nigeria NSF, 2005:22).

The aid received from the donor bodies discussed in the previous chapter, such as UNAIDS, USAID, and PEPFAR, will be briefly reviewed as they relate to Nigeria. While this is not a comprehensive list of all grants received, it provides some indication of the scale of assistance given to the state, which in turn impacts on how effectively HIV and AIDS programmes can be implemented. As was indicated previously, these bodies are specifically mentioned within the NSF (see section 4.7 of the Nigerian policy document), and are recommended as funding partners in the ECOWAS policy document (see chapter two). The manner in which the aid is awarded and the consistency of the contributions are therefore important to the sustainability and effective implementation of Nigeria's HIV and AIDS policy.

i) UNAIDS

The contributions from UNAIDS are considered in terms of its two primary donor programmes, namely MAP and the Global Fund. MAP does not give details on how the grants are spent within the recipient state, apart from stipulating that the US$90.3 million which Nigeria received be spent on HIV and AIDS activities.

Turning to the Global Fund, Nigeria was granted US$450 million in the period between April 2002 and September 2005 (GFATM, 2005:Internet source). As indicated within the previous chapter, grants from the Global Fund are awarded to proposals for specific projects, reflected below.[57]

- Round 1 (April 2002): Scaling up of PMTCT centres (US$27.43 million), investigating means of garnering greater participation from civil societies (US$1.69 million), scaling up of ARV treatment programmes (US$41.77 million);
- Round 2 (January 2003): Increasing the roll out of malaria control programmes in 12 states (US$44.31 million);

[57] As the Global Fund awards grants for HIV and AIDS, malaria and TB activities (and bearing in mind the discussion earlier in this chapter on the importance of acknowledging the relationship between these diseases), the funded programmes for all three diseases are included. As pointed out previously, a detailed breakdown of the Global Fund disbursements can be viewed in Appendix 3.2.

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- Round 3 (October 2003): no grants awarded;
- Round 4 (June 2004): Improving access to malaria treatment (US$86.12 million);
- Round 5 (September 2005): Scaling up ARV treatment, care and support (US$180.64 million), improving TB treatment (US$68.27 million).

While significant amounts of aid have been awarded, it should be noted that the quantities fluctuate radically from one year to the next, with no resources being awarded in the third round. However, payment is staggered over five years, allowing for evaluations of implementation progress, which ensure that some funds will continually be available.

ii) USAID

While USAID does not contribute massive amounts of money every year, it does provide a fairly constant stream of revenue which does not fluctuate widely in value. Table 4.1 below also demonstrates that Nigeria receives approximately double the amount of the average ECOWAS state. For example, in 2005 Nigeria received US$64 314 in comparison with the ECOWAS average of US$30 359 (USAID, 2006:Internet source). This is presumably due to the higher prevalence rate of HIV and AIDS, and the much larger size of the Nigerian population in comparison to the other ECOWAS states.

Table 4.1: USAID Expenditure in Nigeria

	Nigeria (US$)	Average across ECOWAS states (US$)
2002	66 534	34 209
2003	75 146	38 026
2004	61 122	28 198
2005	64 314	30 359

(USAID, 2006:Internet source).

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iii) PEPFAR

PEPFAR records its contributions to recipient states in terms of projects and programmes assisted, and individuals trained. In its first year, PEPFAR spent US$70 million in Nigeria, providing a range of services shown below. Using the gauge of the number of people assisted, reflected in Table 4.2, awareness and prevention concerns, treatment and care programmes, and health worker training are all included.

It should be noted that a distinction is made between prevention campaigns which promote abstinence and being faithful, and those which advocate other prevention strategies such as condom use. The abstinence oriented mass media programmes reached 64 million people, as opposed to mass media programmes promoting condom use, which were not pursued at all. The priority of PEPFAR appears to be prevention (particularly abstinence), as the awareness campaigns receive greater attention (in terms of people assisted) than treatment and care programmes.

However, counselling and testing services were provided to a significant amount of people in comparison to other activities in the treatment and care category (22 200), with basic health care being received by 39 700, showing that a range of essential activities are being pursued by PEPFAR.

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Table 4.2: PEPFAR Assistance in Nigeria

	Nigeria (people assisted)	**Total in all 15 Focus States**
Prevention (Awareness)		
Community outreach programmes (abstinence and being faithful)	7 812 100	35 572 200
Mass media programmes (abstinence and being faithful)	64 378 900	152 227800
Community outreach programmes (other strategies, including condom use)	852 200	11 899 900
Mass media programmes (other strategies, including condom use)	0	76 620 600
Pregnant women receiving PMTCT services	23 500	1 396 400
Health worker training (promoting abstinence)	14 400	196 200
Health worker training (other prevention strategies, including condom use)	3 000	51 000
Health worker training (PMTCT)	700	24 600
Health worker training (blood safety)	251	6 500
Treatment and Care		
People receiving treatment	13 500	155 000
OVCs receiving assistance	4 100	630 200
People receiving palliative care/basic health care	39 700	854 800
People receiving TB care and treatment	0	241 100
People receiving counselling and testing services	22 200	1 791 900
Health worker training (provision of treatment)	36	12 200
Health worker training (OVC care)	300	22 600
Health worker training (palliative care)	800	36 700
Health worker training (counselling and testing)	200	14 100

(USDS, 2005:Internet source).

4.2.4.3 Summary of Nigerian funding policy

The Nigerian policy document has shown its adherence to the ECOWAS guideline of following a multi-sectoral approach. This implies that while the state bears the ultimate responsibility for funding the initiatives outlined in this policy, the financial burden will be shared amongst a number of stakeholders (see Annexure in the Nigerian policy

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document). These include bilateral and multilateral donors such as the agencies in the UNAIDS consortium, USAID, and PEPFAR, whose contributions were outlined above. As the grants from these donors are awarded on the strength of submitted proposals, Nigeria is shown to be fairly proactive in its applications for funding. The assistance of these bodies, together with the additional contributions of the multitude of CBOs, grass-roots organisations, faith-based organisations, corporations, and other NGOs, facilitates the effective implementation of the HIV and AIDS policies of Nigeria.

It should also be noted that while the Nigerian policy document does not stipulate the budget for the HIV and AIDS programmes outlined in the document, it can clearly be seen that a disproportionate percentage of HIV and AIDS funding is coming from foreign donors. As stated previously, the contributions of corporations, CBOs, NGOs, faith-based organisations and grass roots entities (which together are quite substantial), can not be quantified in this study due to space constraints. However, operating on the assumption that the state is dedicating the amount of 15% of its health care budget to HIV and AIDS as recommended by the Abuja Declaration (which is certainly not the case), places Nigeria's HIV and AIDS expenditure at approximately US$306 million. The combined contribution of the three largest multilateral and bilateral donors (namely, the Global Fund, MAP and USAID) represents 53% of this total. It could be argued that even greater assistance could be forthcoming once the corruption and economic mismanagement, which have characterised the state's financial history thus far, is dealt with (see discussion on the policy environment at the beginning of this chapter). Therefore, despite the currently bleak economic context in which this HIV and AIDS policy was formulated, the financial tide could yet be turned in the fight against HIV and AIDS in Nigeria.

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4.3 CONCLUSION

The purpose of this chapter was to ascertain whether the Nigerian policy document adhered to the guidelines provided by ECOWAS, and if the same strengths and weaknesses are reflected in both documents. Beginning with education and awareness campaigns, the Nigerian policy document followed the framework of the regional organisation, although specific activities were outlined for the achievement of goals (such as the utilisation of the mass media and community outreach programmes), which far exceeded the level of elaboration in the regional document. The most notable departure within this aspect of the HIV and AIDS policies of the two entities regards the social marketing of condoms. The omission of condoms from the ECOWAS document could be its single greatest weakness, considering the level of emphasis placed on condoms within the literature on HIV and AIDS (see chapter one). One of the greatest strengths of the Nigerian document is therefore that condom social marketing is continuously addressed, even more so when considering the possible justifications presented within chapter two for this oversight on the part of the regional body. Firstly, it was speculated that condoms were not included due to the fear of losing funding from donors who advocated abstinence programmes, but this situation was circumvented by Nigeria through the inclusion of both strategies. Secondly, the social and cultural complications which were proposed as the second possible reason were revealed to be rife in Nigeria, yet policies centred around bringing about behavioural changes are at the forefront of the state's education campaigns.

With regard to workplace interventions, both ECOWAS and Nigeria's policy documents reiterate the need to involve corporations in the protection of their workforce, yet neither includes a formal policy on the expected extent of this involvement. However, the NSF does identify more high risk groups which should be included in these programmes than the ECOWAS document does. The youth are a clear priority in the ECOWAS document, and the importance placed on this high risk group is also conveyed within the Nigerian document. An exceptional level of detail is provided, such as the establishment of youth-oriented centres (and the activities to be undertaken in them) and the stakeholders who are expected to participate in this process.

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The second aspect of the HIV and AIDS policies which was addressed concerns the guidelines on prevention strategies. The ECOWAS policy document does not fare as well with prevention issues as with those concerning the education and awareness campaigns above. Firstly, the ECOWAS document fails to provide any guidelines regarding the provision of VCT for the general population, and although the Nigerian document does briefly mention the necessity of providing this service, it does not go into its customary level of detail. Sex worker interventions also receive scant attention from either entity, which is surprising given both the estimated one million sex workers operating in Nigeria, and the continuing push for trade (combined with extreme poverty and unemployment) which encourages the growth of this industry (as was discussed both in this chapter and chapter two). Perhaps this omission is be due to the fact that prostitution is illegal in Nigeria, although given that it is a serious issue in the state, it should be addressed regardless.

In terms of treatment, the ECOWAS document provides fairly clear guidelines to member states regarding the importance of strengthening their health care infrastructures. While Nigeria's document reflects the necessity of this action, it does not address the skills development of health care personnel to the same extent as the regional document. Furthermore, Nigeria is experiencing the "brain drain" which was underlined in the ECOWAS document, yet possible steps for stopping this outflow of expertise are not included.

The development of domestic industries for the local manufacture of essential drugs is mentioned in both the ECOWAS and Nigerian policy documents, yet neither entity elaborates on how to achieve this goal. This could be a mutual recognition of the lack of adequate resources or infrastructure to realistically attempt such an undertaking. The provision of home-based care is also neglected by both policy documents, although the Nigerian policy does at least mention it, and notably refers to the need for ensuring that the provision of home-based care is gender-sensitive. The need to provide psycho-social support and counselling is not adequately addressed by the ECOWAS document, which mentions it only in passing with reference to the youth. While Nigeria's policy does stipulate that it is a service which should be provided to the general population, no details are provided. This could, once again, be put down to the dire lack of resources and skilled personnel needed to effectively implement this type of programmatic action.

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The guidelines laid out in the ECOWAS policy document regarding affordable drug procurement are uncharacteristically eloquent, discussing options such as bulk procurement and generic substitution. However, this focus is not reflected in the Nigerian document, which is completely lacking in any long term strategy statements. Next, the correlation between HIV and AIDS and opportunistic infections is not acknowledged by the ECOWAS document, although the NSF presents a number of strategies for dealing with this important issue, including inter-sectoral programmes for better access to the necessary medications.

The vulnerability of women due to traditional social and cultural practices, and exacerbated by economic factors such as poverty and unemployment, is clearly acknowledged within the Nigerian policy, and the document generally shows an awareness of, and sensitivity to, the unique pressures placed on women with regard to HIV and AIDS. The Nigerian document displays initiative in including a number of women-specific programmes, including legal reforms protecting the rights of women, and drives to increase outlets for the dispensing of female condoms. This is made more remarkable by the mediocre attempt at gender-sensitivity displayed in the ECOWAS document, which provides no guidance on this issue whatsoever.

In terms of funding, the Nigerian document adheres closely to the recommendations provided in the ECOWAS document, particularly with regard to the bilateral and multilateral donors which should be approached for assistance. The pursuit of the suggested multi-sectoral approach in terms of corporate involvement, and the participation of NGOs, CBOs and the like, is also adopted in the Nigerian policy.

In general, the sparse guidelines laid out in the ECOWAS policy document necessitate initiative on the part of member states to fill in important gaps, particularly with regard to condom social marketing, VCT, and women. However, important aspects such as affordable drug procurement, and the improvement of the skills of health care personnel (and the prevention of the “brain drain”), are extensively dealt with in the ECOWAS document, and this emphasis is not necessarily reflected in the Nigerian document. Thus, similar strengths and weaknesses emerged, although the Nigerian policy is definitely more elaborative with regard to addressing the issues established from the literature on HIV and AIDS. However, more guidance from the regional body

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on certain issues is certainly needed (as pointed out above), even if all member states do not incorporate every guideline in the regional document into their national policies. The information on how to achieve the stated goals must also be included in the regional document to assist member states in formulating effective health policies of their own. The next chapter will examine if a similar pattern emerges in the case of SADC and its strongest state, namely South Africa.

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CHAPTER 5: SOUTH AFRICA'S HIV AND AIDS POLICY

5.1 INTRODUCTION

As the previous chapter provided an analysis of the extent to which Nigeria's HIV and AIDS policy adhered to the guidelines set forth by the ECOWAS document, this chapter will similarly consider South Africa's policy in contrast to that of SADC. The same format will be followed, namely a brief discussion of the South African policy environment informing the context of the HIV and AIDS policy documents, followed by an overview of the formulation of the current South African HIV and AIDS policy. Retaining the format used in the discussion of the SADC document (and the Nigerian policy in the previous chapter), the South African HIV and AIDS policy will be examined in terms of the indicators established in chapter one; education and awareness campaigns, prevention strategies, and treatment and care programmes. The prominence of gender within the formulation of the policy and subsequent actions will once again be addressed in a separate section.

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5.2 SOUTH AFRICA

The unique social, cultural, political and economic context of South Africa has a marked influence on the policies pursued by the state. These contexts, or policy environments, will be discussed below.

5.2.1 South African Policy Environment

The Republic of South Africa has a population which comprises of many religions, cultures, and indigenous beliefs, and is a dominant force within the regional organisation of SADC (see chapter one). However, South Africa reports that 10.08 million HIV positive individuals are living within its borders, together with 173 530 tuberculosis sufferers, necessitating a strong response from the state. These issues (and many others, some of which are addressed below), need to be examined as they impact on the response of the state to HIV and AIDS.

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5.2.1.1 Health care infrastructure, demography and socio-cultural values

As with most developing states in Africa, South Africa has to contend with an underdeveloped health care infrastructure which is in dire need of more personnel to provide effective and efficient treatment. It is estimated that there are only "7 784 medical doctors, 42 373 professional nurses, and 1 561 pharmacists serving a population of more than 44 million" (Gadebe, 2006:Internet source). The shortage of health care personnel is especially felt in the rural areas, and is a factor in the slow roll out of ARVs, which require the supervision and monitoring of properly trained medical staff for effective administration. The necessity of training health care workers on issues around HIV and AIDS can not be emphasised enough, as it is estimated that 30% of student nurses are HIV positive, and 15% of staff nurses are infected with HIV and AIDS (Geffen, 2002:137). The HIV prevalence rate amongst doctors is estimated at around 10%.

South Africa has a diverse cultural and multi-ethnic population, with a variety of tribal groups and religious sects. Black Africans constitute approximately 79% of the population, followed by whites (9.6%), coloureds (8.9%), and Indians/Asians (2.5%) (RSA, 2006:Internet source). These distinctions are important in the political context due to the colonial legacy of the state and the policy of apartheid, which will be discussed below. Of further import to the discussion of the HIV and AIDS policy environment is the multitude of languages and religions in the state[58], as these particular factors influence the methods employed in education and awareness campaigns aimed at affecting behavioural changes, as well as the languages used. In addition to the major religions such as Islam, Christianity and Judaism (which provide their own differing views on the acceptable manner in which sexual diseases may be discussed and dealt with), there are also a plethora of indigenous beliefs intertwined with these faiths, further complicating the response of the state.

[58] South Africa has 11 official languages (corresponding fairly closely to the major tribal groupings in the state). Christianity is the primary religion in the state (80%), with the remaining 20% of the population practising Judaism, Islam, and Hinduism. Traditional beliefs are often integrated into these religions (RSA, 2006:Internet source).

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As discussed in chapter one, programmes affecting behaviour change (such as high risk sexual behaviour) must be culturally sensitive in order to be successful. Furthermore, if the message is not conveyed in a language which is understood by a significant portion of the population, the programme can not be effective. Provisions must therefore be made within the South African policy to ensure that the major cultural and language groups are accommodated, particularly in high risk communities. This is addressed to some extent with the involvement of traditional leaders in the formulation of HIV and AIDS policy, as will be discussed below.

The importance of ensuring the efficacy of HIV and AIDS programmes is underscored by the fact that South Africa has the highest HIV prevalence rate of the SADC states (10.1 million HIV positive citizens), an average life expectancy of only 48 years, and an economic workforce with an average HIV prevalence rate of 15% (Ford, Lewis & Bates, 2002:13). The contributing factors to these statistics, such as migrant labour from across sub-Saharan Africa, misinformation and social inequalities, are highlighted in the section below. Further, the country had more than 1.2 million orphans as a result of HIV and AIDS in 2003, with the figure continuing to climb (UNAIDS, 2006:Internet source). This has implications for literacy and education, as these children become the heads of their households and can not continue their schooling, pushing them into the informal job sector and continuing the cycle of poverty.

The traditionally subordinate role of women in patriarchal African societies has been discussed at length in chapter one, and South African women are no exception, with Fourie (2005:85) stating that "women's disempowerment finds its most severe application in sexual relations. Rape (including marital rape) is endemic to our society, and cultural factors ensure that women have very little say over their sex lives".
It is noted by Trengove-Jones (2005:Internet source) that:

> *"While violence against women leads inexorably into matters of gender inequality, it also intersects inevitably with broader patterns of violence in our country, patterns which are partly a result of the huge disparities of wealth. Such disparities issue in feelings of anger, frustration and resultant conflict. Women are multiply disadvantaged by HIV and AIDS with their gender, familial and economic positions rendering them especially vulnerable".*

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The cultural practices of polygamy and viewing the number of children as an indicator of wealth further subjugate the rights of South African women. South Africa is making strides in terms of women's representation in decision making structures, with almost 33% of parliamentarians being female.[59] In terms of education and literacy, South Africa is not faring badly for a developing African state, with 80.9% of its female citizens being literate, compared to an average of 68.5% for all SADC states (84.1% of male South Africans are literate). These issues, together with the Constitutional Court battle for the use of ARVs in PMTCT, will be discussed at greater length in the section on women and HIV and AIDS.

5.2.1.2 Socio-political environment

Prior to gaining independence from Britain in 1961, South Africa had been governed by various colonial powers, which began the subordination of the indigenous populations and gradually deprived them of basic legal rights. (RSA, 2006:Internet source).This included the allocation of approximately 13% of the land as reserves, which were the only legal place of residence for the indigenous population, displacing 35 million people. Migrant workers were required to carry pass books when employed in the urban centres, and would reside in dormitory-style hostels and informal housing while working in the cities. Consequently, these (mostly male) workers would be separated from their families for extended periods of time, and high risk sexual behaviour was not uncommon.

After becoming a Republic in 1961, the country continued to be ruled by the white minority party, the National Party (NP), which intensified the segregationist policies into "apartheid" or "separate development". The social impact of subjugating the indigenous population to the status of second class citizens for more than 400 years, together with the economic ramifications of denying legal recourse to these workers, placed these individuals at much higher risk to HIV and AIDS (the link between poverty and disease was explained in chapter one). The NP followed a conservative

[59] The latest round of elections showed significant improvement in women's representation, with Mozambique reporting that women constitute 37.2% of their parliament, followed by South Africa, and Tanzania at 30% (Sadie, 2005b:18). Female parliamentarians now represent almost 20% of the average SADC member state's parliament, up from 16% in 2004 (see chapter one).

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Christian ideology which was often at odds with the traditional beliefs of the indigenous people of South Africa. This intensified the distrust between these people and the white government, as seen in the parodying of the AIDS acronym; "Afrikaner Invention to Discourage Sex" (Fourie, 2005:67).

After the first democratic elections in 1994, the new representative government inherited a legacy of misinformation and inaction, compounded by preconceived ideas of HIV and AIDS as a white and homosexual disease. During the eight years of President Nelson Mandela's term in office, little was accomplished in changing these perceptions. The first major debacle was the Sarafina II AIDS awareness play, which squandered a significant one fifth of the national health budget, alienated AIDS civil society organisations who were not consulted, and called the state's transparency and accountability to key actors in the HIV and AIDS community into question (Fourie, 2005:176).

The second fiasco of the Mandela presidency was the Virodene debate. Virodene was lauded as a new miracle drug for AIDS treatment, despite not having successfully completed clinical trials. The government continued to push for its use despite consensus within medical circles that the drug was toxic and "unfit for human consumption" (Fourie, 2005:178).[60]

The following administration, under the leadership of President Thabo Mbeki, continued to generate controversy by protesting against the use of ARVs in HIV and AIDS treatment, despite overwhelming medical evidence of their efficacy, citing the toxicity of these drugs as the reason for their opposition to the use of AZT and Nevirapene, amongst others (Fourie, 2005:178). This "anti-intellectual" stance continued, with President Mbeki publicly questioning the link between HIV and AIDS, and Minister of Health Manto Tshabalala-Msimang (2003:18) advocating a diet of African potatoes, garlic and olive oil for AIDS sufferers. Apart from widespread derision from the press and the HIV and AIDS community, the impact of muddled and contradictory messages from the government severely hampered the education and awareness drives aimed at the general population. This necessitated a strong emphasis

[60] The interference of the government in established medical practices such as peer review and the dismantling of the independent medical control council is eloquently discussed in Fourie (2005).

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on the correction of misinformation in subsequent HIV and AIDS policies, and the building of meaningful partnerships with the actors in the HIV and AIDS community in the implementation of these policies to lend them some credibility.

5.2.1.3 Socio-economic aspects

South Africa is considered an economic powerhouse within the SADC region, and is a dominant force amongst the SADC states (Hettne, 2001:39; Greer, 1992:31). The country has the highest GDP of the SADC states, earning US$104.2 billion annually, followed by Angola at US$11.2 billion.[61] As a major trade hub, migrant workers and long-distance truck workers are plentiful and, as mentioned in chapter one, these individuals constitute an especially high risk group for HIV and AIDS. A recent study conducted along the Maputo Corridor between Mozambique and South Africa revealed that less than 30% of these long-distance transport workers have medical aid or insurance, and more than half of these workers have sexual relations with multiple partners (Randall, 2002:93). These transport corridors (which are examined within the policy discussion below) also promote commercial sex work, and Ford *et al* (2002:18) postulate that this may be due to the "large surplus labour/unemployment problem and the skewed labour skill, racial and education gradients of HIV and AIDS [which are] all conditions that affect the projected macro-economic impact, and must be factored into policy making".

Further influences on HIV and AIDS policies include the consideration of poverty and access to mass media, as mentioned in the previous chapter. South Africa reports that approximately 34% of its population is living on less than US$2 per day, indicating that poverty is a very real concern limiting treatment options which citizens can realistically afford. In terms of access to mass media, which influences the types of communication campaigns pursued by the state, radios are owned by 36% of the South African population, with 15% owning television sets, and only 3.3% regularly buying newspapers (UU, 2004b:Internet source). Together these factors provide the environment in which South Africa's HIV and AIDS policy is formulated.

[61] South Africa also has the highest external debt (US$27.8 billion), followed by the DRC (US$11.1 billion), and Angola at almost US$9.7 billion (see chapter three).

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5.2.1.4 HIV and AIDS agreements

South Africa is a signatory of a number of regional and international agreements outlining targets for the effective combat of HIV and AIDS. These include the SADC Maseru Declaration, the United Nations Millennium Goals, and the UNGASS Declaration (SADC, 2003:8). The South African policy documents further state that "at the regional level, the response has been accelerated through the identification of HIV and AIDS as a core priority in NEPAD and the International Partnership Against AIDS in Africa" (SADC, 2003:8).

A prominent initiative involving both regional groupings (and their member states) is the Protection and Care of Families Against HIV and AIDS (PACFA), a limited partnership initiative being undertaken in the Great Lakes Region. The programme was formed under the Kigali Declaration of 2004, involving seven core states in the Great Lakes region, with South Africa co-opted (UNIFEM, 2004:Internet source). Specifically aimed at women and children, it is intended to be a complementary extension of the existing national strategies of member states, as well as allowing these states to observe agreements and conventions that have been signed under bodies such as the UN (UNIFEM, 2004:Internet source). These include, amongst others, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the African Union Declaration on Gender Equality, and the Protocol on Women's Rights, signed in Maputo in 2003.

A unique aspect of this programme is that it is the result of concerted, coordinated efforts by the First Ladies of the respective states to ensure that women and children, representing citizens at high risk and who experience the most adverse effects of the disease, are protected and taken into account during policy formulation (UNIFEM, 2004:Internet source). As the goals of this initiative are incorporated into the national programmes of member states, it has led to the development of projects for the protection of women and children that did not exist previously. This initiative has provided the guidelines for policy makers wishing to ensure that the rights of women and children are provided for within programmatic actions.

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The documents also note that the Department of Health (DoH) policy will "pursue collaboration and harmonisation of strategies within the region, in line with the SADC HIV and AIDS Strategic Framework 2003-2007 (RSA DoH, 2003:25). Given the somewhat stilted and rocky start of the South African Government in formulating an effective policy response to HIV and AIDS, expectations were high for the content of the new policy document. Using the indicators applied to the SADC document in chapter two, the documents released by the South African Department of Health (DoH) will be examined to ascertain whether the guidelines provided by the regional organisation are reflected in this new policy.

5.2.2 The South African HIV and AIDS Policy

The South African response to HIV and AIDS began in 1992 with the formation of the National AIDS Coordinating Committee of South Africa (NACOSA) at an AIDS conference (RSA DoH, 2003:13). The first comprehensive policy formulated by the post-apartheid government, entitled the National AIDS Plan (NAP), was released in 1994, but was declared ineffective and idealistic by 1997 (Fourie, 2005:163).[62]

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Following a series of poorly managed debacles (outlined above), the policy was only revisited in 1999, and the resulting HIV/AIDS/STD Strategic Plan for South Africa (2000-2005) was released by the Department of Health (DoH) in 2000. The policy provides the framework for all HIV and AIDS actions undertaken by the state, and together with the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (released in 2003) is the complete South African response to the HIV and AIDS pandemic. The documents incorporate a number of international and regional agreements, including the UNGASS Declaration, to which South Africa (like the other SADC member states) is a signatory, as stated above.

The comprehensive 300-page policy was drawn up in consultation with various parties including faith-based organisations, PLWHA, academic bodies, human rights organisations, organised labour, the media, business and insurance companies, donors,

[62] An evaluation of the NAP described the policy as a "wish-list; the ultimate luxury afforded to policy makers who had been operating outside of the harsh constraints of budget realities and any real consideration for implementation capacity" (Fourie, 2005:163).

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and a variety of health professionals and organisations (RSA DoH, 2000:5; RSA DoH, 2003:17).

Associated contributory problems are integrated into the policy (outlined above in the policy environment section), including "socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy, lack of formal education, stigma and discrimination" (RSA DoH, 2000:8; RSA DoH, 2003:19).

The general purpose of the documents is to serve as a broad strategic plan for the country's response to HIV and AIDS. The policy states that it is "not a plan for the health sector specifically, but a statement of intent for the country as a whole, both within and outside government" (RSA DoH, 2000:5; RSA DoH, 2003:175). It goes on to declare that all sectors, ministries and departments must share in the responsibility for overcoming the pandemic.[63]

A number of causes for the high prevalence rate are identified, including behavioural issues such as unprotected sexual intercourse with multiple partners, biological determinants such as the elevated STD rate (especially amongst the youth), and the contributory issues noted above such as poverty, lack of infrastructure and personnel, and gender discrimination (RSA DoH, 2000:8; RSA DoH, 2003:22). It should also be noted that the policy document acknowledges South Africa's role as host of the SADC Health Desk since 2001, focusing on means of coordinating and harmonising the regional response to the pandemic, and emphasising the "improved quality and coverage of the response to HIV/AIDS/STD both at national and regional level" (RSA DoH, 2000:11; RSA DoH, 2003:15).[64] The implication of this will receive further attention in the discussion below and in the concluding remarks of the next chapter.

[63] For a more detailed evaluation of the South African HIV and AIDS policy and its origins, see Fourie (2005).

[64] The influence of South Africa's stewardship of the SADC Health Desk is apparent when comparing the two SADC HIV and AIDS plans (2000 and 2003), and while the implications are touched upon in the conclusion, the possible South African inputs on the SADC policy will be pointed out in the text.

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5.2.2.1 Education and awareness campaigns

The use of multiple languages in conveying the messages within the education and awareness campaigns is crucial for comprehension and understanding within the general population, as well as increasing the acceptance of the content of the messages since they are delivered in a mother tongue. This is especially relevant in South Africa, as it is a country with a diverse, multi-linguistic population, as discussed above, and is particularly important for those policies attempting to affect radical behavioural changes. The guiding principle for all education and awareness campaigns is thus that "education, counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times" (RSA DoH, 2000:15).

i) Safe sex, nutrition and health care services

As the first line of defence in the fight against HIV and AIDS, accurate information which fosters awareness and understanding of the pandemic is crucial. The DoH strategy is aimed at being an "effective and culturally appropriate information, education and communications (IEC) strategy" (RSA DoH, 2000:16, RSA DoH, 2003:23). A broad range of target groups are identified, specifically the youth, migrant workers, trade unions and transport workers.

The identification of these high risk groups correlates with the SADC document, although the DoH policy documents also list a number of activities which will be undertaken to meet the stated objectives of behaviour change and lifestyle transformations, an inclusion not found in the SADC policy. These activities include life skills education in primary and secondary schools, the use of the mass media (television, radio, billboards etc) and targeted programming such as *Soul City* and *Soul Buddyz*. These state subsidised programmes will be discussed in more detail within the youth participation indicator below. However, it should be noted that the SADC policy document does emphasise the impact of HIV and AIDS on education, as seen in the statement that the "SADC Education Policy Support Initiative has supported studies on HIV and AIDS Education Policy … piloting the integration of HIV and AIDS [into education drives]" (SADC, 2003:9).

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The awareness campaign being proposed within the DoH policy documents also extends to targeting government departments in all sectors, specifically citing correctional services, the police, and local government departments (RSA DoH, 2000:18; RSA DoH, 2003:78). Apart from education drives, this initiative includes counselling and treatment, and the distribution of condoms within government buildings (RSA DoH, 2000:18). Further, the development of e-newsletters and web-site briefings for government employees is discussed, with the aim to provide weekly updates on the HIV and AIDS plan at the provincial and district level (RSA DoH, 2003:180). This emphasis on educating and protecting the employees of the state is not present in any of the other policy documents under discussion, and demonstrates South Africa's commitment to a truly multi-sectoral, all encompassing HIV and AIDS response. The commitment to a multi-sectoral response can be further seen in the statements in the policy document on the involvement of CBOs in education and awareness campaigns. One such declaration is that "community-based services can do a great deal to minimise fear and discrimination, providing and reinforcing accurate information to address the stigma surrounding HIV infections" (RSA DoH, 2003:60).

General awareness about the disease and its transmission is not the only type of education drive being advocated within the policy documents. It is proposed that human rights and the creation of an appropriate social environment could be encouraged through bodies such as the National Inter-Sectoral Campaign on Openness and Acceptance of People Living with HIV and AIDS (RSA DoH, 2000:23). Such a campaign would aim to reduce the discrimination and stigma directed towards PLWHA, as well as facilitating open discourse about sexual practices. The primary goal of such an initiative would be to "target awareness regarding rights and responsibilities of people living with HIV and AIDS in four key areas: employment rights, education, health care, and social service rights" (RSA DoH, 2000:23, RSA DoH, 2003:16).

The importance of legislation protecting the rights of PLWHA is also discussed within the policy documents, as is the monitoring of abuse and discrimination directed against PLWHA. The inclusion of a discussion on legislation is noteworthy when considering that altering the social and legal environment of HIV and AIDS sufferers is a necessary long term consideration, as protective legislation will become increasingly crucial in all

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spheres to ensure that the basic human rights of PLWHA are defended. Perhaps South Africa has acknowledged this need, and given the tedious nature of enacting legislation, the state has thus begun this process despite a lack of guidance from the SADC document.

ii) Condom social marketing

Whereas both regional documents shy away from the issue of condoms altogether, the DoH documents emphasise both the provision and social marketing of condoms. Despite the possible cultural and religious factors acknowledged previously, condoms are mentioned in almost every objective within the policy documents. For example, one stated goal is to provide access to both male and female condoms through "non-traditional outlets", as well as in "high transmission areas" such as truck stops, border posts, mines and brothels (RSA DoH, 2000:18; RSA DoH, 2003:20). Focusing solely on the marketing of condoms, the documents aim to "increase acceptance, attitudes, perceptions, efficacy and use of condoms as a form of contraception among the youth" (RSA DoH, 2000:18). The need for condom distribution amongst the high risk demographic of 15-25 year olds is repeatedly noted in the policy documents, which is especially noteworthy when considering that the SADC policy document makes no mention of condom use at all. While it has been proposed that this could be due to both the cultural value systems of African society and the desire not to alienate donors, the South African documents clearly consider the long term implications of not promoting condom use as outweighing the possible loss of aid grants, as well as determining that affecting behavioural change is crucial despite the challenge of overcoming deep-seated traditional cultural beliefs.

iii) Workplace interventions

South Africa's position as an economic powerhouse within the region has been pointed out above, and as such the protection of the state's workforce is essential. The DoH documents state that, as general health care is already provided by some of the large industries, "entering into partnerships with these industries to support the implementation of this plan for their existing workers that may require HIV and AIDS care and treatment could prevent these workers from flooding the public health

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facilities. In addition, these industries could provide support in … the continuum of care" (RSA DoH, 2003:121). Reiterating the necessity of involving the corporations operating in the region to ensure the welfare of their workers (see discussion in chapter three), South Africa has developed a framework for the involvement of these actors in the HIV and AIDS policy. The *Code of Good Practice on HIV and AIDS in the Workplace* is explicitly mentioned within the policy documents, thereby formalising the requirement of employers to put policies into place which protect their workforce (RSA DoH, 2000:24). This correlates with the SADC policy document, which also references a *Code on HIV and AIDS and Employment*, drawn up in conjunction with international labour organisations (SADC, 2003:13). Both documents state the necessity of drawing up legislation supporting these codes of employment, ensuring that they become an entrenched aspect of the policy environment. As the South African employment code was published first, the inclusion of the workplace intervention guidelines in the SADC document could be evidence of South Africa's influence as host of the SADC Health Desk, referred to earlier. In the next section, further expectations of employers with regard to the provision of on-site counselling and testing services are discussed, which once again demonstrates the determination of the DoH to be more lucid about its demands of corporations operating within the state.

iv) Focus on youth participation

The vulnerability of the youth to HIV and AIDS (and STD's) is stressed within the SADC policy document (see chapter two), and the South African policy certainly emphasises the need to protect this high risk group. Among the many references to the youth within the DoH policy documents, is the objective to "increase access to youth friendly reproductive health services – including STD management, VCT and rapid HIV testing facilities" (RSA DoH, 2000:19; RSA DoH, 2003:57). This will be achieved through ensuring that clinics are youth-friendly, and equipping schools to provide counselling and support services. Further, continual behavioural and STD surveys will be conducted to ascertain the effectiveness of programmes (RSA DoH, 2000:23). According to the DoH documents, the government will also undertake to "review and enact a new Children's Law to take into account the needs of children infected and affected by HIV and AIDS" (RSA DoH, 2000:23). The attention to specific actions which will assist in implementing the policy, as well as the outlining of protective

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legislation, are inclusions which are characteristic of the policy's multi-sectoral, forward-thinking approach.

A number of innovative awareness campaigns are referenced within the DoH policy documents, and as "the current government campaigns have achieved a number of successes in both the development and implementation of their objectives … the communication campaign should build on these achievements" (RSA DoH, 2003:177).

One of these successful initiatives which is being retained by the DoH is *Soul City*, an NGO established by the Institute for Health and Development Communication (IHDC) in 1992 to promote health and development in South Africa through the power of the mass media (Soul City, 2004:Internet source). Through a partnership with Government and various corporate sponsors, two multimedia campaigns were established; *Soul City*, which is aimed at the entire population, and *Soul Buddyz*, which targets children. *Soul City* has been running for ten years, boasting six series that have won awards for both drama and education, and it is ranked as one of the three most watched programmes on South African television. The radio series of *Soul City* is broadcast in nine languages, making it one of the most accessible campaigns available.

This multi-tiered approach allows the programmes to reach an extremely wide section of the population, regardless of their language or socio-economic position. The topical and vibrant approach of the programme towards important issues in South Africa makes the message easier to understand and follows a clear "info-tainment" approach that conveys crucial factual information whilst entertaining the public. This ensures that there is a dedicated viewership, which in turn guarantees that there is repeated exposure to the message (Soul City, 2004:Internet source).

Soul Buddyz was first aired to its key audience of 8-12 year olds in 1999, and was voted the most popular children's television show in South African history (Soul City, 2004:Internet source). *Soul Buddyz* follows the proven multiple media formula of *Soul City* by being broadcast on television, radio and in print in nine languages. Life skills

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books have also been introduced, interactively reinforcing the important messages and life skills presented in the show (Soul City, 2004:Internet source).[65]

Thus, the initiatives outlined above not only aim to educate the youth about HIV and AIDS, but also intend to address the underlying social and cultural values which inhibit frank discussions about essential issues surrounding the disease. Further, the use of peer counsellors (such as the *GroundBreakers* associated with the *LoveLife* campaign) also contributes to the achievement of goals provided in the SADC policy document, such as the " fostering of positive cultural values", as such changes are most effective when the catalyst comes from within the community, as discussed in chapter one (SADC, 2003:22).

As mentioned above, some of these actions (like formulating legislation, or changing cultural beliefs) may not occur within the given time span of the policy. However, the inclusion of such long term plans shows some thought on the part of the South African Government about the potential problems created by an epidemic with a potential lifespan of several decades.

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5.2.2.2 Prevention programmes

The SADC policy documents touch on the essential aspects (presented as indicators) which should be addressed within an effective HIV and AIDS policy, such as the provision of voluntary counselling and testing, ensuring the availability and accessibility of condoms and drugs such as ARVs, and targeted interventions for commercial sex workers. As was discussed in chapter two, the SADC document does not provide comprehensive guidelines within this set of indicators, and it is shown below that the DoH documents place more emphasis on elements such as VCT and condom provision, which is consistent with the literature (see chapter one).

[65] Independent evaluations provide telling evidence on the success of this campaign: 47% of South Africans cite *Soul City* as their leading source of information about HIV/AIDS; 79% had some knowledge about the show and its key messages; 67% of children have been exposed to at least one format of *Soul Buddyz*, of which 65% cited it as their favourite program; 92.9% of caregivers surveyed indicated that the children had achieved a better understanding of the issues facing them in today's society (LoveLife, 2004:Internet source).

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i) Voluntary counselling and testing

The provision of voluntary counselling and testing is considered an imperative aspect of HIV and AIDS policies as it allows the state to determine the true extent of the problem, and make provisions accordingly (see chapter one). The DoH policy documents "propose VCT as a crucial entry point into the care and treatment programme" (RSA DoH, 2003:27). Further, the "programme aims to expand VCT services, so that people may know their HIV status and take appropriate actions" (RSA DoH, 2003:27). In addition to the above stated goal within education and awareness campaigns to increase youth access to VCT, the DoH policy documents also stress the expansion of testing and counselling services for the general population (RSA DoH, 2000:16; RSA DoH, 2003:20). The education and training of peer counsellors is also highlighted by the DoH, as is the construction of more testing and counselling facilities, particularly noting the need to "increase the proportion of workplaces that have on-site counselling and testing services" (RSA DoH, 2000:20). These last three innovations are noteworthy in that South Africa is once again clearly articulating the responsibility of employers in protecting their workforce, as well expanding considerably on the limited mandate outlined by the regional document, which mentions the development of "standards in VCT…to guide member states in implementing VCT programmes", but does not include these standards within the document (SADC, 2003:10).

ii) The availability and accessibility of condoms and drugs (including ARVs)

The importance of condom use (and condom social marketing) can not be stressed enough, as has been shown in the literature in chapter one. Despite this consensus amongst experts in the field, the SADC document makes no reference to condom provision. The South African documents thus depart significantly from that of the regional body as the multiple references to condom availability and use discussed above demonstrates, particularly the provision of condoms within government buildings. Access to treatment (including ARVs) is mentioned in most priority action statements in the DoH documents, with a statement indicating that a priority is placed on the "procurement and/or production of necessary medications and consumables at the lowest prices possible and an increase in the capacity and security of the drug distribution system (RSA DoH, 2003:15). Further, survey results are included in the

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documents, detailing the projected number of patients requiring ARVs, with estimates placing 1.5 million individuals in need of treatment by 2008 (RSA DoH, 2003:53). This level of elaboration is not a reflection of the vague statements within the SADC document, which undertakes to facilitate access to essential medicines, but does not provide suggestions on the manner in which this can be achieved, or the potential scope of the needed medications.

As a further preventative measure, the DoH documents discuss a number of issues relating to blood services, such as ensuring safe blood transfusions, and "improving the recruitment of low-risk blood donors" (RSA DoH, 2000:20), a measure not discussed at all within the SADC document. A related policy objective in the DoH documents which would assist in reducing some of the costs of treatment for patients is the goal to "ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV positive clients" (RSA DoH, 2000:21). Once again, the reference to protective legislation shows foresight on the part of the DoH, as this issue is not addressed within the SADC document.

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iii) Interventions within the sex industry

South Africa's dominant economy (discussed above) creates heavy traffic between states in the SADC region, with both transport and migrant workers moving along the major trade routes. In conjunction with the poverty and unemployment experienced throughout the region, this has created a sex industry along these roads (see chapter one), and targeted interventions are thus needed to prevent infections amongst these high risk groups of commercial sex workers, transport and migrant workers.

This issue is highlighted in the SADC document, which advocates the implementation of "HIV and AIDS information, education and communication activities targeting truck drivers, railway workers and commercial sex workers" (SADC, 2003:9). This mandate is expanded by the DoH, as seen in the forward-thinking strategies such as the launch of a policy (with supporting legislation) which offers protection to victims of sexual violence, including sex workers (RSA DoH, 2000:24). The administering of post-exposure prophylaxis treatment is also mentioned. Further, it is stated that decriminalising commercial sex work will be investigated. This is a significant

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breakthrough, as it acknowledges the human rights of this massive high risk group, as well as conceding that it is a situation that must be dealt with head on as it is likely to remain for the foreseeable future.

Tying in with the sex worker interventions are programmes which target the high risk groups which frequent these sex workers, such as migrant and transport workers. This is addressed within the policy documents, with special focus on cross-border interventions and the Maputo Corridor route (RSA DoH, 2000:18). This initiative is implemented in conjunction with other SADC states, although they are not named within the document, and UNAIDS is also mentioned as an operating partner. Initiatives such as these are also referenced within the SADC policy document, which also mentions initiatives in the Beira, Maputo, North-South, Trans-Kalahari, Walvis Bay, Trans-Caprivi, and Lobito transport corridors (SADC, 2004:32).

5.2.2.3 Treatment infrastructure

The third dimension of HIV and AIDS policies addressed by the SADC policy concerns the treatment infrastructure of member states, and considers the expansion and strengthening of infrastructures to facilitate better service delivery, the development of domestic industries for the provision of essential medicines, and the provision of home-based care. While the latter two indicators are considered to be long term issues, they are emphasised in the literature (see chapter one) and should thus be addressed to some extent within the policy documents.

i) The expansion and strengthening of infrastructure

The importance of infrastructure development and strengthening in ensuring the proper implementation of treatment policies is discussed in the SADC document, which notes the need to address resource constraints and means of "strengthening the regional quality control infrastructure, including the sharing of relevant information" (SADC, 2003:8). Following this lead, the DoH documents are expansive on means of ensuring better service delivery and more effective resource utilisation, specifically noting means of eliminating duplication and increasing coordination between programmes (RSA DoH, 2000:26; RSA DoH, 2003:18). This is to be achieved through the further

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development of infrastructure capacity and the establishment of "strong links between health facilities and community-based support programmes" (RSA DoH, 2000:21). It is further stated that "more than half of the total expenditures envisaged in this plan will go towards strengthening the national health system … [to] improve the overall capabilities" (RSA DoH, 2003:20). The level of detail in the DOH documents far exceeds that of the regional document, although the central tenets remain the same.

ii) Developing domestic industries for the provision of essential medicines

The need to ensure an uninterrupted supply of affordable essential drugs has been discussed both within the SADC document (see chapter two) and in the literature in chapter one. The SADC guidelines specifically mention the encouragement of local manufacturing of generic medicines, as well as developing the "regional capacity for pharmaceutical manufacturing" (SADC, 2005:Internet source).

The DoH policy states that the South African government will "support efforts to develop a Clade C HIV vaccine", including the conducting of biological and behavioural research, the establishment of ethical guidelines, and continuing support for the South African AIDS Vaccine Initiative (RSA DoH, 2000:22). Further references are made to the development of drug procurement strategies which "should allow South Africa to develop over time a fully integrated local pharmaceutical production capacity for essential medicines, including [ARVs]" (RSA DoH, 2003:31).

iii) The provision of home-based care

The provision of home-based care is discussed at length in the SADC document, including an acknowledgment of the need to train more health care personnel to perform this service (SARPN, 2003:Internet source). Delving into more detail, the DoH policy documents discuss guidelines for the implementation of home-based care, including the "establishment of inter-sectoral task teams at community level to develop community/home-based care" (RSA DoH, 2000:21; RSA DoH, 2003:58). The documents also delve into practical considerations of providing home-based care, such as utilising the "available community care and support services such as transportation … often provided by NGOs and CBOs, which will assist in keeping people in care and

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encourage their adherence to treatment" (RSA DoH, 2003:28). Following the lead provided within the SADC document, the current South African strategy appears to be centred around ascertaining the level of need for this service, and the most feasible means of implementing it on a sustainable basis. As mentioned in chapter two, the inclusion of this policy aspect could be optimistic on the part of the state, when considering the severely limited resources at their disposal. It does, however, serve the purpose of laying the initial groundwork for the eventual provision of home-based care, and thus makes the DoH policy more comprehensive as a whole in addressing the range of auxiliary problems created by the HIV and AIDS pandemic.

5.2.2.4 Drugs and services required for effective treatment

The SADC document illustrates the role played by health care personnel in the administration of effective treatment policies, and the issue of proper training and the retention of these skills is thus the first aspect to be addressed within this indicator. In order to provide patients with the most valuable care, an uninterrupted supply of essential medicines is required, together with psycho-social support and counselling for both PLWHA and their care-givers (including health care personnel).

i) Increasing the number of trained health care workers

The range of services performed by health care personnel necessitates that special attention be paid to the training and retention of skills of these workers, as seen in statements in the SADC document that there is a need to develop "competent professional pharmaceutical as well as support personnel through training" (SADC, 2003:12). The DoH documents are very explicit about the actions which must be undertaken regarding the training of health care personnel, stipulating that medical practitioners, nurses, midwives and counsellors should all be equipped with the skills to not only provide competent medical assistance, but also family health planning and counselling (RSA DoH, 2003:19). The further education and training of health care personnel is addressed within the policy documents, not only in terms of HIV and AIDS, but also with regard to the management of STDs (RSA DoH, 2000:19). There is also a reference to the establishment of delivery standards for ARV treatment,

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including assessments of health care personnel to ascertain the extent of training required (RSA DoH, 2003:16).

The South African policy discusses the training of health care personnel in terms of both long and short term activities, and aims to increase the capabilities of staff in HIV/AIDS/STD research, surveillance, and treatment (RSA DoH, 2000:23). The elaboration by the DoH on this issue far exceeds the guidelines contained within the SADC document, with the DoH policy also noting that occupational exposure and needle-stick injuries must be included within treatment programmes in both public health facilities and in the public sector, and that this treatment should also incorporate the use of ARV medications (RSA DoH, 2000:20). Lastly, the DoH documents are the only policy papers which state a specific health care worker to patient ratio, namely "one dedicated employee per 100 000 people" (RSA DoH, 2000:27).[66]

ii) The provision of psycho-social support and counselling

The SADC document refers to "best practice" reports which offer guidelines on the provision of psycho-social support and counselling in member states, but no details are discussed within the actual policy document (as mentioned under corresponding indicator in chapter two). Conversely, the DoH documents mention this in numerous priority areas and intervention activities. Within the provision of psycho-social support and counselling, the high risk youth group is to have "access to friendly and supportive counselling services" (RSA DoH, 2000:19).

Although the South African policy documents lament the general "lack of provincial policies, guidelines or management protocols for comprehensive care and counselling", it ambitiously states that future programmes for "counselling and health care shall be sensitive to culture, language and social circumstances of all people at all times" (RSA DoH, 2000:15). While counselling programmes are mentioned with regard to the general population, and high risk groups such as the youth, government departments are also specifically referenced. This is another innovation on the part of the DoH, as no such guidelines are present in the SADC document. Lastly, the importance of

[66] The training and staff requirements for effective implementation of the DoH plan is outlined in section two, chapter five, of the South African policy document (RSA DoH, 2003:102).

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psycho-social support and counselling is discussed as an integral part of the continuum of care required by PLWHA and PABA (RSA DoH, 2003:55).

iii) Identifying methods of affordable drug procurement

The necessity of an uninterrupted supply of affordable essential drugs has been discussed above, and in the SADC policy (see chapter two). The largest inhibitor of this goal is the exorbitant prices demanded by the pharmaceutical companies, and enforced by agreements such as TRIPS. However, some opportunities to circumvent these obstacles have been identified (see TRIPS discussion in chapter two), and SADC has undertaken to provide some guidance to member states such as South Africa by offering "principles to guide negotiations with the pharmaceutical industry on medicines, including antiretroviral medicines for the treatment of HIV and AIDS" (SADC, 2003:9). In terms of ARV procurement, the DoH states that the plan "takes into consideration the declarations of the SADC Health Ministers [in 2000] … related to legislative and regional legal regimes, that will ensure the availability of technologies and drugs at affordable prices for treatment, including bulk purchasing and manufacturing of generic drugs in the region" (RSA DoH, 2003:145).[67]

The national approach for procurement discussed in the documents states that (apart from collective bulk procurement), a competitive ARV production market should be encouraged. This will be achieved through "engaging with a number of competing manufacturers [which] will further drive price reductions" (RSA DoH, 2003:146). This is also important to ensure that the supply of these essential medicines is uninterrupted. Three mechanisms for procurement are identified in the documents; "regular government tenders using local suppliers, a public-private partnership/initiative, and international tendering (RSA DoH, 2003:147). The absence of details on how member states could actually procure more affordable drugs is thus not reflected in the statements found in the DoH policy documents. The level of elaboration alluded to above shows more foresight than any of the other policy documents examined in this study. There are further references made to vaccine research, the "cost-effectiveness of

[67] The DoH further states that "those options open to member states under TRIPS (parallel importation and compulsory licensing) should not be compromised [and] member states should not be required to assume the responsibility of ensuring that these products do not leave their markets" (RSA DoH, 2003:145).

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other forms of non-retroviral treatment and prophylaxis", and the possible contribution of traditional medicines (RSA DoH, 2000:22, RSA DoH, 2003:23).

iv) Access to medication for sexually transmitted diseases and opportunistic infections

The South African policy documents acknowledge that there is "compelling evidence of the importance of STDs as a major determinant of HIV transmission", estimating that 11 million South Africans are treated for STDs every year (RSA DoH, 2000:8). There is also a succinct recognition of the link between HIV and other infectious diseases, with the DoH stating:

> *"Closely linked to the HIV and AIDS epidemic is a TB epidemic which is fuelled by HIV infection and which is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals, the HIV prevalence in TB patients has been recorded as over 70%"* (RSA DoH, 2000:8).

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This correlates closely with the SADC statement that "many countries are now grappling with the intensifying impact of mature HIV and AIDS epidemics and the related epidemic of tuberculosis, that together are reversing the hard won development gains of the past 50 years" (SADC, 2003:2). The DoH documents state that treatment of opportunistic infections and the provision of ARVs, palliative and terminal care, will "improve functional health status" (RSA DoH, 2003:17).[68]

The use of traditional medicines is explored within the DoH documents, keeping with the guidelines provided in the policy document of SADC. The importance of involving traditional health practitioners, briefly discussed earlier, is reiterated by the DoH:

[68] It must be noted that the "anti-intellectual" stance of the DoH, discussed above, is still evident in statements that "ARVs can be toxic and have adverse side effects that may make patients temporarily sicker" (RSA DoH, 2003:18). Nevertheless, chapter one (section eight) of the policy document provides detailed information on ARV therapy regimes, far exceeding the vague references of any of the other documents.

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> *"A large percentage of patients have deeply rooted traditions around maintenance of health and treatment of illness, and utilise traditional health practitioners as their first point of contact for health care. Traditional health care practitioners hold positions of authority within the community and their advice is widely respected. As a well established and accepted form of health care in South Africa, it is essential that traditional medicine and its practitioners be recognised, respected and engaged in coordinating care for HIV positive patients that wish to utilise both disciplines"* (RSA DoH, 2003:77).

South Africa expands on this, stating specific activities on which traditional leaders will be consulted, as opposed to statements that they will only be involved in the policy formulation process. One such example is the intention to utilise these traditional health care practitioners in the treatment of STDs, as well as in affecting behaviour changes within their communities (RSA DoH, 2000:19; RSA DoH, 2003:16). Further, investigations will be launched into creating a referral system connecting western and traditional medical practices, building the capacity of traditional healers, as well as establishing initiatives which aim to "sensitise the health sector regarding traditional medicine" (RSA DoH, 2000:19). The inclusion of this level of detail in the policy document indicates that serious consideration has gone into reconciling the sometimes opposing views of western and traditional medical practitioners, and tailoring a response for the unique South African context.

5.2.3 Women and HIV and AIDS

The South African policy documents pay the most attention to gender issues in comparison to the other three documents under examination, although statements regarding women are still vague and insufficient at addressing the structural inequalities facing women. A range of issues are addressed, including reproductive health matters, societal and cultural pressures, discrimination and lack of rights awareness. Women are specifically mentioned in almost all priority intervention goals, both in terms of participation and protection. For example, the documents state that "the vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent

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infection" (RSA DoH, 2000:15). However, this hazy generalisation is indicative of the language regarding women in the DoH documents, and details as to how the situation facing women can be addressed, or for that matter what the inequities in society are, are absent – notably so in comparison to the level of elaboration on other priority areas in the policy.

The PMTCT guidelines are more detailed within the DoH policy documents (in comparison to the SADC document), containing goals such as the provision of family planning guidance to women who are aware of their HIV-positive status, and the implementation of "clinical guidelines to reduce the transmission of HIV during childbirth and labour" (RSA DoH, 2000:19; RSA DoH, 2003:64). The documents state that it will "review and revise the policy on ARV use for reducing mother-to-child transmission" through an assessment of current research on the topic (RSA DoH, 2000:22).[69] One innovation not seen in any of the other policy documents under comparison is the mandate to provide better access to VCT services within antenatal clinics (RSA DoH, 2000:19; RSA DoH, 2003:20). The focus appears to be primarily on treatment for pregnant women, with little reference made to the vulnerability and inequality of women in general.

A further issue which appears only within the DoH documents is the commitment to "reduce HIV/STD transmission and pregnancies resulting from sexual assault", including the use of ARV treatment to achieve this goal (RSA DoH, 2000:20). The high incidence of violence towards women (see policy environment) necessitates the inclusion of such statements, although the underlying causes are not addressed. The inclusion of a specific mandate addressing the adoption of AIDS orphans is also not addressed in any other policy document, with the DoH going as far as proposing the subsidisation of the adoption of AIDS orphans (RSA DoH, 2000:22). This is an important addition to the DoH documents, particularly given the more than 1.2 million orphans in the country (as mentioned in the policy environment above). The SADC

[69] The inclusion of PMTCT through the use of ARVs is a direct result of the Constitutional Court case instigated by AIDS activists and organisations (primarily the Treatment Action Campaign), against the government, which had previously refused such treatment provisions (Minister of Health vs TAC, 2002). For a concise discussion of this case, see Fourie (2005).

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document makes no reference to any of these issues.[70] However, the references in the South African policy documents only treat the practical needs of women, and do not address the structural inequalities which place women at higher risk to HIV and AIDS in the first place. Thus, there are no suggestions made as to how the disproportionate impact of HIV and AIDS on women can be alleviated.

5.2.4 Funding

The following discussion of the budgetary allocations and the mechanisms for funding provided for within the South African HIV and AIDS policy shows both the emphasis placed by the state on certain programmatic actions (such as prevention), and provides an understanding of the implementation of regional funding guidelines. Identifying the source of funds (whether they be from domestic or international sources) shows how the DoH policy corresponds with the SADC document, as it has been shown in chapter three that the regional organisation does not contribute directly to the programmes being implemented in member states (with the exception of a few regional initiatives). Thus, using the same indicators applied to the SADC document comparing the means of funding HIV and AIDS policies (see chapter three), two broad categories will be applied. Firstly, the contribution to public health care made by the state will be examined, followed by an overview of major external contributors such as bilateral and multilateral donors.

5.2.4.1 State expenditure

Under the SADC HIV and AIDS Strategic Framework (2000-2004), and the subsequent SADC Declaration on HIV and AIDS, as well as within the Abuja Declaration discussed earlier, member states have pledged to commit a minimum of 15% of their annual budgets towards strengthening their respective health sectors and fighting HIV and AIDS (see chapter three). This target has only been met by two states in the regional organisation, namely Mozambique (19.9%) and the DRC (17.8%), with South Africa spending 10.7%, placing it eighth amongst the SADC member states (see

[70] For a more detailed evaluation of gender mainstreaming in South Africa see Sadie (2005) and Lowe-Morna (2004), or for the influence of SADC on gender mainstreaming (or lack thereof) see Schoeman (2004).

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chapter three). This is strange, given that South Africa has the most HIV infected individuals of all the SADC states within its borders, totalling more than ten million, in comparison with two million HIV positive people in Mozambique and the DRC. A possible explanation could be the lack of urgency on the part of the Health Minister to provide ARVs, together with the influence of the President's views on HIV and AIDS (discussed in the policy environment).

While the health care expenditure of member states has certainly increased dramatically, it still falls far short of required levels (SADC, 2003:8). For example, while Malawi showed an improvement of 7.2% in health care expenditure, the state's private health expenditure is still alarmingly high. South Africa showed an improvement of 5.1%, in comparison to Nigeria which increased its expenditure by 3.9% (UNDP, 2004:Internet source; WHO, 2006a:Internet source). It should also be noted that while 10.7% is less than the Abuja recommendation for health care expenditure, South Africa spent more than US$9 billion on health care in 2002, with the second highest spender in SADC being Zimbabwe at US$705 million (UNDP, 2004:Internet source).[71] Based on the population size of the respective states, this translates to South Africa spending US$192 per capita, compared to Zimbabwe at US$55 per capita, showing that South Africa is spending three and a half times more on health care.

The DoH policy documents discuss the required funding for both the national and provincial levels, and argue that "one method is to establish an agreed resource standard for all provinces to directly place financial resources into HIV and AIDS. This is currently (in 1999/2000 prices) set as R10 per person per year or a total of R400 million per year for the whole country" (RSA DoH, 2000:27). In addition, a number of standards are outlined regarding the disbursement of funds, including commitments to "spend over 80% of the funds in one financial year" and means of rolling over excess funds without incurring penalties (RSA DoH, 2000:27).

The total budget estimate for the period 2003 to 2008 is included within the South African policy documents (an excerpt is displayed in Table 5.1 below), and shows that

[71] For a comparison of health care expenditure across the SADC member states, see Appendix 5.1.

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an emphasis is placed on the procurement of antiretroviral drugs (33% of total funds), new health care staff (21%), and nutrition (17%), with the least amount of funding directed at research (2%). Not included in the table is the directive that a minimum of US$85 million be directed towards prevention strategies, placing this programmatic action above most others on the list (RSA DoH, 2003:57).

Table 5.1: Total Programme Budget Estimate in ZAR Millions (US$ Millions*)

	2003/04	2004/05	2005/06	2006/07	2007/08	TOTAL
New Health Care Staff	21 (3.2)	322 (49.5)	432 (66.5)	662 (101.8)	1 027 (158)	2 464 (379.1)
Laboratory Testing	20 (3.1)	152 (23.4)	311 (47.8)	520 (80)	806 (124)	1 809 (278.3)
Antiretroviral Drugs	42 (6.5)	369 (56.8)	725 (111.5)	1 118 (172)	1 650 (253.8)	3 904 (600.6)
Nutrition	63 (9.7)	343 (52.8)	421 (64.8)	532 (81.8)	656 (100.9)	2 015 (310)
Other Health System Upgrades	70 (10.8)	171 (26.3)	184 (28.3)	160 (24.6)	160 (24.6)	745 (114.6)
Programme Management (National and Provincial)	16 (2.5)	103 (15.8)	128 (19.7)	128 (19.7)	128 (19.7)	503 (77.4)
Capital Investment	30 (4.6)	75 (11.5)	100 (15.4)	100 (15.4)	0	305 (46.9)
Research	34 (5.2)	55 (8.5)	55 (8.5)	48 (7.4)	48 (7.4)	240 (36.9)
TOTAL	296 (45.5)	1 590 (244.6)	2 358 (362.8)	3 268 (502.8)	4 474 (688.3)	11 986 (1 844)

*Based on an exchange rate of US$1=ZAR6.5
(Adapted from RSA DoH (2003:49).

However, as the SADC policy document has pointed out, the resources of member states are not adequate to provide the scale of services required. The DoH documents reflect this, stating that "financing of the programme may be supplemented using donor resources [as] additional financial resources are needed to fund and sustain the programme" (RSA DoH, 2003:49). Donor bodies are very active within South Africa, as will be shown below (the extent of donor body involvement is also illustrated in section 5 of the policy document). This integration of donor funding and state funding is recommended within the SADC guidelines (see chapter two), and the coordination of this funding falls to the South African National AIDS Council (SANAC).

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5.2.4.2 Donor contributions

The South African National AIDS Council (SANAC) bears overall responsibility for the coordination of national and provincial HIV and AIDS programmes, including overseeing the coordination of donor funds (RSA DoH, 2000:10). As advocated within the SADC policy document, community and faith-based organisations, together with a plethora of other NGOs and entities, are very active in providing a range of HIV and AIDS-related services within South Africa. In terms of the involvement of the private sector and corporate social responsibility, the legislative framework referenced earlier provides more details on the participation of these actors (see especially the indicator on workplace interventions). However, while these partners are referenced within most objectives in the policy documents as part of the state's multi-sectoral response, the vast numbers of involved parties make it impractical to list their contributions within this study. Instead, following the format established within the SADC discussion in chapter two, only the major donors and their contributions will be compared.

i) UNAIDS

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The contributions from UNAIDS were examined within the Nigerian analysis in terms of the two primary donor programmes, namely the Global Fund and MAP. MAP does not operate in South Africa, and thus only the Global Fund will be compared below.

South Africa has received US$183.81 million from the Global Fund over the first three rounds, and resources were granted for specific projects, as shown below (GFATM, 2005:Internet source).[72]

- Round 1 (April 2002): Resource assistance for HIV and AIDS and TB programmes in Kwazulu-Natal (US$71.97 million), Assistance to *Soul City* education campaigns (US$20.23 million);
- Round 2 (January 2003): Scaling up HIV and AIDS and TB programmes at national and provincial level (US$25.11 million);

[72] The Global Fund allocates grants for specific projects related to HIV and AIDS, TB and malaria, and as the important inter-relationship between these three diseases has been established previously in this chapter (as well as within chapters one and two), all the funded programmes for the three diseases are included. As noted previously, a detailed breakdown of the Global Fund Grants is included in Appendix 3.2.

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- Round 3 (October 2003): Scaling up HIV and AIDS programmes in the Western Cape (US$66.51 million);
- Round 4 (June 2004): No grants awarded;
- Round 5 (September 2005): No grants awarded.

It should be noted that the sporadic nature of the grants, as well as the fluctuations in the amounts of each grant, make sustainability judgements difficult, although the staggering of payouts and the project-specific grants are useful as the state can distinguish what resources are still required for programme implementation.

ii) USAID

The contributions received by South Africa from this body are fairly consistent, as shown in Table 5.2 below, ranging between US$51 800 and US$62 958 (USAID, 2006:Internet source). The grants are also regularly higher than those received on average by the other SADC states, which range between US$33 543 and US$53 685 (USAID, 2006:Internet source). It should once again be noted that while the grants are not very large, they are more consistent in comparison to the resource allocations received from other donor bodies. The larger grants could be attributed to South Africa's comparably higher prevalence rate of HIV and AIDS.

Table 5.2: USAID Expenditure in South Africa

	South Africa	Average across SADC
2002	US$58 308	US$45 002
2003	US$62 958	US$53 685
2004	US$53 994	US$36 923
2005	US$51 800	US$33 543

(USAID, 2006:Internet source).

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iii) PEPFAR

PEPFAR's contributions within the assisted focus states are noted in terms of programmes and people assisted, as opposed to stipulating exact amounts spent on each intervention. South Africa received US$89.39 million through the activities listed in Table 5.3 below.

Table 5.3: PEPFAR Assistance in South Africa

	South Africa (people assisted)	**Total in all 15 Focus States**
Prevention (Awareness)		
Community outreach programmes (abstinence and being faithful)	274 400	35 572 200
Mass media programmes (abstinence and being faithful)	13 479 500	152 227800
Community outreach programmes (other strategies, including condom use)	542 200	11 899 900
Mass media programmes (other strategies, including condom use)	16 604 800	76 620 600
Pregnant women receiving PMTCT services	563 000	1 396 400
Health worker training (promoting abstinence)	0	196 200
Health worker training (other prevention strategies, including condom use)	4 100	51 000
Health worker training (PMTCT)	8 800	24 600
Health worker training (blood safety)	800	6 500
Treatment and Care		
People receiving treatment	12 200	155 000
OVCs receiving assistance	66 500	630 200
People receiving palliative care/basic health care	401 500	854 800
People receiving TB care and treatment	131 900	241 100
People receiving counselling and testing services	235 900	1 791 900
Health worker training (provision of treatment)	5 300	12 200
Health worker training (OVC care)	1 900	22 600
Health worker training (palliative care)	5 200	36 700
Health worker training (counselling and testing)	3 300	14 100

(USDS, 2005:Internet source).

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Mass media campaigns are the clear focus (assisting 16.6 million people), although it is necessary to note that unlike Nigeria, abstinence programmes did not receive more emphasis than those promoting other strategies such as condom use. Abstinence programmes reached only 13 million people, compared to programmes promoting condom use, which reached 16 million people. Health worker training formed a large proportion of the activities undertaken (assisting 401 500 people), which corresponds with the emphasis placed on this crucial aspect of effective service delivery within the policy documents of both South Africa and SADC. Counselling and testing services were received by 235 900 people, the second highest priority within the treatment and care services offered by PEPFAR, and are reflective of the emphasis in the South African policy documents.

5.2.4.3 Summary of South African funding policy

The South African policy documents demonstrate the necessity of adhering to the multi-sectoral approach advocated within the SADC policy document, with a range of actors participating in the funding of HIV and AID programmes. Although the state retains overall responsibility for the funding and implementation of the HIV and AIDS programmes outlined in the policy documents, specific actors (including the corporate sector, trade unions, NGOs, and UNAIDS, amongst others) are clearly identified as partners of the state. It is also clear from the above discussion of donors that a significant amount of resources are being received by South Africa, especially when considering the plethora of CBOs, NGOs, faith-based organisations (and other partners) providing further assistance.

5.3 CONCLUSION

This chapter examined the extent to which the HIV and AIDS policy of South Africa resembles the guidelines put forward in the SADC HIV and AIDS document. It has been pointed out that South Africa's HIV and AIDS policy has had to contend with issues such as a diverse multi-cultural and multi-tribal population, and difficulties such as poor infrastructure, high incidences of violence towards women (particularly rape), poverty and large migrant populations as a result of its position as an economic powerhouse within the SADC region. Further, the state has had to overcome a legacy

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of poor HIV and AIDS management, characterised by misinformation and discord with the actors in the HIV and AIDS community.

The requirements for effective education and awareness campaigns were addressed first, and presented a similar picture between the SADC and DoH policy documents. The same high risk groups were identified, namely transport and migrant workers, the youth, and commercial sex workers, although the DoH documents presented specific activities which could be pursued in order to affect behaviour change in these high risk groups, as well as emphasising the need to include government departments as a high risk target group, which the SADC document did not. The DoH documents noted the importance of adopting a culturally and socially sensitive approach which takes into account the need to communicate media messages in the native languages of the target groups, which was not addressed to the same extent in the SADC document.

The social marketing of condoms, identified as a crucial aspect in education campaigns by the literature in chapter one, is not discussed at all within the SADC document. The implications and possible justifications for this omission were detailed in chapter two, and the DoH documents depart radically from the regional guidelines in this regard, mentioning condoms in almost all priority intervention areas, presumably due to the massive prevalence rate in the state and the sharp rise in new infections. Detailed activities are thus outlined, including the provision of educational materials and condoms at high transmission areas such as border posts, truck stops, and brothels. In terms of workplace interventions, both policy documents have formalised the expected role of employers in mitigating the impact of HIV and AIDS on their workers. The SADC document references the *Code on HIV and AIDS and Employment*, and the DoH refers to the *Code of good practice on HIV and AIDS in the workplace.* However, only a fleeting indication of the contents of this document is made in the SADC policy. In comparison, the DoH documents refer to numerous obligatory actions for employers, including the increase of testing and counselling facilities on-site.

The heavy emphasis on the youth is mirrored in both documents, with the DoH adhering to and expanding on the guidelines provided by the regional organisation. This expansion includes the development of protective legislation, “youth-friendly”

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clinics providing rapid testing services, and focused education and awareness campaigns such as *Soul City* and *Soul Buddyz*.

The second set of indicators addressing prevention campaigns has received far more attention in the DoH documents than in those of SADC. While VCT is briefly mentioned in the SADC document in terms of developing standards in testing, the DoH is far more expansive, providing detailed actions such as the construction of more VCT sites. Sex worker interventions, stressed within the SADC document (especially with reference to the major trade routes), is similarly emphasised in the DoH policy. The DoH documents again follow the SADC lead in the development of infrastructure for the provision of effective treatment, with both documents noting the need to improve information sharing and coordination in order to avoid duplication. While SADC specifically notes the need to develop the local capacity for the manufacture of essential drugs, the DoH examines the procurement of essential drugs in considerable detail, noting a range of strategies to achieve this goal. The provision of home-based care is explored in detail in the SADC document, including the need to train more health care personnel in the fulfilment of this service. This emphasis is reflected in the DoH documents, which expands by calling for ongoing research and monitoring to ascertain the changing needs of home-based care patients, and means of fostering better involvement from CBOs.

Next, the need to increase training and retain skilled health care personnel was explored, an issue which is extensively discussed in the SADC document. These guidelines are integrated and expanded in the DoH documents, which broaden the mandate by including nurses, midwives, medical practitioners and counsellors. The provision of psycho-social support and counselling is only briefly touched on by SADC, which refers to "best practice" reports available to member states but does not provide any details about the content of these reports. Conversely, the DoH documents are fairly eloquent, noting specific high risk groups in need of such services (such as the youth). Multiple references are again made about ensuring that these counselling and support services are culturally and socially sensitive to ensure maximum effectiveness. Lastly, the SADC document strongly emphasises the link between HIV and AIDS and opportunistic infections. Following this lead, the DoH reiterates the need to treat these related illnesses, including STDs, and expansively notes the role which

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traditional healers could play in this regard. The references to traditional healers contained in both the SADC and DoH policy documents are important as they are indicative of a policy which is taking the cultural and social context into account, and anticipating means of ensuring the efficacy of programmatic actions.

Turning to the focus placed on women and HIV and AIDS revealed that the South African policy pays considerably more attention to gender issues than the SADC document. While the regional policy acknowledges the disproportionate impact of HIV and AIDS on women, the DoH suggests a number of specific actions which may alleviate this burden. These include the provision of VCT in antenatal clinics, increasing the availability of treatment for victims of sexual assault, and the state subsidisation of the adoption of AIDS orphans. None of these activities are suggested within the policy guidelines from SADC. However, it must again be pointed out that although the DoH documents mention women-specific programmatic actions more than SADC, the documents do not begin to address the root of women's vulnerability to HIV and AIDS, nor does the DoH mention any means of affecting the structural inequality of women in terms of gender stereotypes and harmful cultural norms which perpetuate the risk of women to contracting HIV and AIDS.

Lastly, the funding structure suggested by the SADC document has been adhered to fairly closely by the DoH, with a multitude of actors involved in funding the HIV and AIDS policies of the state. Multilateral and bilateral donor bodies endow South Africa with a significant amount of resources, most likely due to its comparably high HIV prevalence rate. A range of CBOs, NGOs and faith-based organisations also participate in this process, as do corporations, as pointed out in the section on workplace interventions.

In conclusion, the SADC document generally provides fairly clear guidelines, although the lack of detail in proposing activities for achieving the stated goals renders these guidelines as little more than starting points in the formulation of member states' HIV and AIDS policies. The next chapter will provide a summary and interpretation of this comparison between ECOWAS and SADC, as well as contextualising the results of the case studies.

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CHAPTER 6: CONCLUSION

The appalling HIV and AIDS prevalence statistics can not begin to convey the enormity of the problem facing the African continent. The lives of those infected and affected by HIV and AIDS hang in the balance, and are dependent on a coherent, comprehensive response from their leaders, both at a national and regional level. The emphasis on regionalism as a means for fostering development in Africa has been discussed, and implies that regional organisations such as ECOWAS and SADC are expected to be at the forefront of the development of innovative strategies for dealing with the greatest challenges facing the continent, not the least of which is the HIV and AIDS pandemic. The use of ECOWAS and SADC as the regional entities to be examined is based on their comparative strength relative to the other regional organisations in Africa.

The purpose of this study was to examine the HIV and AIDS policies of ECOWAS and SADC according to a range of issues addressed in the vast literature on HIV and AIDS. These issues were then grouped and used as indicators to make comparison possible. Three broad categories of indicators were established to address three primary issues, namely; education and awareness campaigns, prevention strategies, and treatment and care programmes. A fourth issue was included, namely the manner in which the policies and programmes are to be funded.

Within each of these four aspects, a list of indicators, representing the controllable variables of the study, were categorised in line with the comparative method, allowing for a comparison between the two regional HIV and AIDS policy documents. By establishing which of these indicators were or were not addressed, conclusions could be drawn on the comprehensiveness of the approach being followed by the respective regional organisations. The ability of the regional documents to serve as guidelines to member states in the formulation and implementation of their HIV and AIDS responses could then be examined. To gauge whether the regional organisations of ECOWAS and SADC are providing adequate leadership to member states in the formulation of their HIV and AIDS policies, the policies of Nigeria and South Africa were compared to the policies of their respective regional organisations, using the same sets of indicators.

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The comparative nature of ECOWAS and SADC lies in the fact that the member states of both regional organisations have high prevalence rates for HIV and AIDS (as well as widespread malaria and tuberculosis), both organisations share the mandate of utilising regionalism to pursue economic development and, finally, the two organisations have comparable organisational structures.

Somewhat similar reasoning was applied in the selection of Nigeria and South Africa as the case studies for the respective regional organisations. The overviews of Nigeria and South Africa showed them to be of comparable size and strength within their respective regional organisations of ECOWAS and SADC, have similar prevalence rates, and the largest GDP's of their fellow member states. Both states have diverse multi-cultural and multi-tribal population groups, and both cite difficulties such as poor infrastructure, poverty and large migrant populations resulting from their role as economic trade hubs within their respective regions. Further, the organisational structure of the health care administrators of both states are fairly similar, with a single coordinating body providing direction for programmatic actions; the Presidential AIDS Committee (with NACA and SACA) in Nigeria, and SANAC in South Africa.

Lastly, it has been noted that a number of related issues are tied into the fight against HIV and AIDS, not least the problems of overwhelming debt, poverty, unemployment, underdevelopment and a serious shortage of resources. Malnutrition and poor education also impact directly on the nature of HIV and AIDS programmes, as do cultural and social beliefs. However, these problems are present, to some extent, in all developing African states, and must thus be factored in during the policy formulation process.

This concluding chapter focuses on the major findings of the comparison between the HIV and AIDS policies of ECOWAS and SADC, using the three broad groupings of indicators discussed above. The sections below present the findings of the contrast between the regional policies of ECOWAS and SADC and the national policies of the member states, Nigeria and South Africa respectively. A separate section is devoted to the emphasis placed on gender sensitivity within the policy documents. The implications of these findings are then considered.

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6.1 KEY FINDINGS

6.1.1 Comparison of the HIV and AIDS Policies of ECOWAS and SADC

The HIV and AIDS policy documents of ECOWAS and SADC were largely carbon-copies of each other, with a commitment to regional development, the harmonisation of policies and the sharing of information being the most oft-repeated phrases. The generally broad and vague guidelines contained in both the ECOWAS and SADC policy documents do, however, address the major aspects identified within the HIV and AIDS literature with regard to education and awareness campaigns, prevention strategies, and treatment and care programmes.

Education and awareness campaigns are emphasised in the policy documents of both ECOWAS and SADC, who appear to be united in their dedication to involve a range of non-state actors (such as CBOs, NGOs, faith-based organisations, and others) in the formulation and implementation of the HIV and AIDS policies in the region, recognising the ability of these actors to increase the probability of successful campaigns. This is especially true of the education and awareness campaigns (which receive the most attention from both regional organisations), as behavioural changes need to be initiated at a community level to be accepted. There is also a clear focus on the youth in both policy documents, although the documents are characteristically vague on methods of achieving stated objectives. ECOWAS and SADC further advise that corporations are to be increasingly targeted by member states to participate in the implementation of workplace interventions. While this move is recommended by ECOWAS in its policy document, it is formally included in a *Code on HIV and AIDS and Employment* in the SADC policy document.

In terms of prevention strategies, all the indicators are addressed to an extent, although ECOWAS neglects to mention the sex worker industry which is a growing issue in both regions. While the broad parameters for formulating an effective HIV and AIDS prevention response are in place, both regional documents commit a fatal error: neither discusses the provision or social marketing of condoms. This omission has been highlighted numerous times within the study, as has the emphasis placed on the provision and use of condoms in the literature, and its importance can not be stressed

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enough. It has been speculated that the prevailing social and cultural beliefs of the populations of member states may be a contributing factor to this oversight. The possible impact on funding was also discussed, especially with regard to donors who promote abstinence programmes and may be reluctant to award grants to programmes advocating condom use. Nevertheless, the proven effectiveness of condom use in terms of both reducing the number of infections, and the cost associated with dispensing the prophylaxis, negate this reasoning.

Turning to treatment and care programmes, the trend of vague statements continues, and although SADC mentions all the major indicators identified in the literature, ECOWAS neglects to address the provision of home-based care services or the need for psycho-social support and counselling. However, the most noteworthy aspect of both policy documents is the inclusion of traditional practices in the formulation of the HIV and AIDS response, showing a commitment to tailoring a response that will be applicable in the unique African context. Lastly, the disproportionate impact of HIV and AIDS on women, discussed at length in the literature, is not acknowledged in a meaningful manner in the policy documents of either ECOWAS or SADC. For example, PMTCT is not mentioned at all in the ECOWAS document, and neither policy puts forward strategies for addressing the structural imbalances which give rise to the inequality of women within African societies particularly, as discussed below.

A clear consensus is visible in terms of funding, with the contributions from member states in both regional organisations going almost exclusively towards administrative costs at the regional level. Further, the pursuit of funding from bilateral and multilateral donor bodies (such as UNAIDS, PEPFAR, USAID and the like), as well as from NGOs, CBOs, and others, is advocated within both policy documents. As both regional organisations, and their member states, are signatories of the UNGASS Declaration, which advocates the spending of a minimum of 15% of annual budgets on HIV and AIDS, the involvement of donor bodies is essential due to their severely limited resources. As has been shown, this expenditure target is currently not being met. While SADC has a significantly higher average prevalence rate of HIV and AIDS in comparison to ECOWAS (18.05% versus 3.35%), its member states are not spending a proportionately higher percentage of their budgets on public health care, with the average state's expenditure on health in 2002 being around 5.93% of their GDP,

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compared to ECOWAS states at 5.24%. This shortfall is considerably aided by the donor bodies discussed in chapter three.

The overall trend which emerges is that both regional organisations show an awareness of the scope of issues which should be addressed in an HIV and AIDS policy, but neither document reflects the necessary level of guidance required to address a pandemic of this magnitude. The absence of detail in most indicators addressed, together with the complete lack of attention paid to the provision of condoms and to women (and their inequality), render both policy documents largely superficial.

6.1.2 HIV and AIDS Policies in Nigeria and South Africa: Conforming to Regional Guidelines?

The use of the established indicators allowed a number of striking similarities and differences to emerge between the two states and their respective regional organisations of ECOWAS and SADC. Firstly, while both states adhered fairly closely to the guidelines provided by their respective regional organisations, Nigeria and South Africa elaborated extensively on the vague references and advice of ECOWAS and SADC respectively. Education and awareness campaign indicators revealed that both Nigeria and South Africa placed great emphasis on the use of condoms (including female condoms), although their regional health policy documents were conspicuously silent on the matter. Both documents contained strong references to women and the youth with regard to education, and both states showed innovations towards the youth in particular. Nigeria showed initiative in the development of future programmes, advocating the use of new technologies, while South Africa won accolades for its mass media *Soul City* and *Soul Buddyz* campaigns. South Africa's policy is also the only document which specifically mentions government departments as a target group for better HIV and AIDS education. Workplace interventions were addressed by both states, reflecting the same high risk groups identified in the regional documents of ECOWAS and SADC. However, only South Africa specifically referenced a legislative document detailing the obligations of employers towards their workers, again reflecting the SADC document guidelines.

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Turning to the prevention strategies contained within the documents, both states discuss the provision of voluntary counselling and testing services, despite the omission from the ECOWAS document and the vague references within the SADC policy. Sex worker interventions are not discussed in depth by Nigeria, and this issue is not included in the ECOWAS document at all. South Africa goes as far as referencing pending legislation aimed at protecting the rights of this high risk group, reflecting a greater commitment to this issue, as shown in the SADC document.

In terms of treatment infrastructure, the development of domestic industries does not receive much attention from either state, with Nigeria and South Africa imparting less information than the regional documents. Only vague references are made to the provision of home-based care in the Nigerian document, although it should be noted that it is not addressed within the ECOWAS document at all. The development of an HIV vaccine is only mentioned by South Africa, but a detailed breakdown of activities is not included. Looking at the provision of drugs and services, Nigeria discusses the training of health workers, but does not address the "brain drain" problem raised by its regional organisation. South Africa adheres to the guidelines provided by SADC, and provides some elaboration on activities to achieve the goals set in this sector. Psycho-social support and counselling is most eloquently dealt with by Nigeria, providing more detail than the policy documents of ECOWAS, SADC or South Africa. No mention is made by Nigeria about acquiring cheaper medicines, and South Africa's policy document is very vague on this issue. Both Nigeria and South Africa definitively acknowledge the link between STDs, TB and HIV and AIDS, and both adhere to the regional guidelines provided on the integration of traditional medicines into the policy framework.

The comparison of the Nigerian and South African health policies with their respective regional organisations showed that the majority of guidelines provided by the regional organisations are reflected in the policy documents of their member states. The level of expansion provided by both states indicated that further guidance from the regional organisations would not go amiss, particularly considering the smaller, weaker states which may not have the resources to develop their policies to the extent which Nigeria and South Africa have. It is also necessary to note that South Africa appears to be

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influencing the SADC regional policy to a greater extent than the regional body is providing guidance to its member state. This observation is further discussed below.

6.1.3 Gender Sensitivity in HIV and AIDS Policies

The impact of HIV and AIDS on women in particular has been well documented, especially noting the exacerbating influences of traditional cultural and social practices, and the lack of representation in decision making bodies. Studies such as those by Schoeman (2004) illustrate the scope of work needed to achieve proper gender mainstreaming and meaningful equality for women. It should be pointed out that SADC, and to a lesser extent ECOWAS, have begun to lay the necessary groundwork for this process. As noted above, not enough emphasis is placed on the needs of women in either regional document, and no suggestions are made on how to address the structural inequalities of women. In particular, the prevention of violence against women, the enactment of protective legislation, and the compilation of gender-disaggregated data to gauge the impact of public policies on women need serious attention. As has been pointed out, ECOWAS fails to include PMTCT entirely, and SADC does not significantly expand on activities aimed at women. Examining the focus placed on women and HIV and AIDS by Nigeria and South Africa, shows that both pay considerably more lip service to women's issues than either ECOWAS or SADC. Nigeria references women in most of the indicators identified, which is particularly notable considering the appalling lack of awareness of women's issues within the ECOWAS document. South Africa is far more expansive regarding the differing needs of women with regard to HIV and AIDS, discussing several issues which appear only in the DoH document. These issues include the provision of VCT in antenatal clinics, increasing the availability of treatment for victims of sexual assault, and the state subsidisation of the adoption of AIDS orphans.

Nevertheless, the Nigerian and South African HIV and AIDS policies can not be described as being gender sensitive, as both hardly address the structural inequalities of women and women-specific concerns which are the root of the high incidence of HIV and AIDS among women. At most, the policies of these two countries show a greater effort towards the integration of women's issues than either ECOWAS or SADC.

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6.1.4 Implication of Findings

The overall trend emerging from the study of both regional organisations is a lack of practical coordination of and guidance to for member states. The purpose of both ECOWAS and SADC is to provide regional leadership with a view to better cohesiveness in the economic, political and social spheres. However, while some of the structures within the regional organisations, most notably the peace and security bodies, have had some success, the health aspect is not adequately addressed. Despite the admission that the HIV and AIDS pandemic has serious repercussions for the economic and political welfare of the region, the regional HIV and AIDS policies put forward by ECOWAS and SADC are not sufficient to begin stemming the spread of the disease, much less start reversing its considerable impact. Given that the policies of the member states, Nigeria in ECOWAS and South Africa in SADC, are far more comprehensive than the vague guidelines provided by the regional organisations, perhaps the more pressing issue is how ECOWAS and SADC could better fulfil their stated mandates of regional leadership. It would surely be more feasible for the regional bodies to put forward a detailed and comprehensive policy covering all possible facets of the HIV and AIDS response, and allow member states to use this all-inclusive policy to formulate their own answer to the pandemic. In other words, a reversal of the current situation is in order, especially in the case of SADC and South Africa, as it appears that the supposed regional leader is instead being led by the member state.

Once the hurdle of uninformative regional policies is resolved, the next issue appears to be the need for a body ensuring implementation of protocols and treaties, such as the recommended minimum in AIDS spending. The time pressure on the AIDS response is also a factor, as both regional bodies have a poor record of timeous implementation of policies. This is expanded on in the studies conducted by Van Nieuwkerk (2001b) and le Pere and Tjonneland (2005), which clearly show the institutional strengths and shortcomings of ECOWAS and SADC respectively.

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6.2 THE WAY FORWARD

HIV and AIDS is but one problem on the already bursting agendas of developing African states. When combined with political instability, poverty, illiteracy, underdevelopment, malnutrition and harmful cultural and social traditions, it progresses into a burden which threatens to undo much of the progress made on the continent. The urgency in addressing the HIV and AIDS pandemic before it reaches devastating proportions is not reflected in the HIV and AIDS policies of either ECOWAS or SADC. Important services such as the provision of condoms, VCT services, and home-based care, are not receiving the attention they deserve. However, the indications are there that attention is being paid to addressing some of the underlying causes of the pandemic, and some measures aimed at stemming the spread of HIV and AIDS are being put into place.

Infrastructural development and regional coordination remain the two most pressing concerns, given their impact on the effective implementation of the HIV and AIDS policies of states. It can be argued that proper use is not being made of the existing capabilities of some states within the regional organisations, as Stremlou (2002:Internet source) points out that "South Africa has the scientific, industrial and financial base to mass-produce a basic three-drug antiretroviral prescription that could greatly extend the lives of millions of parents and workers across Africa". Yet little is said in the South African policy document about developing this capability, and the SADC document could certainly identify those member states with the potential capacity to assist the region in the attainment of essential medicines. Given that the HIV and AIDS pandemic is a long term weight which the region will have to bear, similar far-sighted plans must be developed and put into place.

Particular attention needs to be paid to gender issues and gender mainstreaming in general, and to the provision of medication to pregnant women to prevent the transmission of HIV to their unborn children. This has a lasting impact on a range of high risk groups, as well as implications for the economic, social and political stability of all states grappling with the HIV and AIDS pandemic. The extent to which this issue is addressed by states (including an analysis of involved parties, and the level of subsidisation by the state) would be revealing, especially as it relates to the

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consideration of women's particular needs in the context of the pandemic. Of further importance is the rising number of AIDS orphans and child-headed households briefly mentioned in this study. As PMTCT directly affects both these groups, they add another dimension to this research topic. In general, women's issues need to be placed higher on the list of policy priorities, with more concrete actions undertaken to alleviate the inequalities they face, as opposed to further rhetoric which is currently all that is being produced. In addition, ensuring the meaningful involvement of traditional healers and the use of traditional medicines, while referenced within the policy documents of ECOWAS, SADC, Nigeria and South Africa, needs further expansion. A clear indication of the expected role of traditional remedies, and the actual participation of traditional practitioners at the present time, would foster greater understanding of the multi-sectoral approach being advocated by the regional organisations, as well as illustrate the tailored African response better.

Lastly, neither regional document properly formulates a plan of action which could be implemented in member states; instead vague guidelines are issued which do not necessarily provide strong guidance to the weaker states within their respective regions. While Nigeria and South Africa have arguably shown their strength in formulating more comprehensive policies, it is the expected role of the regional organisations to formulate a detailed, effective regional response. The provision of an appropriate, useful and all-inclusive plan of action for combating HIV and AIDS would allow all member states a clear understanding of the level of commitment required of them, and would also convey the necessary sense of urgency. Instead it appears as though member states, particularly South Africa, are providing the leadership, at least in the formulation of more elaborate and detailed HIV and AIDS strategies. The implication is that the regional bodies are not successfully fulfilling their mandate of strong and cohesive leadership in regional policy development.

It could be argued that the lack of a comprehensive plan of action from either regional organisation is due to their focus on economic development and the pursuit of security, as this has constituted the bulk of their work thus far. However, as the HIV and AIDS pandemic has an immense impact on both of these overarching goals, it is in the best interests of ECOWAS and SADC to provide member states with the necessary guidance, if targets in any spheres are to be met.

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APPENDIX 1.1: HIV AND AIDS PREVALENCE INCREASE 1996 - 2003

	Total Population[1] 2003	Prevalence[2] 1996	Prevalence[1] 2003	Increase (%)
ECOWAS				
Benin	7 900 000	503	150 100	29 741 %
Burkina Faso	12 400 000	1 838	520 800	28 235 %
Cape Verde	500 000	-	-	-
Cote d' Ivoire	17 600 000	5 935	1 232 000	20 658 %
Gambia	1 400 000	78	16 800	21 438 %
Guinea	9 000 000	922	28 800	3 024 %
Guinea-Bissau	1 500 000	-	-	-
Liberia	-	-	-	-
Mali	12 700 000	594	241 300	40 523 %
Niger	13 100 000	652	157 200	24 010 %
Nigeria	125 900 000	5 912	6 798 600	114 897 %
Senegal	11 100 000	227	88 800	39 019 %
Sierra Leone	5 100 000	-	-	-
Togo	5 800 000	1 527	237 800	15 473 %
SADC				
Angola	15 100 000	329	585 000	177 712 %
Botswana	1 800 000	1 364	671 400	49 123 %
DR Congo	54 200 000	4 744	2 655 800	55 882 %
Lesotho	1 800 000	936	520 200	55 477 %
Madagascar	17 600 000	5	299 200	5 983 900 %
Malawi	12 300 000	5 406	1 746 600	32 209 %
Mauritius	1 200 000	5	-	-
Mozambique	19 100 000	2 086	2 330 200	111 607 %
Namibia	2 000 000	2 615	426 000	16 191 %
South Africa	46 900 000	738	10 083 500	1 366 228 %
Swaziland	1 000 000	613	388 000	63 195 %
Tanzania	36 900 000	5 313	3 247 200	61 018 %
Zambia	11 300 000	4 552	1 864 500	40 860 %
Zimbabwe	12 900 000	12 029	3 173 400	26 281 %

[1] UNDP (2004:Internet source); [2] UNAIDS/WHO (1999:612).

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APPENDIX 1.2: REGIONAL HEALTH STATISTICS

	Total Population[1]	HIV/AIDS Prevalence[1]/ %	HIV/AIDS	HIV/AIDS Deaths[2]/ %	Malaria Prevalence[1]/ %	Malaria	Malaria Deaths[3]/ %	Tuberculosis Prevalence[1]/ %	Tuberculosis	Tuberculosis Deaths[3]/ %
ECOWAS										
Benin	7 900 000	150 100	1.9	5 800	845 300	10.70	14 220	0.18	10 270	0.13	790	0.01
Burkina Faso	12 400 000	520 800	4.2	29 000	76 880	0.62	35 960	0.29	33 480	0.27	3 720	0.03
Cape Verde	500 000	-	-	-	-	-	100	0.02	1 750	0.35	200	0.04
Cote d' Ivoire	17 600 000	1 232 000	7.0	47 000	2 138 400	12.15	14 080	0.08	110 880	0.63	12 320	0.07
Gambia	1 400 000	16 800	1.2	600	242 760	17.34	700	0.05	4 620	0.33	560	0.04
Guinea	9 000 000	28 800	3.2	9 000	6 785 100	75.39	180 000	0.20	34 200	0.38	3 600	0.04
Guinea-Bissau	1 500 000	-	-	-	36 300	2.42	2 250	0.15	4 800	0.32	600	0.04
Liberia	3 300 000	-	3.9	7 200	0.22	-	-	0.20	-	-	-	0.05
Mali	12 700 000	241 300	1.9	12 000	0.09	509 270	4.01	57 150	0.45	88 900	0.70	7 620	0.06
Niger	13 100 000	157 200	1.2	4 800	0.04	221 390	1.69	61 570	0.47	51 090	0.39	3 930	0.03
Nigeria	125 900 000	6 798 600	5.4	310 000	0.25	37 770	0.03	176 260	0.14	717 630	0.57	75 340	0.06
Senegal	11 100 000	88 800	0.8	3 500	0.03	1 324 230	11.93	7 770	0.07	48 840	0.44	5 550	0.05
Sierra Leone	5 100 000	-	-	-	-	-	15 810	0.31	32 130	0.63	4 080	0.08
Togo	5 800 000	237 800	4.1	10 000	0.17	446 600	7.70	2 900	0.05	40 020	0.69	4 640	0.08
TOTAL	227 300 000	9 472 200	36.8	438 900	0.19	12 664 000	143.98	568 770	2.66	1 178 610	5.83	123 150	0.68
AVERAGE	16 235 714	947 220	3.35	39 900	0.02	1 151 273	13.09	43 752	0.19	90 662	0.45	9 473	0.05
SADC										
Angola	15 100 000	585 000	3.9	21 000	0.14	1 315 500	8.77	52 850	0.35	60 000	0.40	3 020	0.02
Botswana	1 800 000	671 400	37.3	33 000	1.83	876 600	48.70	360	0.02	6 120	0.34	540	0.03
DR Congo	54 200 000	2 655 800	4.9	9 700	0.02	1 604 320	2.96	119 240	0.22	319 780	0.59	32 320	0.06
Lesotho	1 800 000	520 200	28.9	29 000	1.61	-	-	1 440	0.08	8 100	0.45	720	0.04
Madagascar	17 600 000	299 200	1.7	7 500	0.04	-	-	31 680	0.18	72 160	0.41	7 040	0.04
Malawi	12 300 000	1 746 600	14.2	84 000	0.68	3 191 850	25.95	34 440	0.28	56 580	0.46	6 150	0.05
Mauritius	1 200 000	-	-	-	-	120	0.01	0	0	1 680	0.14	120	0.01
Mozambique	19 100 000	2 330 200	12.2	110 000	0.58	3 460 920	18.12	43 930	0.23	105 050	0.55	11 460	0.06
Namibia	2 000 000	426 000	21.3	16 000	0.8	30 000	1.50	1 000	0.05	9 600	0.48	800	0.04
South Africa	46 900 000	10 083 500	21.5	370 000	0.79	65 660	0.14	0	0	173 530	0.37	14 070	0.03
Swaziland	1 000 000	388 000	38.8	17 000	1.7	28 400	2.84	0	0	7 700	0.77	800	0.08
Tanzania	36 900 000	3 247 200	8.8	160 000	0.43	446 490	1.21	47 970	0.13	173 430	0.47	18 450	0.05
Zambia	11 300 000	1 864 500	16.5	89 000	0.79	3 864 600	34.20	15 820	0.14	66 670	0.59	7 910	0.07
Zimbabwe	12 900 000	3 173 400	24.6	170 000	1.32	697 890	5.41	0	0	58 050	0.45	7 740	0.06
TOTAL	234 100 000	27 991 000	234.6	1 116 200	10.73	15 382 350	149.81	348 730	1.68	1 118 450	6.47	111 340	0.64
AVERAGE	16 721 429	2 133 154	18.05	85 862	0.83	1 298 529	12.48	24 909	0.12	79 889	0.46	7 953	0.05

[1] UNDP (2004:Internet source); [2] UNAIDS (2004a:Internet source); [3] UNSTATS (2005:Internet source).

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APPENDIX 3.1: ARV COVERAGE IN WHO REGIONS

WHO Region	Number of people receiving ARV therapy (low-high estimate)	Estimated Need	Coverage
Africa	310 000 (270 000 – 350 000)	4 000 000	8%
Americas	275 000 (260 000 – 290 000)	425 000	65%
Europe (Eastern Europe and Central Asia)	15 000 (13 000 – 17 000)	150 000	10%
Eastern Mediterranean	4 000 (2 000 – 6 000)	77 500	5%
South-East Asia	85 000 (70 000 – 100 000)	950 000	9%
Western Pacific	17 000 (15 000 – 19 000)	200 000	9%
ALL WHO REGIONS	700 000 (630 000 – 780 000)	5 800 000	12%

(WHO, 2004:Internet source).

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APPENDIX 3.2: BREAKDOWN OF GLOBAL FUND GRANTS

ROUND 5: September 2005

State	Programme Title	Approved Maximum (US$)	5 Year Maximum (US$)
ECOWAS			
Benin	National Programme for the prevention of HIV and TB	19 331 704	50 849 406
Cote d'Ivoire	Prevention of HIV and AIDS (VIH/SIDA)	3 455 256	3 455 256
Gambia	Making HIV/AIDS accessible and affordable	2 561 327	5 032 929
Guinea	TB Combination Therapy Programme	3 326 573	6 105 974
Niger	Support Project for the implementation of new policy for the treatment and prevention of malaria	4 627 434	9 631 344
Niger	TB Programme	6 204 956	11 986 847
Nigeria	Scale up of comprehensive HIV and AIDS treatment, care and support	46 424 283	180 642 512
Nigeria	Scaling up DOTS expansion (TB)	25 570 061	68 265 523
	ECOWAS TOTAL	**111 501 594**	**335 969 791**
SADC			
Botswana	Scaling up DOTS Strategy (TB)	5 515 900	8 956 258
DRC	Scaling up of TB Response	14 598 934	36 234 565
Lesotho	Scaling up of HIV/AIDS prevention, care and treatment interventions	10 013 383	40 346 059
Malawi	Health Systems strengthening and orphan care and support (HIV/AIDS)	26 965 524	65 429 986
Malawi	Scaling up prevention and treatment of malaria	7 770 655	19 104 775
Namibia	Scaling up of HIV/AIDS multi-sectoral interventions targeting poor and vulnerable populations (Including TB and Malaria)	7 222 753	17 777 383
Zimbabwe	Proposal to provide ART in 22 Districts	35 931 159	62 478 891
Zimbabwe	Strengthen National TB Control Programme	9 230 076	12 041 766
Zimbabwe	Make ACT available for treatment of Malaria	20 122 119	28 491 458
	SADC TOTAL	**137 370 503**	**290 861 141**
	OVERALL ROUND TOTAL	**719 507 794**	**1 765 724 327**

(GFATM, 2005:Internet source).

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Round 4: June 2004

State	Programme Title	Approved Maximum (US$)	5 Year Maximum (US$)
ECOWAS			
Burkina Faso	Fight Against HIV/AIDS, TB and Malaria	7 505 405	18 276 470
Guinea Bissau	Expanding the Fight Against Malaria	1 885 791	4 177 512
Guinea Bissau	Scaling up the response to the HIV/AIDS epidemic	1 166 801	5 078 607
Mali	Strengthening DOTS Strategy	2 563 768	6 747 610
Mali	Expansion of the integrated prevention and care networks for STI/HIV/AIDS in Bamako and the 8 regional capitals of Mali	23 483 324	56 340 436
Niger	New partnership for child survival (malaria)	11 257 988	11 257 988
Nigeria	Improving malaria ACT therapy and training of health service providers	20 467 000	86 122 000
Senegal	Programme to reinforce the fight against malaria	23 179 297	33 305 682
Sierra Leone	Development of a comprehensive national response to HIV/AIDS	8 574 255	17 905 201
Sierra Leone	National Malaria Control Programme	8 886 123	14 855 611
Togo	Closing the gaps: an integrated approach to HIV/AIDS prevention	11 517 643	32 421 013
Togo	Integrated innovative approach to strengthening the fight against malaria	6 066 034	10 694 981
	ECOWAS TOTAL	**126 553 429**	**297 183 111**
SADC			
Angola	Support to the National TB Control Programme	7 350 590	11 163 763
Angola	Reducing the burden of HIV/AIDS	27 670 810	91 966 080
Madagascar	Scaling up successful malaria treatment and prevention initiatives	19 304 060	41 527 527
Madagascar	Reduction of morbidity due to TB	3 982 018	8 869 040
Swaziland	Programme to scale up hey components of the National HIV/AIDS Response	16 396 810	48 283 310
Tanzania	Prompt and effective treatment of malaria, and detection and containment of malaria epidemics	54 201 787	90 468 963
Tanzania	Filling critical gaps in the National Response to HIV/AIDS in impact mitigation for OVC, condom procurement, care and treatment, monitoring and evaluation, coordination	103 191 298	293 263 191
Tanzania	Consolidation of malaria control through ACT therapy and insecticide treated nets	5 089 361	9 586 972
Zambia	Scaling up ARV Treatment	26 770 776	253 608 070
Zambia	Scaling up equitable and sustainable interventions for malaria prevention and control	20 279 950	43 495 950
	SADC TOTAL	**284 237 460**	**892 232 866**
	OVERALL ROUND TOTAL	**1 013 856 978**	**2 987 802 578**

(GFATM, 2005:Internet source).

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Round 3: October 2003

State	Programme Title	Approved Maximum (US$)	5 Year Maximum (US$)
ECOWAS			
Benin	Support for the fight against malaria in the Mono and Couffo Departments	1 383 931	2 145 813
Cote d'Ivoire	Prevention of the spread of the HIV/AIDS epidemic in the context of severe political and military crisis	1 023 534	1 023 534
Cote d'Ivoire	Reinforcement of care for TB according to DOTS Strategy	3 830 107	3 830 107
Gambia	Treatment, care and support to PLWHA which is accessible, affordable and maintainable	6 241 743	14 568 678
Gambia	Scaling up prevention and treatment of malaria in coastal region of Gambia	5 665 500	13 861 866
Guinea Bissau	Scaling up the fight against TB	1 503 587	2 646 004
Liberia	Malaria control and prevention through partnership	12 140 921	12 140 921
Niger	Contribution to the fight against sexually transmitted diseases and HIV/AIDS	8 475 297	11 968 331
Niger	Reinforcement Project for the national strategies to scale up interventions to fight malaria	4 815 109	5 886 835
Togo	Strengthening of the fight against malaria	3 479 336	5 885 906
Togo	Intensification of DOTS treatment	1 752 982	2 617 655
	ECOWAS TOTAL	**50 312 047**	**76 575 650**
SADC			
Angola	Support to the National Malaria Control Programme	28 473 354	38 383 000
DRC	Support to the Congolese initiative on HIV/AIDS prevention and care	34 799 786	113 646 453
DRC	Strengthening the fight against malaria	24 966 676	53 936 609
Madagascar	Scaling up of HIV/AIDS	13 415 118	20 009 441
Madagascar	Community action to roll back malaria	5 232 448	10 400 722
South Africa	Strengthening and expanding the Western Cape HIV/AIDS prevention, treatment and care programmes	15 521 457	66 509 557
Swaziland	Coordinated Country Response to fight TB	1 348 400	2 507 000
Tanzania	Scaling up access to quality VCT for TB and HIV/AIDS	23 951 034	86 987 868
Tanzania	Zanzibar country proposal for scaling up TB services	959 482	1 699 867
	SADC TOTAL	**148 667 755**	**394 080 517**
	OVERALL ROUND TOTAL	**615 968 495**	**1 532 917 945**

(GFATM, 2005:Internet source).

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Round 2: January 2003

State	Programme Title	Approved Maximum (US$)	5 Year Maximum (US$)
ECOWAS			
Benin	Intensification of the fight against HIV/AIDS	17 324 228	17 324 228
Benin	Intensification of the fight against TB	3 104 104	3 104 104
Burkina Faso	Project for the enhancement of HIV/AIDS control	16 417 522	16 417 522
Burkina Faso	Reinforcement of malaria prevention measures	7 499 988	7 499 988
Cote d'Ivoire	Strengthening the national response to HIV/AIDS	46 431 529	46 431 529
Guinea	Project to strengthen the fight against HIV/AIDS	4 804 696	13 230 165
Guinea	Project to strengthen the fight against HIV/AIDS, TB and malaria	6 893 509	8 708 945
Liberia	Strengthening of HIV/AIDS prevention, care and treatment	7 658 187	7 658 187
Liberia	Strengthening of TB control and the management of people with TB/HIV co-infection	4 534 017	4 534 017
Nigeria	Scaling up roll back malaria in 12 states	20 994 149	44 314 691
Sierra Leone	National DOTS expansion support project	5 698 557	5 698 557
Togo	Intensification of the fight against HIV/AIDS	15 455 477	15 455 477
	ECOWAS TOTAL	**156 815 963**	**190 377 410**
SADC			
Botswana	Scaling up of the multi-sectoral response to HIV/AIDS	18 580 414	18 580 414
DRC	TB prevention, support and capacity building	7 625 773	7 625 773
Lesotho	Strengthening prevention and control of HIV/AIDS	10 557 000	29 312 000
Lesotho	Strengthening TB prevention and control	2 000 000	5 000 000
Madagascar	Fight against AIDS for our future	1 503 624	1 503 624
Madagascar	Prevention of HIV/AIDS and other sexually transmitted diseases through social marketing	5 024 116	5 024 116
Malawi	Scaling up prevention and treatment of malaria	18 815 810	37 631 810
Mozambique	Prevention and mitigation of the social impact of HIV/AIDS	29 692 640	109 338 584
Mozambique	Building capacity to scale up Roll Back Malaria	12 217 393	28 149 603
Mozambique	Strengthening and expanding TB services	9 202 140	15 201 801
Namibia	Scaling up the fight against HIV/AIDS	26 082 802	105 319 841
Namibia	Scaling up the fight against Malaria	3 719 354	6 304 577
Namibia	Scaling up the fight against TB	904 969	1 532 603
South Africa	Strengthening national and provincial capacity for prevention, treatment, care and support related to HIV and TB	8 414 000	25 110 000
Swaziland	Coordinated Country Response to fight HIV/AIDS	52 544 145	52 544 145
Swaziland	Coordinated Country Response to fight malaria	1 820 500	1 820 500
Tanzania	Participatory response to HIV/AIDS for youth in Zanzibar	2 302 637	2 302 637
AFRICA	Multi-Country Africa (RMCC): Malaria control in the Lubombo Special Development Initiative*	21 432 343	21 432 343
	SADC TOTAL	**211 007 317**	**452 302 028**
	OVERALL ROUND TOTAL	**1 193 428 630**	**1 978 104 536**

* Not included in regional totals. (GFATM, 2005:Internet source).

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Round 1: April 2002

State	Programme Title	Approved Maximum US$	5 Year Maximum US$
ECOWAS			
Benin	Scaling up malaria prevention	2 973 150	2 973 150
Mali	Accelerating the implementation of the national strategic plan to fight malaria	2 592 316	2 592 316
Nigeria	Expansion of Prevention of Mother-to-Child Transmission Centres of Excellence	8 708 684	27 431 874
Nigeria	Programme to assess and promote the effective participation of civil society organisations in the National Response to HIV/AIDS	1 687 599	1 687 599
Nigeria	Programme for the expansion of ARV therapy	17 772 103	41 772 103
Senegal	Strengthening the fight against HIV/AIDS	11 714 285	11 714 285
Senegal	Strengthening the fight against Malaria	4 285 714	4 285 714
	ECOWAS TOTAL	**49 733 851**	**92 457 041**
SADC			
Madagascar	Prevention of Malaria through social marketing	2 000 063	2 000 063
Malawi	National Response to HIV/AIDS	178 614 264	178 614 264
South Africa	Enhancing the care of HIV/AIDS infected and affected patients in resource-constrained settings in Kwazulu-Natal	26 741 529	71 968 018
South Africa	Strengthening national capacity for treatment, care and support of HIV and TB, building on successful behaviour change initiatives in South Africa (*Soul City*)	20 226 665	20 226 665
Tanzania	Scaling up effective district HIV/AIDS response, focusing on communities, primary schools and the informal sector	5 400 000	5 400 000
Tanzania	National Insecticide treated nets implementation plan (NATNETS) support	19 827 716	19 827 716
Tanzania	Implementation of new malaria treatment policy in Zanzibar	1 153 080	1 153 080
Zambia	Zambia National AIDS Network's Programme to combat HIV/AIDS	90 325 778	92 847 000
Zambia	Churches Health Association of Zambia's Programme to combat malaria	39 273 800	39 273 800
Zambia	Zambia National AIDS Network's Programme to combat malaria	47 337 256	47 337 256
Zimbabwe	Strengthen and scale up disease prevention and care for HIV/AIDS	10 300 000	14 100 000
Zimbabwe	Improving the quality of interventions and scaling up malaria control	6 716 250	8 877 500
	SADC TOTAL	**447 916 401**	**501 625 362**
	OVERALL ROUND TOTAL	**1 251 307 136**	**1 362 434 253**

(GFATM, 2005:Internet source).

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APPENDIX 3.3: OECD CONTRIBUTORS TO THE GLOBAL FUND

	Average Contribution (US$ million)	60% of Average Contribution (US$ million)*
Austria	0.9	0.54
Belgium	5.4	3.24
Canada	51.0	30.60
Denmark	14.0	8.40
France	47.1	28.26
Germany	42.0	25.20
Ireland	9.2	5.52
Italy	75.2	45.12
Japan	80.0	48.00
Luxembourg	0.9	0.54
Netherlands	43.6	26.16
New Zealand	0.7	0.42
Norway	5.6	3.36
Portugal	0.4	0.24
Spain	35.0	21.00
Sweden	20.6	12.36
Switzerland	11.0	6.60
United Kingdom	210.3	126.18
United States	137.5	82.50
EC	53.7	32.22
TOTAL	**844.0**	**506.40**

* As indicated in the text, 60% of the total contributions to the Global Fund should be spent on HIV and AIDS (Adapted from OECD, 2004:Internet source).

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APPENDIX 4.1: HEALTH CARE EXPENDITURE IN ECOWAS

State	GDP (US$ billions) 2002[1]	Public Health Expenditure (% of GDP) 2001[1]	Public Health Expenditure (% of GDP) 2002[2]	Total Health Expenditure per capita (US$) 2002[2]	Private Health Expenditure as % of total expenditure on health 2002[2]
ECOWAS					
Benin	2.7	2.1	4.7	20	55.6
Burkina Faso	3.1	1.8	4.3	11	54.1
Cape Verde	0.6	3.8	5.0	69	24.9
Cote d'Ivoire	11.7	1.0	6.2	44	77.6
Gambia	0.4	3.2	7.3	18	55.4
Guinea	3.2	1.9	5.8	22	84.5
Guinea-Bissau	0.2	3.2	6.3	9	51.8
Liberia	-	-	2.1	4	32.0
Mali	3.4	1.7	4.5	12	49.2
Niger	2.2	1.4	4.0	7	49.2
Nigeria	43.5	0.8	4.7	19	74.4
Senegal	5.0	2.8	5.1	27	54.8
Sierra Leone	0.8	2.6	2.9	6	39.7
Togo	1.4	1.4	10.5	36	89.2
TOTAL	78.2	27.7	73.4	304	792.4
AVERAGE	6.02	2.13	5.24	21.71	56.6

[1]UNDP, 2004:Internet source; [2] WHO, 2006a:Internet source.

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APPENDIX 5.1: HEALTH CARE EXPENDITURE IN SADC

State	GDP (US$ billions) 2002[1]	Public Health Expenditure (% of GDP) 2001[1]	Public Health Expenditure (% of GDP) 2002[2]	Total Health Expenditure per capita (US$) 2002[2]	Private Health Expenditure (% of total expenditure) 2001[2]
SADC					
Angola	11.2	2.8	5.0	38	58.1
Botswana	5.3	4.4	6.0	171	38.1
DR Congo	5.7	1.5	4.0	4	71.3
Lesotho	0.7	4.3	6.2	25	15.1
Madagascar	4.4	1.3	2.1	5	45.0
Malawi	1.9	2.7	9.8	14	58.9
Mauritius	4.5	2.0	3.5	137	41.0
Mozambique	3.6	4.0	5.8	11	29.0
Namibia	2.9	4.7	6.7	99	29.9
South Africa	104.2	3.6	8.7	206	59.4
Swaziland	1.2	2.3	6.0	66	40.5
Tanzania	9.4	2.1	4.9	13	45.2
Zambia	3.7	3.0	5.8	20	47.1
Zimbabwe	8.3	2.8	8.5	118	48.4
TOTAL	167	41.5	83	927	627
AVERAGE	11.93	2.96	5.93	66.21	44.79

[1]UNDP, 2004:Internet source; [2] WHO, 2006a:Internet source.

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