ACKNOWLEDGEMENTS

This Strategic Framework aims at strengthening the response to the HIV/AIDS epidemic in the Southern African Development Community (SADC). It has been developed under the leadership of the SADC Health Ministers whose vision of a multi-sectorally driven strategy has given impetus to and seen the birth of this seven-sector framework. The Ministers set up an HIV/AIDS Task Force made up of Health Focal Points which was later expanded into a multi-sectoral Task Force to include the seven sectors involved in this Framework.

The framework seeks to build on the efforts of the many sectors that have been involved in the HIV/AIDS response within the framework of SADC. It is recognized that much of the work in HIV/AIDS has been spearheaded by the National AIDS Coordination/Control Programmes (NACPs) in Member States. The guidance of these NACPs will continue to be desirable in strengthening the response in other sectors, and in providing technical leadership in the implementation stage of the Framework. The Strategic Framework has also benefited from the efforts of many international agencies, whose work has provided insights into options available to Members States' HIV/AIDS responses.

Sector Coordinators from the seven SADC Sectors as well as the SADC Secretariat have participated in the design of this framework and have invested much time in developing this Framework. The coordination in the development of this framework has been spearheaded by the Health Sector Co-ordinating Unit and the overall technical leadership has been provided by the HIV/AIDS Task Force.

Further technical support has been provided to the Multi-Sectoral Task Force by consultants from Ziken International of Harare, who have synthesised inputs from various sectors into this Strategic Framework and Programme of Action.

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1. INTRODUCTION

The SADC HIV/AIDS Task Force in December 1999 adopted the vision of "***A SADC Society With Reduced HIV/AIDS"*** to guide the work of the seven sectors participating in the development and implementation of a multi-sectoral SADC HIV/AIDS Framework for the period 2000 - 2004. The elaboration of this vision led to development of the overarching goal of ***"decreasing the number of HIV/AIDS infected and affected individuals and families in the SADC Region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of Member States"***. This goal provides guidance to all SADC sectors in the formulation of their responses to the epidemic.

The health sector has over the last two decades provided much of the leadership in the HIV/AIDS response and has advocated a strategy that addresses the HIV/AIDS epidemic through the efforts of health care system, communities, youth, the private and public sector and other stakeholders in society. This multi-sectoral HIV/AIDS Framework recognizes that the wider participation of all sectors and communities (including youth, women and children) in the HIV/AIDS response is likely to lead to enhanced synergism and complimentarity of effort for achieving greater impact.

The main strategy being pursued in this Framework is to promote the re-allocation of responsibilities for planning, coordination, implementation and monitoring and evaluation of the HIV/AIDS response across the social and economic sectors of SADC, consistent with the specific mandates and comparative advantage they enjoy. In this manner, the response will become increasingly multi-disciplinary and multi-sectoral in character and take on a more regional flavour.

Overall, the Strategic Framework is guided by Article 10 of the SADC Health Protocol within which all SADC sectors use their comparative advantage to address the needs of those sectors and communities they serve - Transport, Mining, Tourism, Human Resource, Information, Culture and Sports, Labour and Employment, and Health. The underlying strategy of this Framework is to assist each sector build its capacity so that it can develop, implement and monitor an effective HIV/AIDS programme – supported by the Health Sector Coordinating Unit. In working towards that goal, the Strategic Framework provides the context for, and seeks to build capacities in the seven sectors for an accelerated and robust response to the epidemic.

2. PROCESS OF DEVELOPMENT OF FRAMEWORK

This Strategic Framework aims to address the HIV/AIDS epidemic in the SADC region using a multi-sectoral approach within the regional grouping of SADC. It is the product of consultations among the seven sectors comprising a multi-sectoral Task Force on HIV/AIDS in SADC. The Task Force met in Pretoria, South Africa, during 6-7 December 1999. Each of the seven Sector Coordinators conducted extensive consultations within their sectors to arrive at strategies that best reflect that sector's response to the HIV/AIDS epidemic.

In keeping with this consultative process, each sector was encouraged to:

1. Identify those HIV/AIDS activities that it needs to integrate into its overall strategy, and then seek support from Health and other sectors.

2. Use relevant Sector Coordinating Units, to facilitate the sharing of lessons between member states within the sector.

3. Share its lessons with each of the other six sectors.

4. Adopt innovative and relevant strategies that have been tested by other sectors.

The Health Sector Coordinating Unit in this period performed the following functions:

1. Identification of those activities that are best carried out by the health sector and then assist health sector focal points in member states with implementation.

2. Synthesis of inter-sectoral experiences for wider dissemination based on work carried out by the seven sectors involved in this framework.

3. Undertaking and stimulating HIV/AIDS awareness in all other sectors not participating in this multi-sectoral HIV/AIDS Framework, and using experiences from 1 and 2 above to disseminate information on good practices in intra-sectoral HIV/AIDS work.

It is envisaged that in the implementation phase of this Framework, each sector will strive to integrate HIV/AIDS strategies into its overall sectoral strategy whilst the health sector will assist in coordination and technical support. During the five-year life span of this Framework, the SADC Health Sector Coordinating Unit is to be strengthened with expertise that can coordinate work within the following:-

(a) The three social sectors involved in the programme (Health, Human Resources Development, and Culture, Information and Sports);

(b) The three economic sectors (Mining, Tourism, and Transport and Communication) forming part of the programme; and

(c) The integrative sector of Employment and Labour, whose work on HIV/AIDS can provide useful strategies for more effective linkages between social and economic sectors at the national and regional levels.

3. SITUATION ANALYSIS OF HIV/AIDS IN THE SADC REGION

The SADC Region faces a very severe HIV/AIDS epidemic. The current extent of the pandemic has affected virtually every aspect of the lives of the people in the SADC

region and has now reached crisis proportions. Since the mid-80s when HIV/AIDS was identified in most countries of the region, there has been a rapid increase in the numbers of adults and children infected with, and dying from HIV and AIDS, with a corresponding adverse impact on the socio-economic development of the region. HIV/AIDS is now arresting or even reversing the major socio-economic gains of the past two decades in such areas as health, agriculture and education. Health care systems are overwhelmed with HIV/AIDS patients with the result that health workers are overburdened, health care costs are escalating and acute conditions are being "crowded out". Conditions such as tuberculosis (TB) which were almost being brought under control in the 1970s have re-emerged as a result of the HIV/AIDS epidemic, further straining the overstretched health care systems.

The demographic impact of HIV/AIDS in the region has also been serious: life expectancy has dropped significantly to around 40-50 years, child and adult mortality have risen while the number of orphans continues to increase at an unprecedented rate.

From the epidemiological surveillance of HIV/AIDS in the region, it is not uncommon to find HIV seroprevalence rates in excess of 20% or more in the adult population in most urban areas of the SADC region. This in essence means that a large number of productive and skilled men and women will lose their lives prematurely to HIV/AIDS, with dire consequences for the socio-economic development of the region. Yet the full impact of HIV/AIDS is yet to come because of the prevailing high levels of HIV infection in the communities which will ultimately translate into AIDS patients requiring care and social support.

The characterization of HIV/AIDS "as a disease of sub-Saharan Africa" is aptly demonstrated by the following facts available from UNAIDS:

- The region has registered a total of close to 4 million deaths, which have left behind nearly 3 million orphans.

- The estimated total number of AIDS cases in the region is 4 million, leaving another estimated 6 million who are HIV-positive and likely to develop AIDS.

- There are about 10 million citizens living with HIV/AIDS (5% of the total population) in the region.

According to the Joint United Programme on HIV/AIDS (UNAIDS), it is estimated that the region has an average adult prevalence rate of 12% (which would mean close to 10 million people affected by HIV/AIDS in this region).

HIV/AIDS is therefore a major burden and challenge to the health, social, and economic development of the region. There can therefore be no meaningful development in the SADC region as long as HIV/AIDS is not addressed on an **urgent** and **emergency** basis, and justifiably so, the SADC Ministers have identified HIV/AIDS as a crisis that requires a multi-disciplinary and multi-sectoral approach. This entails forging strategic partnerships and alliances across public, private and NGO sectors.

3.1 Health status in the region

The HIV/AIDS epidemic has begun to adversely affect the health status of people in the SADC region. The health indicators have also begun to deteriorate. While the region has registered a steady improvement in the provision of safe water supplies and sanitation facilities during the last decade, the challenge of high morbidity and mortality remains. Infant Mortality Rates in the 1980-97 period only dropped from 109 to 92 deaths per 1,000 live births, while Maternal Mortality Rates in the same period remained at 634 per 100 000 live births. Prevalence of malnutrition among the under-fives was around 25% during the 1990s decade, and under-fives Mortality Rates were 146 per 1,000 live births. The population in the region, with a relatively heavy burden of illness and poor health, is now faced with an even more menacing and growing AIDS/TB co-epidemic.

Regional averages of selected health indicators

	1997
Population with access to safe water (% total)	55
Population with access to sanitation (% total)	51
Access to sanitation in urban areas (%)	75
Public health expenditure as % of GDP	2.7
Infant Mortality Rates, per 1,000 live births	94
Total fertility rate (births per woman)	5.0
Contraceptive prevalence (% women in 14-49 age group)	30
Prevalence of malnutrition among the under-fives	25
Under fives mortality rate, per 1,000 live births	146

Source: World Bank Development Report 2000

The prevalence of communicable but preventable diseases is high in the SADC region and the advent of HIV/AIDS has further complicated the prevention efforts of these diseases. Of particular importance and significance is the emergence or re-emergence of tuberculosis as a major public health and socio-economic problem that threatens the lives of hundreds of thousands of people in the SADC region. Despite efforts by governments in the region over the last decade to address HIV/AIDS and its effects, the epidemic still constitutes the single biggest threat to health within the SADC.

3.2 Socio-economic setting

The SADC has a total population of 191 million people, with an average of GNP per capita of US$1,096. This average GNP figure masks great inequalities within the region, with Botswana, Mauritius and South Africa having a figure of over US$3,000; while countries like the Democratic Republic of Congo, Malawi, Mozambique, and Tanzania have less than a figure of US$200. This gap in GNP per capita for the region (US$80-3,380) has major implications on the availability of resources to support development efforts, including the financing of health services and various measures needed to combat the impact of HIV/AIDS.

Although the region has a low rate of population growth (2% per annum in the 1995-2000 period), this is offset by the very low rates of economic growth for most of the member states, especially for those countries with low GNP per capita figures. This poses a major challenge in the allocation of resources to HIV/AIDS programmes for member states.

Macro-economic stability and the challenge of resource allocation to HIV/AIDS programmes and activities is complicated further by the high levels of ***external debt*** in the region – which in 1997 averaged at 93% of GNP according to the World Bank Development Report 2000 (WBDR 2000). Only Botswana had an external debt less than 10% of GNP – with the highest being Angola at 206% in 1997. In the 1990-97 period, the region only received a total of US$2.7 billion in foreign investments, most of it going to South Africa. In the same period, the per capita Official Development Assistance to the region dropped from US$63 to US$45 - a drop from 16% of GNP to 10% (WBDR2000). Thus, for countries with a high dependence on external assistance to finance the social sector, the challenge of resource constraints will remain for some time to come.

Regional averages of selected economic indicators

	1990	***1997***
Direct foreign investments ($b)	-6	2.7
Total external debt ($b)	43	76
External debt as % of GNP		93
Official Development Assistance $/capita)	63	45
Official Development Assistance (% GNP)	16	10
GNP per capita (value in US$)	1 6	11
GNP per capital annual growth rate (%)		0.3
Food production index (1995-7; 1989-91=100)	69	84
Arable land (hectares per capita)	0.4	0.3

Source: World Bank Development Report 2000

With the establishment of SADC and COMESA and the end of apartheid in South Africa in 1995, the region has shown signs of increased economic integration. In the period 1996-98, South Africa invested a total of US$4.2 billion in eleven of the fourteen member states according to a survey by *Focus on Africa 2000*. Increased economic integration and intra-regional investment flows have the effect of opening up possibilities for the increased allocation of private sector finance to HIV/AIDS programmes.

The overall difficulty of registering high economic growth figures in the region will pose the greatest challenge to the allocation of adequate resources to programmes aimed at enhancing the HIV/AIDS epidemic in the region.

All member states have literacy levels above the 40% mark, with Mauritius, Seychelles and Zimbabwe registering over 80%; and the bottom three being Angola, Malawi, and Mozambique (UNESCO, 1998). Due to 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. High enrolment rates in primary schools is conducive to the provision of health education to this population, but low

secondary school enrolment is a major handicap in reaching the teen age group that is usually in Secondary Schools. For higher education, the figures are even lower, less than 5% in the region, and the use of non-visual communication in the region has limitations due to this pattern of educational levels. This issue poses major challenge to all sectors involved in the implementation of the multi-sectoral activities.

4. HIV/AIDS RESPONSE ANALYSIS IN THE SADC REGION

Member States in the SADC region have been implementing HIV/AIDS programmes since the mid-80s in order to (i) prevent or reduce the transmission of HIV and other STDs and (ii) reduce the socio-economic impact of HIV/AIDS among individuals, families and communities.

In the early stages of the epidemic, many countries were guided in the implementation of HIV/AIDS Programmes by the WHO's Global Programme on HIV/AIDS (GPA) which was later supplanted by UNAIDS in 1996.

The early HIV/AIDS response was mainly centered around raising awareness on HIV/AIDS through IEC and communication for behaviour change (abstinence, mutual faithfulness), condom promotion, treatment of STDs as well as clinical and home-based care. These early approaches were predominantly medical and health-focused in nature and largely neglected the participation of other sectors in the response. In addition, it emerged that there was (and there still is) the challenge of narrowing the gap between knowledge and behaviour.

As the epidemic continued to evolve in the 1990s and its effects became increasingly cross-cutting, there was a realization that the health sector alone could not respond to, and cope with the wide-ranging socio-economic consequences and manifestations brought about in its wake. Therefore, there was a shift in the programming paradigm from a medical to a more multi-sectoral, participatory and inclusive approach.

The main actors in the HIV/AIDS response in the region are:

i. The Governments, through National AIDS Coordination/Control Programmes (or AIDS Commissions, Councils) which provide overall leadership, guidance, policy formulation and coordination.
ii. The Non-Government Organizations (NGOs), Community-Based Organizations (CBOs) and Religious Organizations which have increasingly been playing a bigger role in prevention, care, social support and other forms of impact mitigation, thereby complementing Governments' efforts
iii. Private Sector working mainly through work place programmes are also beginning to take ownership for responding to the epidemic
iv. Regional Organizations and Cooperating Partners who have provided resources and technical support in the HIV/AIDS response

The extent to which interventions have been successful in averting the further spread of HIV in the region is extremely variable across countries of the region, depending on the maturity of the epidemic and the intensity of the response. There are reports of

a stabilizing epidemic in some countries, albeit at extremely high levels while some countries have reported declines in the rate of new infections, particularly in the age group 15 to 19 years. Notwithstanding these isolated favourable changes, the rising trend of HIV infection in the southern part of the SADC region is worrying, particularly in parts of South Africa over the last five years.

It is clear therefore that the HIV/AIDS epidemic remains serious in SADC and many of the "effective" interventions have remained small, fragmented and remain stuck in pilot mode. In addition, the strategies have largely been single-sector efforts (health) and efforts to develop and catalyze a concerted multi-sectoral approach have not yielded the desired results. Many sectors outside health have inadequate technical expertise and capacity to 'internalize' the HIV/AIDS problem through their policy frameworks, institutional arrangements and service delivery.

In order to produce a greater positive impact on the HIV/AIDS situation in the region, it is desirable to broaden and expand the number of sectors participating in the response and to considerably scale up the interventions. This will have the effect of improving and widening coverage - both in terms of geography and in relation to populations and clients served.

Consistent with the lessons learnt thus far in the epidemic, there is now greater movement towards developing multi-sectoral and regional approaches in the response to the HIV/AIDS epidemic

5. GUIDING PRINCIPLES

The development of this Strategic Framework has been guided by the following principles:

1. The 'comparative advantage' of each sector should be identified and utilized in the implementation of strategies aimed at addressing the epidemic and its effects in the sector

2. The SADC Strategy seeks to complement on-going National Responses to HIV/AIDS epidemic as outlined in the respective National HIV/AIDS Plans and Programmes.

3. The recognition that there are other international, regional and national organisations/bodies already participating in the response to HIV/AIDS pandemic in the region.

4. Respect for rights of individuals and promoting partnerships and respect.

6. SADC VISION, GOAL AND OBJECTIVES OF THE SADC HIV/AIDS STRATEGIC FRAMEWORK

Vision
SADC society with reduced HIV/AIDS

Overarching Goal

To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of Member States

Main Objectives

1. To reduce and prevent the incidence of HIV/ infection among the most vulnerable groups in SADC.
2. To mitigate the socio-economic impact of HIV/AIDS/AIDS.
3. To review, develop and harmonise policies and legislation aimed at prevention and control of HIV/AIDS/AIDS transmission.
4. To mobilise and co-ordinate resources for the HIV/AIDS multi-sectoral response in the SADC region.

Outputs

1. Reduced incidence and prevalence of HIV/AIDS in SADC region;
2. Strategies for responding to the socio-economic impact of HIV/AIDS are developed and implemented in all SADC sectors;
3. Adequate regional and international resources mobilised and efficiently utilised in a coordinated manner for the region;
4. Harmonised and coordinated SADC policies on HIV/AIDS

7. INSTITUTIONAL FRAMEWORK

The organization of SADC programmes in Sectors has the potential to mobilize the region to successfully tackle the HIV/AIDS pandemic - using coordinated and effective strategies as outlined in the SADC Health protocol, Article 10. This initiative for a multi-sectoral HIV/AIDS strategy brings together seven Sectors in the fourteen member states, creating 98 (7x14) sector national points where HIV/AIDS can be tackled through coordinated strategies. The potential to mobilize other institutions in the region using these 98 national sector points is enormous, and it is this organizational capacity that the multi-sectoral plan seeks to exploit.

The SADC framework also provides for mechanisms to coordinate the use of resources available from the budgets of member states and from contributions by the international donor community. It is planned that the multi-sectoral HIV/AIDS plan will tap into these resources to ensure that all available resources are deployed in an efficient and cost-effective way.

This plan will have a number of country-based and sector-specific projects for implementation under the guidance of the Health Sector Coordinating Unit in Pretoria to ensure that lessons can be shared, results disseminated, and efficiency promoted between various projects. The reporting mechanisms will primarily be output-based to ensure that the deployment of resources can be justified by the outputs each project produces.

Three technical officers will be deployed at the SADC Health Sector Coordinating Office in Pretoria to provide support to all the national Sector Coordinating Units working on this programme. The work of these officers will be to facilitate the documentation and dissemination of best practices from the various sectors, to follow-up on administrative and technical issues identified by sectors involved in the plan, and to prepare inter-sectoral progress reports – highlighting successes, constraints, and lessons learnt.

The three programme officers to support coordination will require strong management backgrounds, and should have the following experiences:-

1. For the economic sectors, should be someone with knowledge in the economic sectors.

2. For the social sectors, the person should be knowledgeable in social sector concerns and work.

3. The most senior person should have experience in inter-sectoral work, and be able to use the Employment and Labour Sector to synthesise the work of economic and social sectors.

The three programme officers would be contract posts (funded by project funds) and answerable to the Health Sector Coordinator

8. SECTOR STRATEGIES

8.1 Culture, Information and Sport Sector

Background

An important feature of the Southern African region is its common history and traditions. Population migration has characterized demographic patterns off many countries in the region**.**

Among other reasons, the causes for such movements have been attributed to socio-economic and political reasons. Colonialism and the struggle against apartheid have accounted for greater proportion of the population displacement in the region.

Furthermore, over the last four decades, the region has experienced internal conflicts, civil wars and wars for liberation which have resulted in increased numbers of refugees and as such have caused great disruptions in the live of people in this region. In addition, the Southern African region is a major tourist destination. This has as such resulted in a influx of people in most parts of the region.

The economic imbalances amongst the member states in the region, as well as improvements transport and communication infrastructure, have contributed to easy movements of people, who, among other reasons, are in search for better employment and economic opportunities. Within the boarders of the individual member states, there is evidence of rural – urban migration. This is mainly pronounced amongst the youthful generation who also migrate to urban and/or industrialized places in search of better economic opportunities as well. Such migrations have resulted in population explosion in urban areas often resulting in squatter settlements. The results of this is poverty, lack of educational opportunities, prostitution, crime, drug and substance abuse which are all pre-disposing factors to contraction and spread of the HIV/AIDS.

Anecdotal evidence suggest that there are traditional practices which have been associated with facilitating the spread of HIV/AIDS. Most societies have a negative attitude towards people living with HIV/AIDS. There is a big stigma attached to those people infected by the virus and they often suffer from social alienation. However, culture has a key role to play in the development of positive attitudes towards HIV/AIDS infected and affected individuals at any stage of the disease. The people of the Southern African region have much in common such as the type of dress, food, family structures, education, health systems, entertainment and other aspects of life that would make a regional approach to addressing the HIV/AIDS pandemic issues more appropriate. The caring and sharing values enshrined in the national cultures of all the SADC member states should be strengthened and employed in mitigating the effects of the epidemic. The media needs to play a major role in the education and information dissemination on HIV/AIDS.

Sport offers social interaction, promotes involvement, integration and responsibility in society and contributes to the development of the communities. In this connection, sport and sporting activities offer avenues and opportunities for intervention programmes for HIV/AIDS to reach the bulk of the population in dissemination of appropriate information and services.

In this regard, the Sector for Culture, Information and Sport seeks to harness the socio-economic and cultural ties resulting from the above process to support regional integration, and its work as is expect to have a major impact on the regions's response to HIV/AIDS.

The common culture and availability of appropriate media infrastructure for dissemination of information on HIV/AIDS and programmes designed by the sector creates a conducive environment and a possible success by the sector in addressing the HIV/AIDS epidemic.

In this regard, the sector seeks to play a key role in strengthening some of the positive aspects of the people's culture and minimize the negative impacts of the HIV/AIDS epidemic. The sector shall therefore ***strengthen, promote and consolidate the long standing historical, social and cultural affinities and links among the people of Southern Africa***. Further, the sector will explore possibilities of establishing alternative communication media in an attempt to communicate the HIV/AIDS strategies, collaborate with the NGO's especially sports clubs, artists and drama groups, in the fight against the disease.

Culture, Information and Sports Sector

Sector mandate: To strengthen, promote and consolidate the long-standing historical, social, and cultural affinities and links among the people of Southern Africa.

Impact of HIV/AIDS: There are positive (to be enhanced) and negative (to be minimised) impacts of HIV/AIDS in relation to the following areas:

- Labour movement and trans-border trade increases vulnerability (historical)
- Youth yielding to peer pressure (sports)
- Size of labour force (artisans, musicians, artists, sports-persons, youth, media workers, etc.).

Culture, Information and Sport: Log Frame

OVERALL GOAL	OBJECTIVES	ACTIVITIES	OUTPUT	INDICATORS	ASSUMPTIONS/RISKS
To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of the member countries.	1. To mobilize and empower Artists, Media, Entertainers and Sports persons (AMES) in the fight against HIV/AIDS in the region.	1. Convene Regional workshops and seminars for orientation of AMES associations on strategies to mitigate against the effects of HIV/AIDS. 2. Recruitment of volunteers to assist in public education and awareness.	Two-thirds of AMES in SADC mobilized and equipped with knowledge on HIV/AIDS	Number of AMES organisations reached	AMES will address HIV/AIDS related issues in their artistic work, be it in performance, literature or music to create awareness and behavioural changes among audiences / fans.
		Facilitate holding of national workshops on orientation of AMES on HIV/AIDS.	Mobilize and equip AMES on national level with knowledge on HIV/AIDS.	Number of AMES reached	Knowledge of HIV/AIDS is high among AMES Positive attitudes on HIV/AIDS in AMES Behaviour change in AMES Risk – some AMES may not practice what they preach.
		Mobilize AMES, traditional leaders, perfoming arts and People living with AIDS to disseminate HIV/AIDS information during such event as commemoration of World Health Day, SADC Day Performers' Day and World AIDS Day.	Collective and positive regional response to HIV/AIDS issues	1. Number of events where HIV/AIDS messages are disseminated. 2. Removal of the stigma on HIV/AIDS.	Traditional leaders have power to influence the attitudes and behaviour of their people. Power of performing arts to counter spread of HIV/AIDS. People living with HIV/AIDS disseminate convincing messages on need for safe sex.
		Convene and Facilitate	Number of sporting		

OVERALL GOAL	OBJECTIVES	ACTIVITIES	OUTPUT	INDICATORS	ASSUMPTIONS/RISKS
		sports events e.g SADC Day competitions, Under 17 tournaments as an alternative means to disseminate HIV/AIDS information.	events sporting events where HIV/AIDS message are disseminated Reduced member of sportsmen and women who contract the disease.		
		Production and distribution of HIV/AIDS IEC and promotional materials.	Increase knowledge of SADC citizens on HIV/AIDS related issues.	Number of materials produced	Behaviour changes in SADC citizens Risk messages are not actually acceptable
	2. To strengthen systems and structures in the Sport sub-sector for the integration, development and promotion of HIV/ AIDS programme	Encourage the Supreme Council for Africa in Africa Zone VI to establish an Adhoc Committee to promote HIV/AIDS education in sport	HIV/AIDS Adhoc Committee formed and operational by Dec 2000	Committee on HIV /AIDS in Sport formed	The SCSA – Zone VI will be active and effective
	3. To ensure a coordinated and systematic sharing of information on HIV/AIDS in the region	Complilation of database of AMES active in HIV/AIDS information dissemination activities in the region	Member states link database on AMES active in HIV/AIDS activities	Number of functional and up to date databases	Databases in form or another exist in most member states The risk is that not all member states will be electronically connected.
		Commission research on socio-cultural factors that effect the spread and the impact of HIV/AIDS on the SADC population.	Socio-cultural research studies	Number of socio-cultural studies conducted	Study results will be used to strengthen programmes by member states

AMES = Artists, Media, Entertainers, and Sports persons

CULTURE, INFORMATION AND SPORTS BUDGET

CODE	*ACTIVITY*	*Inputs required*	*Measure*	*Total Inputs*	*Unit cost (US$)*	*Subtotal*	*Total (US$)*
Culture, Information and Sports Sector							
	Regional Orientation						
CIS 1.1	workshops	Participants	Numbers	78			
		Travel	Trips	50	900	45 000	
		DSA	Days	312		46 000	
		Venue hire	Days	2	600	1200	
		Translators	Numbers	4	200	800	
		Interpreters	Numbers	4	200	800	
		Honorium translators	Days	4	300	12 000	
		Honorium interpreters	Days	4	300	12 000	
		Administraton	Days	4	10 000	40 000	
		Communication	Numbers	1	10 000	10 000	
		SUBTOTAL				**168 600**	**168 60**
	National orientation workshops	Participants		280			
		Travel	Trips	250	100	25 000	
		DSA	Days	560	150	84 000	
		Venue hire	Days	14	200	2 800	
		Administration	Days	2	10 000	20 000	
		Materials	Numbers	14	500	7 000	
		SUBTOTAL				**138 800**	**138 80**
	World AIDS &						
CIS 1.2	Performers Days	AMES	Numbers	420			
	Commemorations						
		National music shows	Numbers	14	2 000	28 000	
		Regional sports tournament	Numbers	14	5 000	70 000	
		Appearance fees	Numbers	42	5 000	210 000	
		Advertising	Numbers	14	5 000	70 000	
		Venue hire	Numbers	14	600	8 400	
		Equipment hire	Numbers	14	1 000	14 000	
		Security services	Days	2	1 000	2 000	
		Communication	Numbers	14	500	7 000	
		SUBTOTAL				**409 409**	**409 40**
	Sport competition and events	Accommodation of teams	Days	28	20 000	560 000	
		Uniforms and kits	Numbers	112	200	22 400	
		Trophies and medals	Numbers	56	100	5 600	
		Promotion materials	Numbers	112	500	56 000	
		Prize money	Numbers	42	5 000	210 000	
				1400000			
		Condoms	Numbers	0	0.04	560 000	
		SUBTOTAL				**1 414 000**	**1 414.0**
	Production & distribution of print	Message design workshop	Days	5	30 000	150 000	
		Designers	Numbers	5	2 000	10 000	
		Editors	Numbers	10	500	5 000	

CODE	*ACTIVITY*	*Inputs required*	*Measure*	*Total*	*Unit cost (US$)*	*Subtotal*	*Total (US$)*
		Translators	Numbers	10	300	3 000	
		Journalists	Numbers	4	300	1 200	
		Communication	Numbers	1	10 000	10 000	
		SUBTOTAL				**179 200**	**179 20**
CIS 1.3	Compilation of data base	Interpreters	Numbers	4	300	1 200	
		Data collection	Days	10	100	1 000	
		Data coding	Days	5	50	250	
		Data entry	Days	5	50	250	
		Computer equipment	Numbers	10	10 000	100 000	
		Computer programme	Numbers	5	2 000	10 000	
		SUBTOTAL				**406 600**	**406 60**
CIS 1.4	Expansion of best practices	Projects	Numbers	28	10 000	280 000	
	Socio-cultural	Studies	Numbers	15	20 000	300 000	
		SUBTOTAL				**580 000**	**580 00**
	-						
	GRANDTOTAL						**3 296 6**

8.2 Employment and Labour Sector

Background
The HIV/AIDS epidemic has had a tremendous impact on the demand and supply of labour in the SADC Region and has affected the sector in several ways:

(a) Trends of employment figures and the impact of HIV/AIDS;

(b) Identification of any particular labour practice that persists and is considered an obstacle to the tackling of HIV/AIDS pandemic;

(c) Trends in labour productivity in the region and the impact of HIV/AIDS; and

(d) Costs of managing HIV/AIDS at the workplace (absenteeism, medical costs, funerals).

Regional integration in the context of the global economy is also influenced by the availability of labour, and SADC has a history of large-scale labour migration and a relatively free movement of people. One benefit has been that there are fairly common labour practices in the region, which should make it easier to share strategies – be it in the organization of labour or in the provision of services to workers. This is the context within which the HIV/AIDS Code is being approached, and a major strategy for the Employment and Labour Sector is the effective implementation of this Code in all member States.

Even before the advent of AIDS, the region had a relatively high proportion of children in the 10-14 age group active in the labour force (30% of the population in this age-group was part of the labour force in 1980 and has only dropped to 24% by 1998 – WBDR 2000). The proportion of women active in the labour force has over the last two decades remained at 44%. The major change in this region has been the growth in urbanisation – with the population living in urban areas having risen from 22% in 1980 to 37% in 1998. These changes have had major impacts on the way the HIV/AIDS problem has developed in the region.

Sector mandate: To co-ordinate all matters related to employment and labour in the region with a view to enhancing labour productivity for sustainable economic growth and development.

Impact of HIV/AIDS
Increased use of child labour due to loss of adults.
- High attrition and loss of labour force
- Reduced labour productivity.
- Increased costs to employer and State.
- Increased use of child labour due to loss of adults

EMPLOYMENT AND LABOUR SECTOR: BUDGET

OUTPUT	TARGET	ACTIVITY	TOTAL INPUT	UNIT COST	TOTAL COST
Increased Capacity of Government, Worker and Employer to Implement HIV/AIDS Code	2000 Institutions in SADC	Printing and Disseminating the SADC Code on HIV/AIDS and Employment	2000	US$20	US$40,000
	2000 Institutions in SADC	Preparation, printing and dissemination of explanatory leaflets on the background and implementation of the Code	2000	US$4	US$8,000
	50 Trainers from SADC Sectors	Workshop SADC Sector Coordinating Units (SCUs) to implement the provisions of the HIV/AIDS Code	150	US$900	US$135,000
	420 People (30 persons per Country)	National workshops for Government, Workers and Employers organisations on implementation of the Code in all Member States. Formation of National HIV/AIDS Tripartite and Bipartite Committees	840	US$300	US$252,000
	14 Member States	Implementation of National HIV/AIDS and Employment Projects	14	US$30,000	US$420,000
	14 Member States	Training Seminar on Monitoring, evaluation and impact analysis	14	US$30,000	US$420,000
	14 Member States	Develop national mechanisms to monitor the impact of HIV/AIDS on the labour market	14	US$30,000	US$420,000
OUTPUT	**TARGET**	**ACTIVITY**	**TOTAL INPUT**	**UNIT COST**	TOTAL **COST**
Audit of Member States on implementation of HIV/AIDS Code/Regional situation analysis on HIV/AIDS and Employment	10 Persons (Working Group)	♦ Workshop to establish audit teams within the Employment and Labour Sector. ♦ Develop a standard audit and reporting format on HIV/AIDS and Employment	20	US$900	US$18,000
	1 Center	Create a Database on HIV AIDS and Employment at the ELSCU in Lusaka, Zambia	2	US$7000	US$14,000
	14 Centers	Create Databases on HIV/AIDS and Employment in each Member State	14	US$5,000	US$70,000
	14 Member States	Survey and report at the end of each year on Best Practices on Implementation of the Code	294	US$1,800	US$529,200
	14 Member States	Preparation and Printing of the Annual regional analysis on HIV/AIDS and Employment for each year (3 Years)	2100	US$5	**US$10,500 TOTAL 2 569 600**

8.3 Health Sector

BACKGROUND
The Health Sector has been providing leadership and technical guidance in the HIV/AIDS response in many Member States, but there is recognition other sectors need to increasingly take ownership for addressing the epidemic. In the past, the health sector has attempted to do too much in articulating the multi-sectoral response. Consequently, this sector will shift its focus and emphasis from implementing HIV/AIDS interventions that lie outside its comparative advantage to specific activities within the realm of its mandate. It will therefore concentrate on the following:-

(a) Developing and implementing improved clinical management standards and strategies (clinical care and nursing, treatment, drugs procurement and supply, laboratories support, etc.)

(b) Improving HIV/AIDS disease surveillance systems and disseminating epidemiological information to the other sectors;

(c) Providing health-related technical assistance to the other sectors as these plan, implement, and monitor their strategies aimed at addressing the epidemic.

(d) Catalyzing and creating opportunities for other sectors to become creative, innovative and take ownership for the HIV/AIDS response

Sector mandate: Attain an acceptable standard of health for all citizens by promoting, co-ordinating and supporting the individual and collective efforts of member states.

Impact of HIV/AIDS
- Over-burdened and overstretched health care systems leading to dilution of care
- Rising costs associated with provide health care, leading diverting resources from critical needs (national and household) to health care.
- Negative demographic trends – reduced life expectancy, increased morbidity and mortality, orphans
- Creation of new demands in training, services without corresponding resources
- Low morale among health workers due to burn out and helplessness
- Increasing health workers' attrition rates due to deaths.

Objective 1. To prevent HIV/AIDS transmission among the youth in SADC

Strategy: establishment of youth friendly services

Reports from the SADC region indicate that about 50% of the region's population comprise of young people in the age group 12-29 years. This group is an important asset and resource to the development of the region. Research

findings, need assessment and experience indicate that young people in the region are vulnerable to a number of problems. These include HIV/AIDS, alcohol and drug abuse, teenage pregnancy, unemployment, school dropouts, abuse(by parents, teachers, adults etc), negative impact of modernisation, gender inadequacy and lack of recreational facilities in rural/urban areas.

It therefore becomes necessary from these conditions affecting youth that only appropriate structures and mechanisms that are holistic in their approach, well co-ordinated and responsive to their situation are utilised.

Against this background. It is urgent that SADC develops a plan of action that will address those concerns. In this regard, consultants will be appointed by the health sector, to provide youth friendly services. Grants will be made available for the national trainers to conduct district level training workshops. Yearly fora will then be held to exchange experience .

Objective 2. To improve the clinical management of HIV/AIDS, including management of opportunistic infections and MTCT, and access to affordable drugs

Strategy: the review and develop standards and protocols for the clinical management of HIV related conditions.

HIV/AIDS is a relatively new clinical area in which research is progressing quite rapidly. While dealing with HIV/AIDS related conditions clinicians may find that accepted standards of diagnosis and treatment are unclear, changing or even lacking. To respond to these needs, it is imperative that a consistent clinical management approach be developed to guide clinicians in the region. This will be done through review and harmonisation of existing standards and protocols in the management of opportunistic infections and for prevention of mother-to -child transmission of HIV.

A regional consensus meeting will be organised to develop minimum standards to be adhered to by the national Departments in the management of HIV/AIDS . A full time consultant will be hired by to visit Member States for successive training as may be required by individual countries.

As the major problem faced by Member States is non-availability of affordable drugs, regional initiatives will be undertaken to improve the institutional frameworks that prevent this. Harmonisation of registration requirements and improved procurement procedures will be explored with the relevant SADC health sector subcommittees.

Support for drugs and supplies has to be budgeted in as some Member States do not have enough resources to purchase adequate supplies.

Objective 3. To improve care offered to HIV/AIDS affected through strategic partnerships

Strategy: building strategic partnerships with organisations involved in

HIV/AIDS care and supporting care initiatives.

This area is not a competency of the health department and the Welfare Departments and community organisations have to be encouraged to take the lead.

To build partnerships with these organisations consultations have to be held with them. Their initiatives have then to be supported.

In some instances home based protocols and supplies have not taken rural circumstances into account. There is need for further development of appropriate protocols and lists of supplies.

Objective 4. To strengthen regional HIV/AIDS information base.

Strategy: Standardise surveillance systems in the region.

Information is an essential component in monitoring HIV trends and understanding what is going on regarding AIDS activities and research. One of the ways of monitoring the trends of HIV/AIDS has been through sentinel surveillance by each country in the region. To make data from this surveillance comparable, it is necessary to standardise and harmonise the surveillance systems in the region.

The activities envisaged to pursue this goal are:
- To harmonise and standardise surveillance systems.
- To encourage and support behavioural surveillance along side sentinel surveillance.
- Encourage exchange and sharing of authentic information on HIV/AIDS in the region.

Objective 5. To achieve convergence on how to respond to the HIV/AIDS epidemic in the region.

Strategy: Harmonise HIV/AIDS policies in the region.

Harmonisation of policies on key HIV/AIDS and STD issues of member states is a key element in achieving a stronger and more cohesive response to the epidemic in the SADC region. One of the priority areas identified in the SADC Health Sector biennial priorities for 1999 is the collection and evaluation of HIV/AIDS/STD policies of member states in order to develop draft regional policies for different sectors.

A review of policies in the context of legislative/legal frameworks, government responsibilities and some specific HIV/AIDS issues would be useful for the region.

The analysis will primarily focus on the following elements:
- Similarities and difference policies between member states.
- Policy gaps.
- Policy areas that require regional consensus.

Regional consensus will then be achieved where this is possible.

The policy work will be additional to work already being undertaken with support from the US, and UNAIDS. The activities will be in the form of studies, regional workshops, and dissemination of materials/policies that are produced through this process.

Objective 6. To improve the knowledge base for HIV/AIDS

Strategy: Support research into HIV/AIDS, including support for the development of a vaccine for HIV/AIDS;

Improved knowledge about HIV/AIDS and its impact on the region can only improve and make more appropriate, the response to the disease. Research is taking place but is not fed into the operational health services, where it is needed most. The implementation of research findings is thus as important as the research itself.

The development of an effective vaccine for the continent is imperative, as HIV/AIDS interventions so far have not produced the expected results. Work in this area will be through the African Strategy for an HIV/AIDS Vaccine.

Many organisations currently undertake research on HIV/AIDS and the challenge is to support those that are doing appropriate research that can be used by the services. The provision of research grants will stimulate further research in relevant areas, and the results of the research can be shared in various fora including conferences, workshops, and study visits. Pilot studies will provide a practical way of exploring the feasibility of implementation of any interventions.

OBJECTIVE	STRATEGY	OUTCOME INDICATOR
1. To prevent HIV/AIDS transmission among the youth in SADC	2. Promote and support the establishment of youth friendly services as part of reproductive health services at district level 3. Training of trainers for reorientation of Health professionals and relevant stakeholders 4. Establish 6 pilot sites in the region for the implementation of Youth friendly services	A 10% reduction in HIV/AIDS prevalence among the 15 –19 year age group, as measured by antenatal surveys 6 trainers trained per Member States 6 pilot sites functional
2. To improve the clinical management of HIV/AIDS, including management of opportunistic infections and MTCT, and access to affordable drugs	1. Review existing standards and protocols for treatment of opportunistic infections and for MTCT, and reach national and regional consensus on them	National standards and protocols on management of HIV/AIDS exist Regional consensus on standards and protocols exists.
	2. Training of trainers on opportunistic infections	All levels of health care implement standards and protocols for management of HIV/AIDS
	1. Biennial meetings for information exchange on successes and constraints on the implementation of developed standards and protocols	Regular information exchange mechanisms and fora exist
	4. Harmonisation of drug registration procedures in region	Drug registration procedures in Region harmonised
	5. Adopt the best drug procurement practices	Optimum procurement practices adopted by sector
	6. Advocate for grant support for supplies, where the need exists	Grants available where needed

3. To improve care offered to HIV/AIDS affected through strategic partnerships	1. Hold biennial meetings with key strategic partners with competencies in providing care, focussing on sharing best practices	Strategic partnerships for care of those affected by HIV/AIDS exist, with clear role definitions
	2. To support the delivery of quality home-based care programmes.	Home based care available to the community
	3. Establish standards for home based care	appropriate standards and supplies for home based care available
4. To harmonise HIV policies in the region	1. Studies 2. Consultative work to agree on regional policy/protocol • Workshops • Technical assistance • Training 3. Printing of materials and dissemination	Regional instrument on HIV/AIDS available and adopted by SADC structures Regional instrument available and implemented in Member States.
5. Research and pilot studies	1. Identify priority research areas 2. Encourage networking by SADC scientists 3. Provide grants to selected SADC scientists/ institutions	Research grants available for specific areas, e.g. MTCT, HIV/AIDS vaccine development
6. Standardisation of data and surveillance systems	1. Review sentinel surveillance systems in region 2. Institute behaviour surveillance as part of sentinel surveillance 3. Technical assistance 4. Training	Data and surveillance systems standardised

Health Sector Budget

HLT3.1	Training of trainers for reorientation of health professionals (6 trainers per country, 5 training sessions of 5 days each)	Consultant professional fees	Numbers	40	300	12 000	
		Travel		20(4x5days)	900	18 000	
		DSA		20	150	3 000	
		Travel	Trips	84	900	75 600	
		DSA	Days	420	150	63 000	
		Training material				5 000	
		Seed money for national workshops	Numbers	14	20 000	280 000	
		Subtotal				***456 600***	***456 600***
	Establish pilot sites in region, for youth friendly services (6 per year)	Staff and training materials	Numbers	6	100 000	600 000	600 000
							108 200
HLT3.2	Review stds/mgt protocols for opportunistic infections and MTCT	Consultants	Numbers	12	300	3 600	
		Participants	Numbers	28			
		Travel	Trips	30	900	27 000	
		DSA	Days	180	150	27 000	
		Translators	Numbers	12	200	2 400	
		Interpreters	Numbers	12	200	2 400	
		Honorarium for translators	Days	10	300	3 000	
		Honorarium interpreters	Days	10	300	3 000	
		Administration	Days	5	2 000	10 000	
		Communication & postage	Numbers	1	10 000	10 000	
		Stationery	Numbers	1	10 000	10 000	
		Technical assistance				50 000	
		Subtotal				***148 400***	***148 400***
	Harmonise national drug registration procedures	Participants	Numbers	28			
		Travel	Trips	28	900	27 000	
		DSA	Days	180	150	27 000	
		Facilitators	Numbers	12	300	3 600	
		Translators	Numbers	12	200	2 400	
		Interpreters	Numbers	12	200	2 400	
		Honorarium translators	Days	10	300	3 000	
		Honorarium interpreters	Days	10	300	3 000	
		Administration	Days	5	2 000	10 000	
		Communication & postage	Numbers	1	10 000	10 000	
		Stationery	Numbers	1	10 000	10 000	
		Subtotal				***98 400***	***98 400***
	Develop best drug procurement procedures	Participants	Numbers	14			
		Travel	Trips	14	900	12 600	
		DSA	Days	84	150	12 600	
		Stationery	Numbers	1	5 000	5 000	
		Administration	Days	3	2 000	6 000	
		Communication & postage	Numbers	1	5 000	5 000	
		Subtotal				***41 200***	***41 200***
HLT3.3	Develop stds/guidelines on quality home based care programmes	Participants	Numbers	14			
		Travel	Trips	14	900	12 600	
		DSA	Days	84	150	12 600	
		Communication & postage	Numbers	1	5 000	5 000	
		Stationery	Numbers	3	2 000	2 000	
		Communication & postage	Numbers	1	5 000	5 000	
		Subtotal				***41 200***	***41 200***
	Compilation of best practices on home based care	Consultants	Numbers	15	300	4 500	
		Participants	Numbers	28			
		Travel	Trips	30	900	27 000	
		DSA	Days	200	300	6 000	
		Stationery	Numbers	1	10 000	10 000	

		Subtotal	***47 500***	***47 500***
HLT3.4	Harmonise HIV/AIDS policies in region	Professional fees for studies	100 000	
		Workshops	50 000	
		Printing and dissemination	100 000	
		Subtotal	***250 000***	***250 000***
HLT3.5	Research and pilot studies	Grants	100 000	
		Research seminars	50 000	***50 000***
		Subtotal	***100 000***	***150 000***
HLT3.6	Standardisation of data and Surveillance	Workshops	41 000	
		Training	40 000	
		Technical assistance	50 000	
		Supplies	40 000	
		Subtotal	***141 000***	***141 000***
		Grand Total		***1 482 500***

8.4 Human Resources Development Sector (Education and Training)

BACKGROUND

All sectors have a common concern for the development and availability of human resources and how HIV/AIDS has affected the production, deployment, management and other issues related to the efficiency of labour in the region. As most HIV transmission in the region is due to heterosexual contact, many of the infected persons are THOSE who are sexually active. Unfortunately this is also the economically active age group. HIV infection is on the increase among the 15-29 age group. This means that the "window of hope" is immensely reduced and shrinking and that young people are contracting HIV at a very young age. The HIV/AIDS pandemic is making serious inroads into the education and training sector in the region, and some of the main issues are:-

- HIV/AIDS negatively affects the supply of skilled personnel providing educational services and reduces the efficiency in the sector by raising costs of service delivery (e.g. payment for sick leave versus payment for actual work undertaken, increased output regarding teacher training to fill vacant posts, etc.). The sector is experiencing significant losses in teacher numbers due to HIV/AIDS. Many teachers are themselves, like other families, taking on the orphans of those who have died of AIDS, and increased time is spent going to funerals, and caring for the sick. This is seriously undermining member States' efforts to increase the pool of trained teachers in a bid to improve both the quality and quantity of education.

- Alarming is the growing numbers of orphans as a result of HIV/AIDS. Many of these risk the danger of not attending or completing school. This has implications on future generations and the development of the region as a whole.

Children who have lost one or both parents, 1997-98

Country	Number	Per 1 000 people
Botswana	25 000	13
Democratic Republic of Congo	310 000	6
Lesotho	8 500	4
Mozambique	150 000	9
Namibia	73 000	36
South Africa	180 000	4
Tanzania	520 000	16
Zambia	360 000	36
Zimbabwe	360 000	30

Source: ***Newsweek*** *January 17, 2000*

- The number of children who have lost both parents is particularly significant for those countries with small populations (Botswana and Namibia) and those countries with high

HIV/AIDS prevalence rates (Zambia and Zimbabwe). This has a number of implications in terms of schooling, entry into the labour market, and quality of life for these children (many of whom are likely to join the growing number of children living under difficult circumstances created by economic and political hardships).

- Due to illness and death in the family, many children of school-going age have to carry out adult responsibilities, which include taking care of their sick parents and/or taking care of their siblings. Such children also lack financial support. This may affect their attendance and performance in school.

- Both students and teachers encounter problems of stigmatisation and discrimination due to lack of knowledge on how to deal with people living with HIV/AIDS. The school children also suffer psychological effects due to peer pressure and exposure to AIDS related death. This creates demand for teachers to provide counseling services to children to mitigate poor performance.

It is thus imperative that concerted effort is made to reduce the spread of HIV/AIDS and mitigate its impact on this and other sectors.

These strategies will give the sector additional tools for addressing the wider issues of curriculum reform in formal and vocational training, and offering advice to any sector involved in programmes that contribute to Human Resources Development. The research will also allow the sector to develop appropriate and sensitive indicators on the relationship between the AIDS pandemic and developments within the sector and its contribution to overall development indicators.

Sector mandate: Provide skills, knowledge and attitudes that build the necessary human capital vital for economic and social development.

Impact of HIV/AIDS

- Increased numbers of orphans needing education.
- Children leaving schools to undertake adult responsibilities due to loss of parents.
- Stigmatization and discrimination in schools.
- Need for better integration of HIV/AIDS education and life skills in the school curriculum.

	Indicators	**Assumptions/risks**
Overall Goal To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of the member States	- Annual trends in HIV/AIDS infections within the SADC region - Trends in cost of HIV/AIDS for each sector	Assumed that the quality of available data will improve to accurately reflect the real situation within the region
Objectives 1. To create a supporting environment for the fight against HIV/AIDS within the education and training sector 2. To impart knowledge on HIV/AIDS/AIDS and skills which are life-enhancing to both learners and educators 3. To co-ordinate, at regional level, research in order to inform policy and decision-making in the fight against HIV/AIDS/AIDS 4. Information dissemination to change attitudes, reduce stigma and promote best practices. 5. Empower educators through training of trainers 6. Resource mobilisation to mitigate impact of disease	- Trends in the HIV/AIDS infections among learners and educators - Trends in attitude and behaviour change within the SADC Region - Regional databank on HIV/AIDS in the sector	- Religious and traditional leadership are supportive - Support and technical inputs from the health and other sectors is available - Co-operation from all institutions/organisations that are involved in research is forthcoming
Outputs 1. Revised education/training policies 2. Revised curricula incorporating HIV/AIDS 3. Regional database on HIV/AIDS in the education and training sector in place, and mechanism for exchange of such data and information established and in operation 4. Information to reduce stigma disseminated and changes in attitude observed. 5. Educators empowered 6. Resources available to implement programmes on HIV/AIDS	- Number of revised policies in the region - Number of member States with curricula integrating HIV/AIDS in the education system - Regional database on HIV/AIDS in education and training - Number of trainers trained - Amount of resources mobilised	- Resources are available and member are willing to commit them to the strategy - Differing priorities of member States - resistance to policy change - resistance to curriculum change - confidentiality of information on HIV/AIDS

Activities	Inputs	
Policy Development 1. Review existing education and training policies regarding HIV/AIDS 2. Develop and disseminate appropriate regional policy guidelines 3. Facilitate the development and implementation of national policies to address HIV/AIDS 4. Monitor the development and implementation of national policies	1.1 Recruit a programme co-ordinator (PC) 1.2 Organise a sectoral mobilisation workshop 2.1 Following Workshop, the TA to develop regional policy guidelines 2.2 Convene another workshop to agree on the regional policy guidelines 3.1 Finalise and disseminate regional policy guidelines to member States 3.2 Undertake training of policy developers –1 regional training workshop 4.1 The PC will develop a monitoring tool and undertake periodic monitoring visits; day-to-day monitoring to be undertaken by existing national structures. 4.2 Impact assessment of new policies may be necessary after a reasonable length of time	
Curriculum development 5. Set up a curriculum development committee to develop a regional curriculum framework 6. Conduct national curriculum reviews to ensure adherence to regional standards 7. Monitoring and evaluation of programmes	5.1 Convene a meeting of curriculum experts to review existing situation and develop guidelines or a regional curriculum framework, along with teaching/learning materials standards. 6.1 National curricula centres to undertake curricula reviews using regional guidelines to incorporate HIV/AIDS education. 6.2 Implement curricula – national structures. 7.1 Regular monitoring to be undertaken by national structures; a regional feedback meeting to take place to evaluate impact and recommend improvements after 2 years of implementation	
Co-ordination of Regional Research 8. Undertake a study to establish the current position with regard to HIV/AIDS in the sector and to determine research needs 9. Establish a regional database on the impact of HI/AIDS in	8.1 Engage a team of 1 regional 14 national consultants to undertake study. 9.1 Equipment and short-term consultancy to establish database and develop a tool for maintenance and regular updating of database. 12.1 Provide funds for research based on identified research needs	

the sector 10. Develop a regional mechanism for research 11. Undertake impact assessment of previous research activities 12. Undertake joint research activities **Information Dissemination** 13. Inventory of interventions in countries 14. Sharing of information 15. Promote initiatives in region on living with AIDS **Empowering educators** 16. Regional training workshops for trainers 17. Regional workshops for curriculum design 18. Facilitate collaboration among teaching institutions **Resource mobilisation** 19. Develop a strategy for mobilising resources from all sectors.	13.1 Create inventory through commissioned studies, on best practices for intervention programmes in the region. 16.1 Funds to run workshops for trainers. 17.1 Funds to run workshops for curriculum development	

HUMAN RESOURCES SECTOR BUDGET				
Activity/Input	2000	2001	2002	TOTAL
	US$	US$		US$
Overall				
1. Programme Co-ordination				
♦ Programme Co-ordinator		60,000	60,000	120,000
♦ Programme Secretary		8,400	8,400	16,800
♦ Equipment & Supplies (computers, office furniture, fax modem, stationery,etc)		2,000	5,000	7,000
♦ Communication		5,000	5,000	10,000
2. Sectoral Mobilisation Workshop, 3 days duration				
♦ Travel & perdiems for: 2 persons x 13 countries, programme co-ordinator, 2 members from SADC HRD SCU, and one representative each from SADC Secretariat, SADC Health Sector, UNAIDS	60,000			60,000
♦ Conference facilities	2,000			2,000
Policy Development				
1. One regional Workshop to discuss draft regional policy, 2 days duration				
♦ Travel & perdiems for 1 participant per country, programme co-ordinator, 2 members from SADC HRD SCU, and one representative each from the SADC Health Sector and UNAIDS		22,500		22,500
2. Production & printing of policy document		3,000		3,000
3. One regional training workshop of 5 days' duration for policy developers & planners				
♦ travel & perdiems for 15 participants, two trainers and programme co-ordinator		30,600		30,600
♦ fees for 2 trainers at ten days each		6,000		6,000
♦ Training materials		2,000		2,000
4. Monitoring visits by Programme Co-ordinator		5,000	5,000	10,000
Curriculum Development				
♦ 2 meetings of Curriculum experts, three days duration each, to review and produce a regional curriculum framework (travel & perdiems for 18 participants)		61,200		61,200
♦ Production and printing of regional curriculum framework		3,000		3,000
♦ Monitoring visits by Programme Co-ordinator			5,000	5,000
♦ Regional feedback (evaluation) meeting (travel & per diems, conference facilities)			35,000	35,000
Regional Research				
1. Study		100,000		100,000
2. Regional database			10,000	10,000
3. Funding for research			500,000	500,000
Information Dissemination & Exchange				
There are no major budgetary implications foreseen due to the following: ➢ The inventory of existing interventions will be undertaken as part of the study under Research ➢ It is proposed that the delivery of papers or running of workshops or sessions on HIV/AIDS during sectoral meetings and other fora, will be undertaken by the technical or program officer on social sectors whom will be attached to the Health				

SCU ➢ The HRD SCU already has a Documentation Centre, a Web page and a Newsletter which is published once a year at present.				
Training of Trainers ➢ 3 Workshops of five days duration each, 32 participants for training of trainers[1]: - travel and perdiems for 28 participants per country, 1 HRD SCU staff member, PC, two trainers - fees for two trainers at 10 days each trainer per workshop - training materials ➢ 3 Workshops of five days duration each, 32 participants for curriculum developers (same specification as for TOT)[2]		54,400 6,000 2,000 124,800	108,800 12,000 4,000 62,400	163,200 18,000 6,000 187200
Resource Mobilisation Budget undetermined				
TOTAL	62,000	495,900	820,600	1,378,500
Contingency at 5%				68,925
GRAND TOTAL				1,447,425

Details of the sectors' proposal are available in Annexure 2.

[1] One Workshop will be held in 2001 and two in 2002,
[2] Two workshops will be conducted in 2001, and one in 2002

8.5 Mining Sector

BACKGROUND

Mining has been described as the backbone of economies in the region, usually competing with agriculture as the major earner of foreign exchange and provider of employment opportunities. Towards the end of the 1990s, it was estimated that mining on average contributed to 60% of foreign exchange earnings, 10% of GDP and 5% to formal employment in the region. Declining investments in the sector, combined with unstable world prices for most minerals, has contributed to a fall in the importance of the sector relative to service sectors (tourism and finance for instance). Nevertheless, mining remains an important sector for socio-economic development in the region.

The region is a major producer of such minerals as asbestos, cobalt, copper, chrome, diamonds, gold, and others needed by industrial process.

Available evidence suggests that this sector has been hard-hit by HIV/AIDS because most miners work away from home as migrants and are therefore likely to have multiple sexual partners. With the movement of labour between mines and rural homes, there are many opportunities to spread diseases between rural and urban areas, and HIV transmission has followed this movement of labour. Most information on these issues has come from work carried out by the health sector and its NGO partners; but there has been few mine-led initiatives to tackle the HIV/AIDS pandemic. It is for this reason that the immediate plan for this sector is to establish the size of the problem, to provide support to the infected/affected, and to draw up long-term plans.

Regional averages of selected mineral production figures, 1997

Asbestos (tons)	236 492
Coal (tons)	223 165 372
Cobalt (tons)	5 305
Chromite (tons)	6 449 191
Copper (tons)	523 019
Diamonds (carats)	34 482 004
Gold (kgs)	519 772
Lead (tons)	83 619
Nickel (tons)	65 121
Zinc (tons)	143 878

Source: SADC Progress Report, 1999

The Mining sector has organised its work under six sub-committees, and some of them could make significant contribution to the tackling of HIV/AIDS. In particular, sub-committees dealing with marketing, information, and human resources development might find it relatively easy to link HIV/AIDS management strategies to sector strategies once this multi-sectoral HIV/AIDS management plan is implemented.

Sector mandate: Facilitate the transformation of mineral resources into wealth at regional level.

Impact of HIV/AIDS
Reduced productivity (through absenteeism, sickness, deaths, etc.).
Increased direct and indirect costs

Strategies for 2002
- To establish the extent of HIV/AIDS in the SADC mining sector.
- To minimise the spread of HIV/AIDS in mining sector.
- To provide adequate care for the already infected and affected in mining sector.

The implementation of these strategies will assist the better definition of the sectors work by:-

(a) Providing documentation on the status of HIV/AIDS on mines;

(b) Giving an indication of the link between mine productivity and HIV/AIDS;

(c) Making it possible to assess the economic impact of HIV/AIDS on mines (be it on labour, financial returns, social services, etc.).

(d) Providing arguments for a better understanding of how mine investments in HIV/AIDS programmes impact on the economy and national tax regimes.

PROGRAMME FRAMEWORK

PROGRAMME STRUCTURE	VERIFIABLE INDICATORS	SOURCES OF VERIFICATION	ASSUMPTIONS AND RISKS
Overall Goal To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that it is no longer a threat to public health and to the socio-economic development of member states	Annual trends in HIV/AIDS infections within SADC region; Trends in cost of HIV/AIDS in each sector	Ministries of Health Reports Reports from international Organisations (WHO, UNAIDS etc) Sectoral reports on impact of HIV/AIDS	The quality of available data will improve to accurately reflect the situation within the region
Sector Objectives 1. To establish the extent of HIV/AIDS in the SADC mining sector 2. To minimise the spread of HIV/AIDS in mining sector 3. To facilitate provision of adequate services for the already infected and affected in the mining sector	Status of HIV/AIDS in mining sector established Spread of HIV/AIDS in mining communities minimised Adequate care for infected and affected persons provided	Number of HIV/AIDS status reports on the mines Reports on trends in HIV/AIDS infection rates on the mines Number of infected and affected persons receiving care on the mines	Mining houses fully co-operate
Outputs 1. HIV/AIDS situational analyses on infected and affected numbers completed 2. Mining communities reached with HIV/AIDS awareness programmes 3. Mine facilities providing effective care to the infected and affected increased	Number of national and regional situation analyses reports Number of mining communities reached Number of mine health facilities participating in the programme	Reports Reports Mine Reports	Data already exists and most work will be in analysis Resources available Mining houses fully co-operate

Activities			
1. Conduct situational analyses 2. Establish mechanisms to collect and analyse existing data and collect where none exists 3. Identify trends and design interventions for implementation 4. Design and implement awareness programmes for mine managers, employees and mining communities 5. Train AIDS counselors and Educators 6. Facilitate the increase of condom availability on mines, including Small Scale Mines 7. Monitor and support the HIV/AIDS intervention activities 8. Facilitate establishment of HIV/AIDS Kiosks in mining areas 9. Promote intensification of treatment of STDs on mines 10. Facilitate support of existing facilities and identify new ones where HIV/AIDS related illnesses can be treated 11. Provide 2 scholarships per year for training in HIV/AIDS data collection and analysis 12. Develop Follow-up strategies			Assumed that Mining Houses are willing and able to contribute resources to the programme Small scale Miners willing to participate in the Programme

Mining Sector: Budget

MNG5.1	Situation analysis on HIV/AIDS in the mining sector	Researchers	Number	360	300	108 000	
		Travel	Trips	12	900	10 800	
		DSA	Days	360	150	54 000	
		Subtotal				172 800	
	Orientation seminars	Consultants	Numbers	60	300	18 000	
		Participants	Numbers	336			
		Travel	Trips	336	900	302 400	
		DSA	Days	1 680	150	252 000	
		Administration	Days	60	2 000	120 000	
		Communication & Postage	Numbers	12	2 000	24 000	
		Training of AIDS Counsellors and Educators.	numbers			160 000	
		Subtotal				***876 600***	***876 600***
MNG5.2	HIV/AIDS awareness campaign	Consultants	Numbers	60	300	18 000	
		Participants	Numbers	336			
		Travel	Trips	336	450	151 200	
		DSA	Days	1 680	150	252 000	
		IEC materials	Numbers	12	5 000	60 000	
		Journalists	Numbers	60	300	18 000	
		Subtotal				***499 200***	***499 200***
MNG5.3	Establish HIV/AIDS kiosks	Building materials	Numbers	240	500	120 000	
		Furniture	Number	240	400	96 000	
		Supplies	Number	5 760	500	2 880 000	
		Counsellors	Months	432	200	86 400	
		Subtotal				***3 182 400***	***3 182 400***
	Procure and distribute condoms	Condoms	Numbers	24 000 000	0	1 200 000	
		Postage & courier services	Numbers	1	120 000	120 000	
		Subtotal				***1 320 000***	***1 320 000***
	Management of STIs	Drugs	Numbers	60	40 000	2 400 000	
		Laboratory equipment	Numbers	60	50 000	3 000 000	
		Laboratory supplies	Numbers	1 440	10 000	14 400 000	
		Subtotal				***19 800 000***	***19 800 000***
	Establishment of HIV/AIDS scholarship	Funds	Numbers	4	20 000	80 000	
		Subtotal				***80 000***	***80 000***
	Follow-up meetings	Participants	Number	56			
		Travel	Trips	56	900	50 400	
		DSA	Days	280	150	42 000	
		Stationery	Numbers	2	5 000	10 000	
		Subtotal				**102 400**	
		TOTAL					**US$ 25 758 200**

8.6 Tourism Sector

BACKGROUD

Tourism is a major earner of foreign exchange and provides both direct and indirect employment opportunities. The region has set aside nearly 10% of its land as protected areas – where tourist resorts are found in the form of national parks. In the latest available figures (WBDR 2000), each tourist brought US$384 to the region, although there are wide variations between countries with low volume and those with high volumes of tourists. Of the 10.6 million tourists who came to the region, half went to South Africa and 20% to Zimbabwe. Thus, nearly three-quarters of all tourists to the region have South Africa and Zimbabwe as the destination.

Regional averages of selected tourism indicators

	1997
National protected areas, as % of total land	9
Value added, % of GDP (Services)	41
Arrivals (millions)	10.6
Receipts, $ billions	4.1
Receipts per tourist (US$)	384

Source: World Bank Development Report 2000

With a population of 190 million, the region attracts a tourist for every 19 people living in the region. Thus, there is potential for extensive social interactions between tourists and visitors in the exchange of services, and community and eco-tourism are on the increase. It is in this context that those agencies involved in the marketing and coordination of tourism have become active in the development and implementation of this strategic plan.

A major argument advanced by those working in this sector has been that tourists (regional and international) are concerned over the quality of health services in member states, especially over the quality of blood and blood-related products. An inspection of recent figures on modes of HIV transmission in the region shows that over 86% of all cases are due to heterosexual behaviour, and only 4% is due to blood products. Most cases of contaminated blood were reported from Angola and Mozambique, where large parts of the country have been inaccessible due to war, and therefore should be insignificant in a regional context. The other significant cause of transmission has been mother-to-child, with a regional average of 7%. Homosexual and intravenous drug-use make very small contributions to HIV transmission in SADC member states.

The second concern by the Tourism Sector is over the transmission of HIV between tourists and the local population. Given the high incidence of heterosexual transmission and the relative ease of sexual contacts between local and tourist populations, this issue is particularly important. In the proposed sector strategy for 2002, this problem will be addressed by promoting improved preventive measures in community-based tourism.

In line with evidence from available statistics, the message to tourists and the local population will be ‘avoid unprotected sexual encounters – and preferably avoid sex altogether’. For this reason, the strategy will involve regional tourism bodies (SATA, RETOSA, etc.) in mounting campaigns aimed at: -

(a) Educating tourists on the availability of health facilities that are of acceptable standards in the region.

(b) Equipping tour-operating companies with skills and information to promote safe sex among tourists and local populations.

(c) Promoting safe sex awareness among all workers in this sector.

Sector mandate: Promote sound and efficient development of the sector to increase the welfare of the SADC population; and remove all possible obstacles to the development of tourism.

Impact of HIV/AIDS

- Fear among tourists that health facilities are inadequate.
- Interaction between tourists and local population can lead to transmission (both ways).

	Objectively Verifiable Indicators	**Assumptions/Risks**
OVERALL OBJECTIVE To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that it is no longer a threat to public health and to the socioeconomic development of the member countries	- Annual trends in HIV/AIDS infections within the SADC region. - Trends in cost of HIV/AIDS for each sector.	Assumed that the quality of available data will improve to accurately reflect the situation within the region.
OBJECTIVES 1. Formulate HIV/AIDS policy for the tourism sector in the SADC region	- Number of tourism related programmes with integrated HIV/AIDS programmes	1.1 Lack of political and instability may hamper implementation of policies. 1.2 Governments give incentives for industry to invest in HIV/AIDS programmes 1.3 Divergence between nation and regional priorities and different context and national sector priorities in the SADC region may hamper the formulation of common policies
2. Reassure tourists on the availability of high quality health care in the SADC region.	- Trends of HIV/AIDS infections within the sector. - Number of information material produced	2.1 Lack of quality health services in some member states could hamper the production of a comprehensive directory 2.2 Medium of communication may delay the production of promotional materials
3. Support community based tourism in the SADC region through HIV/AIDS prevention activities	- Cost saving trends from HIV/AIDS prevention - Number and types of prevention activities.	3.1 Red tape could delay the appointment of team conducting the needs assessment

OUTPUTS 1. Policy on tourism and HIV/AIDS developed and implemented. 2. Regional directory on health services available in the SADC region and Promotional materials produced. 3. Needs assessment conducted.	Number of revised policies in the region.	
ACTIVITIES 1. Policy on tourism and HIV/AIDS developed and implemented. 1.1 Request member states to submit information on HIV/AIDS concerning the tourism sector and how they are tackling the problems, prior to the study 1.2 Recruit the services of a consultant to prepare a policy paper on HIV/AIDS for the tourism sector 1.3 Organise a workshop to discuss the paper 1.4 TCU to follow-up and ensure the implementation of the strategy paper 2. Regional directory on health services available in the SADC region and Promotional materials produced. 2.1 Production of a regional directory on health care especially on HIV/AIDS met for tourists travelling in the SADC region and other promotional materials 2.2 Distribution of promotional materials through travel agents and tour operators. 2.3 Mobilize regional and national tourism organizations and bodies (private and public) for efficient coordination between them and ensure regular consultation on the HIV/AIDS issues.	The services of a consultant would be required to prepare the policy paper on HIV/AIDS on Tourism. Directory produced (Number) Number of promotional materials distributed	Inputs to be received from member states Framework to implement these policies Proper coordination mechanism between these organisation Quality of health information on HIV/AIDS therein Originality of message and means of disseminating information

2.4 Involvement of RETOSA which is the promotion arm of the SADC tourism sector in the fight against HIV/AIDS 2.5 Mobilize regional and national tourism organizations and bodies.		
3. Needs assessment conducted. 3.1 Conduct a region-wide needs assessment in all member states and conduct a KABP (Knowledge, Attitude, Belief and Practice) survey to obtain information which can be used for orientation of future IEC(Information, Education and Communication) strategies. 3.2 Identify ways and means to assist and support the local resident population 3.3 Work in close collaboration with RETOSA in the promotion community based tourism in the SADC region 3.4 Identify institutions and other bodies, including NGO which are actively working on the field for disseminating information appropriately 3.5 Develop training courses for trainers or NGO's or other active recognised groups working on the fields to assist the local population 3.6 Formulate any sensitisation programme apart from formal training to support the local population	The services of a consultant would be required to conduct the need assessment. Number of training courses organised Number of sensitization programme conducted	Cluster of regions may hamper assessment Standards norms and registered community Training budgets and identification of trainers

Tourism Sector

TSM6.1	HIV/AIDS Policy for the Tourism Sector PHASE 1					
		Consultants	Numbers	45	300	13 500
		Participants	Numbers	50		
		Travel	Trips	65	900	58 500
		DSA	Days	350	150	52 500
		Translators	Numbers	3	500	1 500
		Interpreters	Number	3	500	1 500
		Venue Hire	Days	3	600	1 800
		Administration	Days	5	1 000	5 000
		Communication & postage	Numbers	1	10 000	10 000
		Stationery	Numbers	1	2 000	2 000
		Subtotal				***146 300***
	PHASE 2					
		Consultants	Numbers	60	300	18 000
		Participants	Numbers	56		
		Travel	Trips	70	900	63 000
		DSA	Days	400	150	60 000
		Venue Hire	Days	28	600	16 800
		Administration	Days	30	1 000	30 000
		Communication & postage	Numbers	14	2 000	28 000
		Stationery	Numbers	14	2 000	28 000
		Subtotal				***243 800***
TSM6.2	Production and distribution of a Regional Directory on the availability of health care services in SADC					
		Consultants	Numbers	60	300	18 000
		Travel	Trips	15	900	13 500
		Printers	Numbers	30	2 000	60 000
		Postage	Numbers	20	2 000	40 000
		Administration	Days	10	1 000	10 000
		Subtotal				***141 500***
	Production of promotional materials					
		Communication consultants	Numbers	30	300	3 000
		Participants	Number	30		
		Travel	Trips	45	900	40 500
		DSA	Days	210	150	3 500
		Designers	Number	3	2 000	6 000
		Editors	Number	2	2 000	4 000
		Administration	Days	10	1 000	10 000
		Publicity	Number	1	20 000	20 000
		Printing and postage	Numbers	20	2 000	40 000
		Subtotal				***161 000***
TSM6.3	Conduct a KAPB survey					
		Researchers	Numbers	45	300	13 500
		Travel	Trips	14	900	12 600
		DSA	Days	270	150	40 500
		Printers	Numbers	100	30	3 000
		Administration		10	2 000	20 000
		Subtotal				***89 600***
	3.2 Orientation workshops (HIV/AIDS/AIDS awareness)					
		Participants	Numbers	28		
		Travel	Trips	65	900	58 500
		DSA	Days	350	150	52 500
		Administration	Days	5	2 000	10 000
		Communication & postage	Numbers	1	5 000	5 000
		Honorarium translators	Days	3	500	1 500
		Honorarium interpreters	Days	3	500	1 500

		Venue hire	Days	3	600	1 800
		Stationery	Numbers	1	2 000	2 000
		Subtotal				***137 800***
3.3.	Develop a Tourism Data base on HIV/AIDS and create a website					
		Programmer	Numbers	45	300	13 500
		Data collection	Numbers	30	300	9 000
		Computer	Numbers	2	3 000	6 000
		Software	Numbers	1	3 000	3 000
		Web site	Numbers	1	10 000	10 000
		Administration	Numbers	20	20 000	20 000
		Subtotal				***61 500***
	Grand Total					**981 500**

8.7 Transport and Communication Sector

BACKGROUND

With a region as vast as the SADC and given the historical migration of populations in search of economic opportunities, transport is an important sector for socio-economic development. The importance of railways is for instance even captured in popular music describing the role of trains in bringing people together. With several members of SADC being land-locked, there is a particular importance attached to roads, rail and air travel in the region. For those countries with a coast-line, transport has had the added impact of maritime trade (with sailors from all over the world having used these ports over the last five hundred years). Disease and trade have come with travel, and this sector is particularly important in promoting trans-national awareness on measures aimed at curbing the spread of HIV/AIDS. This sector also deals with telecommunications, an important avenue for disseminating information in a world becoming increasingly integrated by information technology (radio, TV, computers, satellites, newspapers, etc). The availability of telephone lines in the region is less than one-twentieth of that available in high income countries, while cell phones, Personal Computers, and internet hosts are even lower. This low level of technological development (except for South Africa) poses a major challenge for those designing communication strategies in this programme.

Regional averages of selected transport and communication indicators

	1997
Paved roads (% of total)	23
Goods transported by rail (tone-km million)	830 771
Air passengers (million)	9.7
Main telephone lines per 1,000 people	25
Mobile telephones per 1,000 people	4
Personal Computers per 1,000 people	11
Internet hosts per 10,000 people	5

Source: World Bank Development Report 2000

Sector mandate: The SADC Protocol on Transport, Communications and Meteorology entered into force on 6 July 1998. The mandate of the Sector has been defined as "To establish transport, Communications and Meteorology systems which provide efficient, cost-effective and fully integrated infrastructure and operations, which best meet the needs of customers and promote economic and social development while being environmentally and economically sustainable".

Impact of HIV/AIDS

- There are no comprehensive reports on impact, but labour productivity has been reduced in railways, maritime, civil aviation, road transport, postal, telecommunications, and meteorology services.
- High rate of attrition among young and skilled labour.
- Increasing direct and indirect Cost

LOGICAL FRAMEWORK MATRIX FOR SATCC

NARRATIVE SUMMARY	ACTIVITIES	**RESPONSI-BILITY**	**RESOURCES/ INPUTS**	**TIME-FRAMES**
Programme Goal: To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio –economic development of member countries	As contained in Sectoral Plans	SADC Health Sector Coordinating Unit (HSCU)	HSCU, Culture, Information & Sports, HRD, Mining, Tourism, SATCC USD 30 million	2000-2001
Programme Purpose/Objective: 1. Sectoral Programme to contribute towards the decrease of the number of HIV/AIDS infected and affected individuals and families in the SADC Region.	SATCC-TU	SATCC-TU	SATCC-TU, Consultants, All Member States	2000-2001
OUTPUTS				
1.1 Funds available	1.1.1 SATCC to source funds through HSCU	HSCU, SATCC	HSCU, SATCC, All Member States USD 3 million	2000 - 2001
1.2 Situational Assessment carried out				
1.3 Sectoral Orientation Workshop conducted	1.2.1 Prepare Terms of Reference for the Study	SATCC-TU, HSCU		End of April 2000
1.4 Coordination and Implementation Machinery established and functional	1.2.2 Search for Potential Consultants to undertake the Study	"	SATCC-TU HSCU, Subsectors	Early May 2000
1.4.1 Recruitment of Programme Personnel	1.2.3 Evaluation of Tenders	"	"	"
1.4.2 Training of Trainers	1.2.4 Award contract to a successful bidder (Consultant)	Consultants, SATCC-TU	"	Study Report
1.5 Community and Work-based programmes carried out	1.2.5 Consultants to undertake the following:	"	Consultants, HSCU, SATCC-TU, other sectors	
1.6 Information sharing and Exchange of Experiences	1.2.5.1 Design and prepare methodology for data collection and information	"		

1.7 Monitoring and Evaluation	1.2.5.2 Collection of data and information 1.2.5.3 Identify high-risk areas 1.2.5.4 Identify all the stakeholders i.e. institutions and individuals 1.2.5.5 Analyse data and information	" " " "		
	1.2.5.6 Prepare study report, with recommendations on actions and appropriate coordination machinery and elaboration of a Sectoral Policy Document 1.2.5.7 Present the report to a Sectoral Workshop 1.3.1 Prepare documentation for the Workshop 1.3.2 Decide on dates and duration of Workshop 1.3.3 Send invitations for the Workshop, together with relevant documentation 1.3.4 Convene workshop, reviewing Study Report etc 1.3.5 Provide Secretarial Services to the workshop 1.3.6 Preparation of outcomes and recommendations of the Workshop	" " " SATCC-TU, Consultants SATCC-TU " " Consultants		
	1.3.9 Agreement on a Sectoral Plan 1.4.1.1 Draft Job Descriptions for Programme Coordinator and Administrative Assistant 1.4.1.2 Advertisement of positions.	Workshop Participants SATCC-TU, HSCU " "		

	1.4.1.3 Recruitment exercise 1.4.1.4 Mobilisation of personnel 1.4.2.1 Identify potential trainers, peer educators and counsellors 1.4.2.2 Prepare trailer-made TOT courses to create a cadre of professional HIV/AIDS Trainers 1.4.2.3 Mount TOT courses 1.4.2.4 Evaluation of TOT courses 1.4.2.5 Use of Trainers in designing and developing tailor-made courses and training materials/media for communities and work places to create awareness and instil responsibility at public and personal levels.	" Consultant SATCC-TU Consultant " Consultant, SATCC-TU "		
	1.4.2.6 Review and evaluate reach-out programmes to assess impact levels. 1.4.2.7 Establish Programme (Project) Steering Committee to oversee implementation. 1.5.1 Direct interventions or teach-ins at various levels involving all subsectors (i.e. railways, maritime, civil aviation, road transport traffic, telecoms, postal and meteorology) and SATCC-TU itself. 1.5.2 Addressing hig-risk areas, such as transit border areas, ports, etc. Publicity and campaign activities 1.5.3 Support to national focus groups and SATCC-TU on the implementation of HIV/AIDS Programme.	Consultant, SATCC-TU SATCC-TU, Workshop, Consultant, HSCU Consultants, Trainers, SATCC-TU Trainers, Consultants Trainers, Consultants SATCC-TU, Consultant SATCC-TU,		

	1.6.1 Ongoing exercise but could involve consultative fora/meetings 1.6.2 Regular interaction with HSCU 1.6.3 Consultations among subsectors to ensure harmonised approaches and efforts, avoiding	Consultant "		
	1.6.4 Liaison with other Sectors 1.7.1 Monitoring and evaluation of implementation and assessment of impact levels of programme activities, using short-term consulting services and Programme Coordinator.	SATCC-TU, Consultant Consultant, SATCC-TU		

ACTIVITY	**COST ESTIMATES IN USD**	**TIME FRAME**
1. Situational Assessment	200 000	May - June 2000
2. Sectoral Orientation Workshop	300 000	June - July 2000
3. Implementation		
3.1 Establishment and functioning of a Coordination machinery	950 000	September 2000 and on going
3.2 TOT - Design & Development of campaign and training materials	300 000	September-October 2000
3.3 Programmes/ activities	850 000	November 2000-2001
3.4 Information Sharing	150 000	

and exchange of experiences within and among sectors 3.5 Monitoring & Evaluation - Consultation - Steering Committee	250 000	Regular feature in the programme implementation, using visits, electronic mail etc. Mid-tern and end of programme
TOTAL	**3 000 000**	**2 YEARS**

SUMMARY OF SECTORAL BUDGETS

SECTORAL OBJECTIVES	TOTAL COS
CULTURE, INFORMATION AND SPORT 1. To mobilize and empower relevant organizations working with artists, media, entertainers and sports persons (AMES) in the fight against HIV/AIDS in the Region 2. To ensure the coordinated and systematic sharing of information on HIV/AIDS in the Region	**$3,296,600**
EMPLOYMENT AND LABOUR SECTOR 1.To increase capacity of government, workers and employers to implement HIV/AIDS Code 2. To audit Member States on the implementation of HIV/AIDS Code/Regional situational analysis on HIV/AIDS and employment	**$2,569 600**
HEALTH 1. To prevent HIV/AIDS transmission among the youth in SADC 2. Improve clinical management of HIV/AIDS 3. To improve care offered to HIV/AIDS affected through strategic partnerships 4. Harmonisation of policies 5. To facilitate and guide research and pilot studies 6. Standardisation of data and surveillance systems	**$1,482,500**
HUMAN RESOURCE DEVELOPMENT 1. To create a supportive environment for the fight against HIV/AIDS within the education and training sector 2. To impart knowledge and skills on HIV/AIDS to both learners and educators 3. To coordinate research	**$1 447 425**

MINING 1. To establish the extent of HIV/AIDS in the SADC mining sector 2. To minimize the spread of HIV/AIDS 3. To facilitate the provision of adequate services for the already infected	**$25,758,200**
TOURISM 1. Formulate HIV/AIDS policy for the tourism sector 2. Reassure tourists on the availability of high quality health care in the region 3. Support community based tourism	**$981,500**
TRANSPORT AND COMMUNICATION 1.To decrease the number of HIV/AIDS infected and affected individuals and families in the SADC	**$3,000,000**
TOTAL	**$35,652,150**

NOTE: For the breakdown of the Sectoral Budget in terms of activities please refer to detailed sectoral budgets.

Annexure 1. Article 10, SADC Health Protocol (1999)
HIV/AIDS and Sexually Transmitted Diseases

1. In order to deal effectively with the HIV/AIDS/STDs epidemic in the Region and the interaction of HIV/AIDS/STDs with other diseases, State Parties shall:

   (a) harmonise policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce the transmission of STDs and HIV infection;

   (b) develop approaches for the prevention and management of HIV/AIDS/STDs to be implemented in a coherent, comparable, harmonised and standardised manner;

   (c) develop regional policies and plans that recognise the inter-sectoral impact of HIV/AIDS/STDs and the need for an inter-sectoral approach to these diseases; and

   (d) co-operate in the areas of:-

      (i) standardisation of HIV/AIDS/STDs surveillance systems in order to facilitate collation of information which has a regional impact;

      (ii) regional advocacy efforts to increase commitment to the expanded response to HIV/AIDS/STDs; and

      (iii) sharing of information.

2. State Parties shall endeavour to provide high-risk and transborder populations with preventive and basic curative services for HIV/AIDS/STDs.

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