SADC HIV AND AIDS STRATEGIC FRAMEWORK

2010-2015

Final Draft

October 2009

I. Foreword

One of the greatest challenges facing the Southern African Development Community (SADC) as it moves towards greater integration is the adverse effect of HIV and AIDS on social, political and economic development. The region has the highest levels of HIV infection to be found globally. However, there has undoubtedly been progress in recent years in addressing the multiple challenges of HIV and AIDS in the region in the context of the many commitments made by Member States. The epidemic still presents a major threat to societies and development within SADC though and requires an urgent, more effective and better-resourced response by MS and other stakeholders. The challenge of maintaining and extending gains is amplified by the huge scale of needs, combined with the prospect of greater resource constraints due to pressures on the regional and global economy.

Building on initial successes, SADC member states will, over the years to 2015, have to rise to the challenge of mobilising the resources and systems that allow for a comprehensive, scaled-up, sustainable response to HIV and AIDS. Member states and their partners face the prospect of meeting Universal Access and other development targets in the context of increasingly severe resource constraints. This framework builds on what has been achieved under the previous Strategic Frameworks (2003–2007) and establishes strategic objectives and actions of operation for the period 2010–2015.

II. Acknowledgements

This Strategic Framework was developed based on inputs of various stakeholders, including experts from SADC Member States, Civil Society Organisations and the SADC Secretariat. Multi-lateral and bi-lateral cooperating partners who are already playing an important role in the regional response to the epidemic, and whose support will be essential for taking forward more effective policies and programmes forward also provided valuable input.

The SADC HIV and AIDS Technical Advisory Committee and representatives of National AIDS Authorities provided critiques of the document that shaped the final form.

The Technical Support Facility and Health and Development Africa consultants provided additional technical input.

III. Executive Summary

This document provides a strategic framework for the Southern African Development Community (SADC) response to the HIV and AIDS epidemic. The framework builds on what has been achieved under the previous Strategic Framework (2003–2007) and establishes strategic objectives and actions of operation for the period 2010–2015. The Strategic Framework is intended to provide guidance to the response to HIV and AIDS, especially to move towards Millennium Development Goal (MDG) 6 and its targets:

- Halt and begin to reverse the spread of HIV and AIDS by 2015
- Achieve, by 2010, universal access to HIV and AIDS treatment for all those who need it

The response will be guided by the SADC Regional Indicative Strategic Development Plan (RISDP), the Maseru Declaration and other SADC regional instruments such as the Protocol on Health. The framework is a platform on which all regional actors are brought together. It was informed by a review of documentation, and consultations with Member States and other key partners within the region in the field of HIV and AIDS.

The Framework is forward-looking in its focus and scope, seeing beyond immediate, urgent issues in order to guide action on HIV and AIDS until 2015. The framework is guided by a vision of *a common future with no threat of HIV and AIDS to public health and to sustained socio-economic development*; supported by a mission statement articulating the following: *SADC region controls and reverses the HIV and AIDS epidemic and its impacts as shown by the achievement of the Millennium Development Goals and Universal access commitments by 2015.* The goal of the framework states that *All Member States demonstrate a 50% reduction in the rate of new infections to half of the 2008 levels and mitigate concomitant impacts by 2015.* This illustrates the priority that is given to prevention of new HIV infections.

In order to meet MDG targets and other regional priorities, the Framework situates the regional response to HIV and AIDS in the context of the five priorities identified in the Maseru Declaration as needing urgent attention. These are: -

- Prevention and social mobilisation
- Improved access to care, counselling, testing, treatment and support
- Accelerating development and mitigating the impact of HIV and AIDS
- Intensifying resource mobilisation
- Strengthening institutional monitoring and evaluation mechanisms

Each of the priority areas has a defined objective that is outlined below:

Objective 1: All Member States deliver on their universal access to prevention targets by 2015

Objective2: All Member States deliver on their universal access targets to achieve access to quality treatment for people living with and affected by HIV, AIDS and TB by 2015

Objective 3: Reduced impact of HIV and AIDS on the socio-economic and psychological development of the region, Member States, communities and individuals with all OVC and youth having access to external support by 2015

Objective 4: Sufficient resources mobilised for a sustainable scaled-up multisectoral response to HIV and AIDS in the SADC region that channels resources to operational and community levels

Objective 5: Enhanced institutional capacity in the region supports evidenced based programme design, implementation, monitoring and evaluation at region and MS levels to support progress towards regional, continental and global commitments

The five objectives are supported by 12 priority outcomes.

In many of the Maseru Declaration priority areas, important progress has been made by member states. However, further action remains for an effective response in the region. In particular, there is a need to intensify prevention and increase access to treatment.

Building on initial successes, SADC member states will, over the years to 2015, have to rise to the challenge of mobilising the resources and systems that allow for a comprehensive, scaled-up, sustainable response to HIV and AIDS. Member states and their partners face the prospect of meeting Universal Access and other development targets in the context of increasingly severe resource constraints. There is thus increasing recognition that programmes should be more evidence based: they should draw on growing knowledge about vulnerability to HIV and AIDS, as well as which interventions are the most effective.

The Framework has prioritised the achievement of certain results within the region, to ensure feasibility, focus and enhanced impact of the HIV and AIDS response. Furthermore, prioritisation has considered what initiatives are most appropriate for a regional level Framework: they need to target issues where regional action is likely to add value to delivery at MS level, and not where action driven primarily at MS level is most appropriate.

At the regional level, the priorities will be operationalised within SADC's identified strategic focus areas of: policy development and harmonisation; mainstreaming; capacity building; facilitating a technical response and resource networks; and monitoring and evaluation of regional and global commitments.

The operational plan and indicative budget of the strategic framework is defined in the SADC HIV and AIDS Business Plan 2010 – 2015.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral drug
ART	Antiretroviral treatment
BCC	Behaviour-change Communication
CCM	Country Coordinating Mechanism
CTX	Cotrimoxazole
CSO	Civil Society Organisation
DFID	Department for International Development
DSHD	Directorate of Social and Human Development
EU	European Union
FANR	Directorate of Food and Natural Resources
GIPA	Greater Involvement of People with AIDS
GFATM	Global Fund for AIDS, TB and Malaria
HBC	Home based care
HIV	Human Immuno-deficiency Virus
HR	Human Resources
ICP	International cooperating partners
IDU	Injecting Drug Users
I&S	Directorate of Infrastructure and Services
IOM	International Organisation for Migration
JFTCA	Joint Financing and Technical Co-operation Arrangement
MC	Male Circumcision
MDG	Millennium Development Goals
MS	Member States
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
M&E	Monitoring and Evaluation
NAA	National AIDS Authority
NAC	National AIDS Council
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental Organization
NSP	National Strategic Plan
ODA	Overseas Development Assistance
OVCY	Orphans, Vulnerable Children and Youth
PEPFAR	Presidents Emergency Plan for African Relief
PHC	Primary Health Care
PLWHA	People Living with HIV and AIDS
RISDP	Regional Indicative Strategic Development Plan [of SADC]
SADC	Southern Africa Development Community
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TIFI	Directorate of Trade Industry Finance and Investment
UA	Universal Access
UNAIDS	Joint UN Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	UN General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Test

1. Introduction

One of the greatest challenges facing the Southern African Development Community (SADC) as it moves towards greater integration is the adverse effect of HIV and AIDS on social, political and economic development. The region has the highest levels of HIV infection to be found globally. The majority of Member States (MS) have experienced adult infection levels in excess of 15%, and several have been tackling epidemics where 20% or more of adults are infected. In contrast, the global average is just 1%.[1] Many MS are now grappling with the escalating impact of mature epidemics of HIV and AIDS, as well as HIV and Tuberculosis (TB) co-infection. Eleven SADC MS are among the 27 countries that are estimated to account for 80% of all children living with HIV worldwide. To date up to an estimated 530,000 children are infected annually, mainly through mother-to-child transmission (MTCT). More than 1 million children under the age of 15 are infected with HIV accounting for 8% of people living with HIV in the region. The HIV and AIDS as well as TB/HIV epidemic are eroding hard-won development gains of previous decades and have a particularly heavy impact on women and children.

There has undoubtedly been progress in recent years in addressing the multiple challenges of HIV and AIDS in the region. However, the epidemic still presents a major threat to societies and development within SADC. This requires an urgent, more effective and better-resourced response by MS and other stakeholders. The challenge of maintaining and extending gains is amplified by the huge scale of needs, combined with the prospect of greater resource constraints due to pressures on the regional and global economy.

This Strategic Framework is intended to provide guidance for MS, SADC Secretariat and all stakeholders at country and regional level, on implementing a coordinated, multidisciplinary approach to HIV and AIDS in the region.

Process in developing the framework

A range of stakeholders from MS governments, civil society and development partners provided input to develop the Framework. They identified areas of the HIV and AIDS response that are expected to be the most important to successfully tackle the epidemics in MS in the years to 2015; including emerging issues. They then prioritised actions that are most effectively performed or facilitated at regional level. The process covered a period of just over a year where the initial framework was developed, then tabled at the meeting of National AIDS Council Directors, Southern Africa Partnership Forum and the Technical Advisory Committee in October 2008, followed by a review of the documents by expert from MS and partner institutions. Subsequent to this process, the framework was subjected to a results based orientation and further discussed at a meeting the Steering Committee of the Joint Financing and Technical Cooperation Arrangements. The final draft document was tabled at the Ministerial meeting that was held in April 2009 for endorsement but the meeting felt that there was not sufficient consultation on the document and referred to the document for more consultation. The framework then incorporated all the feedback that was submitted by MS and stakeholders; and was endorsed by the NAC Directors, the Partnership Forum and the SADC Technical Advisory Committee meetings that were held in the Democratic Republic of the Congo in October 2009. The Framework was then approved by the Joint Ministerial Committee on Health and HIV and AIDS in November 2009.

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[1] The SADC Regional Strategy and Action Plan for Universal Access to Prevention (2008–2010).

2. The context of HIV and AIDS in the region

2.1 The HIV and AIDS epidemic in SADC

As at end of 2007, the SADC region had an estimated 12 million People Living with HIV and AIDS (PLWHAs), accounting for about 36% of all PLWHA globally. Additionally, the region accounted for over a third of new infections and AIDS deaths per year[2]

HIV transmission in the region is mainly *heterosexual*, and an estimated 92% of all infections are attributed to this mode of transmission. HIV is thus most prevalent in sexually active people in the 20-39 year age group. However, infections with HIV, and the effects of illness and deaths due to the epidemic, reach into all age and population groups. The distribution of HIV varies within SADC countries, but urban populations are often more affected than rural communities.

More women are infected than men, and they are infected at earlier ages. Young women aged 15-24 years are particularly vulnerable to becoming infected, for biological reasons and also due to social and economic factors. These make them less informed about HIV prevention, less able to insist on safer sex, and more likely to have older sexual partners who are infected already. Currently in sub-Saharan Africa, 76% of young people (15-24 years) living with HIV are female.

Importantly, there is ***diversity of epidemics*** between and within MS. Varying levels of adult HIV prevalence are driven by a diverse range of behavioural, social, cultural and economic factors.[3] Twelve MS are considered to have *generalised epidemics* that are sustained by sexual networking in the general population, and where HIV prevalence is consistently over 1% among pregnant women. Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe are countries with *hyper-endemic* scenarios. Not only are their epidemics generalised, but HIV prevalence is over 15% in the adult population, implying all sexually active adults are at risk of HIV infection. Other MS that have generalized epidemics include Angola, Democratic Republic of Congo, Malawi and Tanzania.

In contrast, Madagascar, Mauritius and Seychelles have *low-level* and *concentrated epidemics*. Adult HIV prevalence is less than 1%, and sexual transmission is low in the general population, but it is high and concentrated in certain population groups. In Mauritius, prevalence among prisoners, sex workers and injecting drug users (IDUs) has been estimated to be 15% to 25%. Sharing of needles and inconsistent condom use in high-risk groups are key drivers of the epidemic.

The diversity of MS epidemics means that *responses have to be customised* to reflect differences. Good epidemiological and behavioural information is needed to identify the dynamics of each epidemic and design appropriate responses. In low-level and concentrated epidemics, responses should be targeted at sub-populations at highest risk, such as IDUs and sex workers. In generalised epidemics, campaigns and services for the whole population are needed. However, services targeted at higher-risk sub-groups are still important. These may include large groups such as young and married women, not just the marginalised groups that are traditionally considered to be at high risk.

2.2 Contributing factors

[2] SADC HIV and AIDS Epidemic Report 2007

[3] The SADC Regional Strategy and Action Plan for Universal Access to Prevention 2008–2010.

Several factors contribute to the severity of the epidemic in the region. At the SADC Expert Think Tank Meeting on HIV Prevention in Southern African, high prevalence countries concluded that *key drivers* of the epidemic in SADC countries include a combination of multiple and concurrent partnerships; low and inconsistent condom usage; and low-levels of male circumcision.

The effect of these key drivers is reinforced by a range of *social circumstances* that predispose many SADC communities to high risk of HIV transmission:

- Cultural practices and social norms conducive to multiple concurrent sexual partnerships, and intergenerational and transactional sex.
- Stigma and discrimination, and lack of open communication, around HIV and sex.
- Gender inequalities and male dominance in sexual decision-making, as well as high levels of sexual violence in many communities.
- High levels of untreated sexually transmitted infections (STI)
- Alcohol and drug abuse
- Cultural practices in some communities e.g. dry sex; forced sexual initiation of girls or boys.

Beyond these circumstances, a number of *structural factors* add to high risk of HIV transmission, such as:

- Uneven economic development and resulting migration within and across countries
- Poverty, unemployment and economic inequality, fuelling acceptance of transactional sex[4]
- Norms and institutionalized practices that reinforce discrimination on the basis of gender, class, age and ethnicity
- Weak policies, laws and law enforcement that protect women, girls and other vulnerable groups and barriers to accessing prevention and other services.

2.3 Emerging Trends of HIV and AIDS

2.3.1 Prevalence and incidence of HIV infections

SADC already has the highest prevalence of HIV infections globally, but levels of *new* infections (incidence) also remain high and are rising. If the current trend continues, the region will not reach the MDG target of reversing and halting the epidemic by 2015.

Without substantial and rapid reductions in HIV incidence, the treatment burden of AIDS is set to be unsustainable, even in the wealthiest Member States. This warrants bringing effective HIV prevention strategies to scale with the right intensity and quality, with sound monitoring and evaluation.

The SADC Epidemic Report for 2007 examined *HIV prevalence rates among young adults aged 15-24*, a key indicator of the number of new infections in countries. Prevalence reported in MS population surveys ranged from 2.7% to 16.2%, and it is clear in many parts of the region where more than one person in every ten aged 15-24 is infected with HIV. Infections among women outweigh male infections in this age cohort, making prevention among girls and young women of particular and urgent concern.[2] Data is still limited for identifying trends in the number of new infections in MS.

[4] Poverty is a priority concern of SADC member states. An estimated 70% of the population of SADC lives below a $2 per day poverty line. Unemployment is extremely high, particularly among youth. Income inequality is a major challenge both between and within MS: several SADC counties have some of the highest levels of income inequality in the world.

However, in several countries, it appears that prevalence in this age group did not decline and in some cases actually increased, in the years leading to 2008. Overall there is recognition that HIV incidence remains too high in the majority of MS for them to avoid serious impact on their countries.

On the other hand, a review of evidence for the SADC Prevention Strategy identified signs of some positive changes in epidemic dynamics. Trend data suggest modest declines in HIV prevalence for most MS over the last decade.[5] Zimbabwe demonstrates the largest decline, and there is evidence that behaviour change has contributed to these, through more condom use with non-regular partners and reduction in the numbers of partners.[6] Declines in HIV prevalence among people 15-24 years old have been observed in several other hyper-endemic MS.[7]

2.3.2 Mortality

Rates of HIV and AIDS related illness and deaths in the region have reduced by increasing access to ART and PMTCT. However, by the end of 2007, more than 10 million people were estimated to have died of HIV and AIDS related diseases in the region. SADC contributes about 42% of the 2.1 million AIDS-related deaths globally.

2.3.3 Prevention of Mother to Child Transmission of HIV

Transmission of HIV from mother to child (MTCT) has been a particular effect of the HIV epidemic, and a major underlying factor in many infant and childhood illnesses and deaths in MS. There are indications, however, that PMTCT programmes are beginning to have a noticeable impact on the incidence of HIV and AIDS in children.

2.3.4 TB/HIV co-infection

The TB epidemic in the SADC region is driven by the high prevalence of HIV in most Member States. People infected with HIV infection have a ten times increased risk of developing TB compared to those not infected with HIV. Five (5) of the twenty two (22) high TB burden countries globally are from the SADC region. Furthermore, twelve out of the 15 MS are among the 41 priority countries that accounted for 97% of the estimated global number of HIV-positive TB cases in 2006.

About two thirds of TB patients have a dual TB/HIV infection; the prevalence of TB/HIV co-infection ranges from 3% in some of the low HIV prevalence Member States to about 80% to some of the high prevalence Member States. In addition there is increasing concern about emergence of large numbers of Multi and Extreme Drug Resistant TB cases.

2.3.5 Paediatric HIV and AIDS

Paediatric HIV and AIDS in the SADC region is mainly due to high levels of HIV infection among women of reproductive age which is passed to children through mother-to-child transmission. Eleven SADC MS are among the 27 countries that are estimated to account for 80% of all children living with HIV worldwide.

HIV infected children follow a more aggressive course of illness and about 32.5 percent of infected children die by age one and more than 50% by age two; largely because of the lower efficiency of the child's developing immune system.

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[5] See James D. Sheldon, et. al., "Has global HIV incidence peaked?" March 2006, The Lancet, DOI:10.1016/SO140-6736 (06) www.thelancet.com

[6] Comprehensive Review on BCC as a Means of Preventing HIV Transmission in Zimbabwe. 2006

[7] SADC Regional Strategy and Action Plan for Universal Access to Prevention 2008–2010.

SADC Member States are providing ARV therapy to children however, only a few children (about 12%) in need of ARV are receiving it. Furthermore, it is estimated that in the Eastern and Southern Africa region, only about 6.9% of children born to HIV+ mothers are receiving preventive cotrimoxazole therapy (pCTX). Additionally, there are limited paediatric HIV diagnostic facilities and therefore most HIV-infected children are diagnosed very late in the course of illness, or not at all emphasising the need for more work in this important area. Additionally, most clinicians are not adequately experienced in treating children.

Some gaps have been identified in understanding paediatric HIV and AIDS including the following:

- Limited data on the natural history of paediatric HIV infection
- Clinical and biological indicators of disease progression in HIV-infected children beyond the first 3 years of life
- Effectiveness of ART in HIV-infected children
- Optimum drug selection in children exposed to perinatal nevirapine

2.3.6 Orphans and vulnerable children

High levels of adult deaths have led to increased numbers of orphans. The trends in the number of children orphaned by HIV and AIDS or other factors, have been difficult to track due to limited data and the possible influences of ART on the number of parents lost. However, the SADC Epidemic Report's analysis of MS data shows that up to a third of children below 18 years in some MS have lost one or both of their parents. Around 38% of the total number of orphans in SADC, or 6,390,000 children, has lost parents to HIV and AIDS.[8] In addition, around 8% of people living with HIV in the SADC region are under the age of 15.[8]

2.4 The Impacts of HIV and AIDS

HIV and AIDS were initially characterised as a health problem but have now been recognised as a serious and ongoing challenge to human and economic development in the region. HIV and AIDS affect adults in their prime years as workers and parents implying that their illness and deaths disrupt economic, community and household life. HIV and AIDS are estimated to have directly or indirectly affected almost two-thirds of the total population of SADC by 2008. The scale of the epidemic means that, while treatment programmes can lessen the impact, levels of illness, deaths and various costs due to HIV and AIDS will probably remain substantial for the foreseeable future.

HIV and AIDS have been eroding many of the development gains of the 1980's. Adult and under-five child mortality have risen dramatically, and life expectancy is declining to levels that were typical of the 1950s in many countries. Five countries in the SADC region account for the greatest impacts of AIDS on under-5 mortality and they include Botswana (57.7), Zimbabwe (42.2), Swaziland (40.6), Namibia (36.5) and Zambia (33.6). This has resulted in a deteriorating human development index (HDI) in many MS between 1995 and 2004.[9] HIV and AIDS also affect achievement of key MDGs that are specific to HIV and AIDS, and related ones such as gender, maternal and child health, education and poverty.

At the household and family level, the impact of HIV and AIDS tends to be most severe. Prolonged illness and death of a family member, especially the breadwinner, often

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[8] Comprehensive Care and Support for Orphans, Vulnerable, Children & Youth (OVCY) in SADC - Framework and Plan of Action 2008-2015.

[9] Life expectancy at birth is the average number of years a person can expect to live at current levels of mortality. Life expectancy and HDI values are estimated by the UN. National estimates for some countries may differ from these.

reduces household income leading to poverty. The poorest tend to be most vulnerable and can be pushed further into poverty. There is evidence in urban communities of an emerging class of people recently impoverished by AIDS.

Women, particularly the girl child and elderly women, disproportionately bear the brunt of the epidemic. Women have higher infection rates, increased workloads in providing care and support, and are often faced with decreasing household resources, in addition to the trauma from the illness and death of an infected family member.

Children who are orphaned by AIDS have highlighted the vulnerability of a much wider pool of children and youth. Not all orphans are more vulnerable than non-orphans, but it is now documented that orphans suffer trauma and alienation, and are at greater risk of a reduced standard of living, school dropout and interruption, and reduced access to other key public services. Vulnerable children have direct implications for intergenerational poverty, their socialisation and their potential to contribute to the future development of the region.

The *burden on caregivers* is increasingly recognised as a challenge for sustainability. In addition to the stress of those who care for the ill and the bereaved, there are often large financial and psychosocial burdens related to orphan care. It is estimated that over 90% of orphans are cared for by extended families and grandparents care for 40% of the children orphaned by AIDS.

HIV and AIDS have had a significant impact on a range of sectors in the region, but especially government services. *Health sectors* have been seriously affected by increased demand on already over-burdened systems, coupled with illness, death and demoralisation of many health workers. This has made it difficult to sustain HIV and AIDS and other services, particularly support for outreach services such as community and home-based care. ART has reduced the load on some services and improved morale, but creates its own demands on capacity. Containment of opportunistic infections, particularly the resurgence of TB and drug resistant TB, has also become a major challenge to public health systems.

Welfare services are another sector under pressure, and often struggle to cope with massively increased needs of infected and affected people. *Education sectors* also face extra demands to respond to needs of staff and learners for prevention, care and support. HIV and AIDS impact on staff has sometimes been a significant extra challenge to capacity of stretched education systems.

The *economic impact of the epidemic* of HIV and AIDS across MS is widely recognised, although representative information on its scale is not available. The impact of HIV and AIDS on private and public sector workplaces varies in magnitude, but there are documented effects of illness, absenteeism to take care of family responsibilities, stress, lower morale, loss of skilled and experienced workers, and costs of medical care and other benefits.

Increasing focus is now being placed on the potential *fiscal and macroeconomic impact* of large-scale spending on HIV and AIDS, and particularly ART and welfare programmes. There are indications that there may be significant fiscal challenges even in wealthier MS, although a study in Botswana suggests that macroeconomic benefits of effective treatment, care and support programs there are likely to outweigh the costs.[10]

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[10] Econsult (2006). The Economic Impact of HIV/AIDS in Botswana. National AIDS Co-ordinating Agency (NACA) and United Nations Development Programme (UNDP).

3. Commitments by SADC Member States

SADC leadership has demonstrated long-standing commitment to reversing the HIV and AIDS epidemic, and mitigating its impact on human development. The *Maseru Declaration on HIV and AIDS (2003)* by SADC Heads of State reaffirmed this and reinforced earlier commitments under other continental and global initiatives. Of particular significance are the *Millennium Development Goals (MDGs)* adopted in 2000, the *Abuja Declaration on HIV and AIDS, Malaria and other Communicable Diseases* (2001), the *Declaration of Commitment of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS)* of 2001 and the United Nations General Assembly Declaration on Children.

Another major commitment was the signature by all MS of the *Brazzaville Declaration on Universal Access (UA) to HIV prevention, treatment, care and support* (2006). Supporting MS to achieve these and other international and regional commitments is one of the key tasks of SADC. In recognition of this, SADC political leadership has directed that there should be a standing agenda item on the HIV and AIDS situation and responses, in meetings of SADC structures at all levels.

The Strategic Framework is situated within the *development context of the region*, and reaffirms the region's approach to HIV and AIDS as a developmental challenge. The impact of the epidemic is both aggravated by, and worsens, poverty as well as inequalities including those of income and gender. HIV and AIDS is also addressed in a way that recognises *existing health system challenges*, and threats to health such as Malaria, and TB, and, increasingly, non-communicable diseases.

The strategy has specifically considered the effects of further regional integration on the epidemic and vice versa. In this respect the Framework is aligned with the *Regional Indicative Strategic Development Plan (RISDP)*. This is the main guide to regional economic integration and has set priorities, focus areas of intervention, and major programmes of SADC for the years to 2015.

HIV and AIDS, gender and poverty are addressed in the RISDP as crosscutting issues that are mainstreamed into all of its key intervention areas. The RISDP's interventions create opportunities for more effective responses to HIV and AIDS, through actions to enhance efficiency, build economic and human resources, and streamline development assistance. However, it could also increase the vulnerability of some populations, and these need to be assessed and monitored. For example, trade and economic liberalisation is expected to increase population mobility, and infrastructure projects can put workers and surrounding communities at greater risk of HIV infection. Macroeconomic convergence could also limit MS spending on health programmes.

Consistent with a developmental approach, the Framework has considered not only short term priorities in the HIV and AIDS response, but also *a longer term view of the epidemic*. Although the HIV and AIDS epidemic represents an emergency in the SADC region, it has to be seen as an intergenerational challenge that requires longer term, strategic approaches.

The SADC HIV and AIDS Strategic Framework (2010 – 2015) is intended to guide and support MS in this context, to address MS priorities under the Maseru Declaration and to fulfil their commitments to MDG goals and targets. The Framework draws on experience of implementing the previous SADC HIV and AIDS Strategic Framework 2003-2007, its Business Plan, and also priorities identified in specific programme areas under frameworks and strategies.

Experience with the previous Framework and other common challenges in SADC have shown the power of unified regional approaches to appropriate issues. Regional initiatives tend to have comparative advantages over MS initiatives under conditions where:

- An issue is difficult to tackle at individual MS level, especially if it is of an inter-country nature, such as migration.
- Coordinated action at regional level is more efficient because it can deliver combined capacity, economies of scale or scope, or synergy of combined national efforts, that are not feasible at individual MS level. Examples include research into issues of common concern or good practices.
- MS can benefit from harmonisation of approaches, such as development of consistent guidelines, medicines registration, bulk purchasing of medicines and advocacy messages on key issues.

The following strategic intervention areas have been identified as adding value to the response in the region:

- Policy and strategy development and harmonization
- Mainstreaming of HIV and AIDS
- Monitoring and evaluation of regional and global commitments
- Capacity development
- Facilitating a technical response
- Facilitating resource networks
- Facilitating cross border initiatives for universal access

These strategic areas will continue to be the focus of the regional programme activities under this Framework. In addition, because of the pressing need to meet the MDGs, this Framework seeks to prioritise regional level challenges and objectives in Maseru Declaration areas that can have the *greatest impact* on the wellbeing of the people of the region.

A number of mechanisms have been established at the SADC regional level for decision-making, consultation and advice in order to ensure that regional level efforts are appropriate, accountable and adequately supported. They include: the Technical Advisory Committee (TAC); National AIDS Authorities (NAA) Directors meetings; the Partnership Forum; the Monitoring and Evaluation annual meeting; meetings of Ministers in charge of HIV and AIDS Programmes; and the Summit Situation analysis of HIV&AIDS in the Region. However, the number and length of meetings must be managed to avoid discussions that do not end up with implementations of agreed decisions.

4. The HIV and AIDS Response in the Region

The HIV and AIDS epidemic has prompted a range of responses in SADC. *High-level political commitment* to address HIV in the region is strong, as evidenced by the Member States' commitments to the SADC Maseru Declaration, the OAU Abuja Declaration and Plan of Action, the United Nations Millennium Development Goals (MDGs) targets and UNGASS.

4.1 Regional Response

At regional level, the epidemic is considered a priority and the regional response has been guided by the SADC Strategic Frameworks (2000–2004 and 2003-2007). At national level, all Member States have developed *National policies* on HIV and AIDS and *National*

Strategic Plans (NSPs). In addition, since 2000 there has been *a major improvement in the levels of funding* of national HIV and AIDS programmes. This has transformed the opportunities for scaling-up of programmes.

Nevertheless, there are *ongoing challenges* to fill the gaps between the development and implementation of NSPs. The deterioration of the *world and regional economies* in 2008/9 has highlighted the major challenge of mobilising resources to sustain and extend responses to HIV and AIDS in SADC, as well as the vulnerability of poor communities to the impact of HIV and AIDS.

The following sections provide an overview of the response and challenges, at regional and national levels, in addressing the challenges of the epidemic in the region.

4.1.1 Assessment of Implementation of the SADC HIV and AIDS Strategic Framework (2003-2007)[11]

The SADC HIV and AIDS Strategic Frameworks (2000–2004 and 2003-2007) have guided the regional response to the epidemic, and have promoted a multi-sectoral approach. The previous Strategic Framework identified six strategic areas of focus (referred to as strategic intervention areas in this framework) for the region, and set out priority activities in an operational plan. By the end of 2008, SADC had substantial achievements in each of the strategic focus areas of the Framework as summarised below

The establishment of the SADC HIV and AIDS Unit was a major milestone that was achieved in 2003. Regional projects of several development partners helped to kick-start implementation despite limited initial staffing and funding of the Unit itself.[12] A number of priority areas of the strategic framework were piloted with this support, such as models for support of OVC and youth, and cross border health initiatives on STI. These informed later development of policies, strategies and activities in these key areas, as well as the Business Plan on HIV and AIDS 2005 -2007.

The following sections assess progress and key challenges in meeting objectives specified in the Strategic Framework (2003-2007) and its Operational Plan. Many activities only commenced in the two years from 2007, when key Unit staff were appointed, Joint Financing and Technical Cooperation Agreement (JFTCA) funding was secured and implementation of the Framework and Business Plan accelerated. Progress is mainly assessed in terms of implementation of processes and outputs, as longer implementation and follow up will be required in most cases to assess the outcomes of initiatives.

4.1.2 Policy Development and Harmonization

The previous Strategic Framework identified areas in which key policy frameworks would be developed during the period 2003-2007. SADC developed a number of regional frameworks, harmonised policies and protocols which facilitate harmonised responses to HIV and AIDS in the region. Table 1 summarises performance against planned objectives in the previous framework.

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[11] The assessment is based on report of the Final Evaluation of the JFTCA 2-year Short Term Support and its Financing Arrangements, supplemented by further document review and key informant inputs.

[12] Key partners were: European Commission, Department for International Development (UK) and Belgian Government.

Table 1: SADC Performance in developing HIV and AIDS-related regional policies, frameworks and protocols and policy harmonisation

Planned Objectives	Status	Achievements (at Jan 2009)	Outstanding or further actions needed
Policies and plans in SADC to address HR needs for development in response to HIV epidemic	Partly achieved	HR policy and strategy in place	- M&E plan being developed - For ongoing attention: HR policy and plans; MS planners' capacity development; monitor staffing and attrition in key sectors e.g. Education, Health
Development of policy and guidelines for care and treatment in SADC ART access	Achieved for key issues	➢ STI Framework and Guidelines (2006) ➢ TB framework ➢ SADC Pharmaceutical Plan for AIDS, TB and Malaria	- For ongoing attention: harmonised ART guidelines; bulk drug and supplies procurement; other protocols
Harmonised policies on migrant/ mobile labour, displaced populations and HIV and AIDS	In process		- Regional framework for mobile populations being finalised - Continue regional framework for populations such as refugees
Policies and programmes to address needs of OVC and youth	Achieved	➢ OVCY Framework (2008) in place	- Specific policies to be developed
Develop special programmes to protect youth from HIV infection	Partly achieved	➢ Expert Meeting (2006) ➢ HIV Prevention Strategy (2008)	- Implementation required

SADC has also pursued policies in other key areas that can help to reduce HIV and AIDS impact. Of particular importance is expansion of social protection for families affected by HIV and AIDS, including care givers and children.[13] The First Conference of Ministers in charge of social development (Windhoek 2008) and the SADC Code on Social Security (2008) also promoted social protection and structures have established to take it forward.[14]

The policies, frameworks and guidelines create a foundation for further action in this new Framework. A general challenge is to ensure that agreed policies, frameworks and guidelines are implemented effectively by SADC and MS so that they do produce the desired outcomes.

Box 1 shows some of the key policies and frameworks, which go beyond areas specified in the operational plan, that were developed, in the period under review.

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[13] The framework on Care and Support for OVCY has been supported by several other regional initiatives. Relevant protocols, codes and plans cover areas such as Education and Training; Health; Child Labour (2007); Gender and Development (2008); and Poverty Eradication and Sustainable Development (2008).

[14] African Union governments committed to "establishing, improving and strengthening social protection schemes" in the Ouagadougou Plan of Action for Promotion of employment and poverty alleviation (2004). Interventions under a social protection framework include: social security and insurance schemes; income security; cash transfer schemes; integrated policy with a strong developmental focus such as employment creation, accessible health and other services, social welfare, and quality education. There is an emerging consensus that well managed minimum packages of social protection components can significantly impact on poverty, inequalities, economic growth and vulnerability to economic shocks. They also appear to be affordable within existing resources even in low income countries, if properly managed.

Box 1: Selected HIV and AIDS-related regional policies, frameworks and protocols developed by SADC

1. Code of Conduct on HIV and AIDS and Employment (1997; 2003)
2. Recommendations by SADC Ministers of Health on strengthening Nutrition and Use of Traditional Herbal Therapies (2004) - (This motivated work on Traditional Medicines driven by the Health and Pharmaceuticals programme)
3. Framework for Coordinating the National HIV and AIDS Response in the SADC Region (2005) to guide implementation of "Three Ones"
4. Sexually Transmitted Infection Framework and Guidelines (2006)
5. Framework for Advocacy on Challenges Facing PLWHA in SADC (2006)
6. HIV and AIDS Mainstreaming Guidelines (2007)
7. SADC HIV and AIDS Surveillance framework (2008)
8. Regional Research Agenda (2007);
9. HIV Prevention Strategy (2008);
10. Partnership Framework guiding cooperation between NAAs and Civil Society Organisations (2008);
11. Harmonisation and Alignment framework for HIV and AIDS funding (2008)
12. Framework on Care and Support of OVC and Youth (2008)
13. Sexual and Reproductive health Strategy (2008);

4.1.3 Mainstreaming of HIV and AIDS in all policies and programmes of SADC

The previous Framework set out plans of action for each Directorate in the Secretariat to establish focal points and mainstream HIV and AIDS into relevant sector plans and implementation. Table 2 summarises performance against planned objectives in this area for DHSD and other directorates.

Table 2: SADC Performance in HIV and AIDS mainstreaming

Planned Objectives	Status	Achievements (at Jan 2009)	Outstanding or further actions needed
Plans for each Directorate on key areas of HIV and AIDS; manuals on integrating AIDS in core programs	Partly Achieved	✓HIV and AIDS Mainstreaming Guidelines (2007)	- Updated plans, implementation needed
Action Plans for the HSD Directorate of SADC	Achieved	✓Work-plans in place. Ongoing activity	
Facilitate mainstreaming HIV and AIDS into core sectoral programs	Partly achieved	Mainstreaming in Directorates and related sectors has not been systematically facilitated or monitored. But some progress in is known in related sectors: • Border control reforms reducing HIV risk (TIFI; I&S) • Mining and transport industry responses (TIFI; I&S) • Corridor projects (I&S); • Military programmes (OPDS) • Mobile populations (TIFI; I&S)	Framework issues to take forward - M&E of Directorate and sector responses - Impact/vulnerability research and M&E (I&S; TIFI; FANR) - Resource mobilisation (TIFI) - Drug procurement and production (TIFI) - Studies on e.g. tourism sector - HR capacity development (FANR: other) - Food security(FANR)
SADC personnel policy and programme for HIV and AIDS	Partly achieved	✓Policy drafted	- Policy to be reviewed and program implemented

Planned Objectives	Status	Achievements (at Jan 2009)	Outstanding or further actions needed
Coordinate and monitor MS implementation of SADC Workplace Code of Conduct	Not done		- To be carried forward
Support programs reducing women's vulnerability by improving social and economic status	Partly achieved	✓Gender Unit established; project gender expert in place (2008)	- Operationalise support

Limited information is available to assess the extent of mainstreaming at MS or regional level. Activities in several of the Directorates and associated sectors have incorporated HIV and AIDS. However, mainstreaming has been difficult to operationalise and there has been very little coordinated implementation of Directorates' HIV and AIDS mainstreaming activities that were proposed under the previous Strategic Framework, either for programmes or secretariat staff. Important exceptions include the development of the Framework on care and support of OVC and Youth (2008), which has helped to clarify the roles of HIV and AIDS programmes, education, health, welfare and other sectors. Dialogue also started on mainstreaming at secretariat level between the HIV and AIDS Unit and Education to build on previous action in education sectors.

Mainstreaming of HIV and AIDS and gender across sectors remains an important area for further action. Impediments to progress will need to be assessed and addressed in the coming period.

4.1.4 Capacity building

Capacity building was intended to have a particular focus on mainstreaming in all policies and processes, including RISDP components and workplaces, as well as M&E of HIV and AIDS programmes. Achievements include development of materials and training of trainers from 14 MS in mainstreaming HIV and AIDS in various sectors. All trained MS developed roll-out plans for a cascading effect of the training but have had no specific resources to roll them out. Support was provided for mainstreaming in the Education, Employment and Labour sectors, and a M&E capacity development strategy has also been developed. However, capacity development to enable the Secretariat to mainstream more effectively has only been partly implemented.

Table 3: SADC progress towards capacity building objectives

Planned Objectives	Status	Achievements (at Jan 2009)	Outstanding or further actions needed
Enhance understanding of HIV and AIDS and development in SADC Secretariat and develop skills in policy and programming	Not done		- To be carried forward
Enhanced understanding of HIV and AIDS among key Ministries i.e. Education, Labour, Health	Partly achieved	✓Training of trainers done	- Roll-out training to be done

Education and awareness raised in HSD Directorate on links of HIV with substance abuse	Not done		Consider in new activities

Specific capacity development objectives under the framework were thus implemented to a limited extent (Table 3). However, networking activities and system development in various areas has contributed to development of skills and capacity. In addition, specific plans for capacity development in new priority areas such as harmonised policy implementation have been developed and can be operationalised under the new Framework.

4.1.5 Facilitating a technical response through technical discussions, guidelines and sharing of best practices in key areas

Support to facilitate implementation of regional policies and frameworks has become an increasingly prominent need. SADC has begun to operationalise the SADC Framework on documenting Best Practices by following up MS documentation of best practices in their countries with training for representatives of MS. Sharing of Best Practices has been an important agenda item in the annual meeting of Directors of National AIDS Authorities. Documentation of learning from pilot initiatives under the SADC HIV and AIDS program was produced, and guidelines have also been developed in various areas (including STIs and aspects of M&E).

4.1.6 Facilitating Resource networks

Improving networking between regional resources involved a number of regional activities. For coordination of regional activities and to draw on available technical expertise, key *consultative and decision-making mechanisms* were set up, that include meetings of the JFTCA, the Forum of National AIDS Authorities, HIV and AIDS Technical Advisory Committee (TAC) and Regional Partnership Forum (RPF). Other important regional activities included the meeting of the expert think-tank on HIV prevention in 2006, which has been influential in shaping the response across MS. The establishment of the SADC Research Database and Information Portal facilitated sharing of key information. SADC has also begun to play a role in facilitating more effective collaboration between NAA and Civil Society, in line with the agreed Partnership Framework.

Key achievements in facilitating the technical response and facilitating of networking are summarised in the Table below.

Table 4, Progress towards facilitating a technical response and resource networks

Planned Objectives	Status	Achievements (at Jan 2009)	Outstanding or further actions needed
Support to research networks in SADC; Exchange of information	Achieved	✓SADC Framework on documenting Best Practices; training of MS representatives ✓Facilitating best practice in NAA and Civil Society collaboration. ✓Guidelines in various areas e.g. STIs; M&E ✓Documentation of learning from SADC pilot HIV and AIDS initiatives	- To be continued

Coordination of regional activities on HIV and AIDS	Achieved	✓Annual meetings of NAA; HIV Technical Advisory Committee; Partnership Forum ✓Other discussions, workshops, exchange of information between partners ✓SADC Research Database and Information Portal and database.	-
Develop a regional response to HIV and AIDS through networks in the thematic/ sectoral areas	Achieved in priority areas	✓Expert think-tank meeting on HIV prevention (2006); Prevention Technical Working Group in place ✓Regional partners worked together to develop SADC regional indicators.	- Networks in other thematic and sectoral areas to be considered
Facilitate appropriate research to inform policy	Achieved	✓Regional Research Agenda (2007);	- Need agenda updates and ongoing results dissemination

4.1.7 Monitoring and Evaluation

SADC M&E initiatives are intended to facilitate harmonisation of M&E activities, and effective tracking and reporting on regional progress in implementation of regional, continental and global HIV and AIDS commitments.

Since key M&E staff were recruited to the Secretariat HIV and AIDS Unit from late 2007, the information gathered is beginning to inform policy and strategy development across the region. A number of important SADC HIV and AIDS regional documents have been produced.[15] They are helping to operationalise the SADC HIV and AIDS M&E Framework (2006) in order to monitor progress as well as identify opportunities for SADC assist in strengthening performance.

Table 5; Progress towards monitoring of global and regional commitments

Planned Objectives	**Status**	**✓Achievements (at Jan 2009)**	**- Outstanding or further actions needed**
Development of a M&E Plan on HIV and AIDS for SADC	Achieved	✓M&E of Business Plan.	- Limited M&E of Framework or Directorate responses
Review performance in achieving global and regional targets, UNGASS, MDG and Abuja	Achieved	✓SADC Epidemic Report ✓SADC HIV and AIDS Surveillance Framework (2008) ✓Annual and other meetings	- M&E quality to be refined

4.1.8 Resource Mobilisation

The Framework identified resource mobilisation as a priority and a resource mobilisation plan was developed. An estimated $10.5 million was required to support activities of the Secretariat, excluding further regional activities to be implemented by MS. A notable achievement was innovative resource mobilisation and management in the form of joint

[15] In 2008 alone, documents that were finalised included: Indicator Guidelines; Management Information System Guidelines; the M&E Capacity Building Plan 2007-2009; the 2006 SADC HIV and AIDS Epidemic Report; the SADC HIV and AIDS Research Agenda; and the SADC Harmonised HIV and AIDS Surveillance Framework.

financing by a group of donors through the JFTCA. This provided $5.5 million to support action by the secretariat. Other contributions were made by the EU, ADB and DFID to support activities of the SADC HIV and AIDS programme. A total of over $15million was raised during the period, and in addition MS have funded two HIV and AIDS Unit posts.

In addition to mobilising resources for the secretariat, an autonomous Regional Fund was established under the Framework, to raise resources for national and regional responses from MS, the private sector and ICP. By March 2009, MS had contributed $ 533 000 to the Fund.

Table 6; Progress towards resource mobilisation

Planned Objectives	Status	Achievements (at Jan 2009)	Outstanding or further actions needed
Resource mobilisation for HIV and AIDS programmes and health sector for delivery of HIV and AIDS services	Achieved	✓Regional AIDS Fund Established and committed MS contributions;	- HIV Economics & Finance Reference Group being established - To be carried forward
Resource Mobilization Plan on HIV and AIDS for Secretariat	Achieved	✓Plan in place ✓Over $ 15 million raised for activities	- Need to update plan

In sum, many of the regional initiatives still require further follow-up support and monitoring to consolidate them and to act on the opportunities created by putting various Policies, Frameworks, Strategies and guidelines in place. A challenge to SADC is to increase its ability to facilitate implementation and increase adherence of MS to agreed commitments. New needs have also emerged, and limitations on the approach, capacity and systems assumed under the previous framework have been recognised.

4.2 National Responses – Progress, gaps and challenges

SADC Member States have been implementing HIV and AIDS programmes for some time, in certain cases since the mid-1980s. The initial response concentrated mainly on health-related aspects of the epidemic. However, from the 1990s, the scale and sophistication of responses increased and commitment to address the HIV epidemic became much stronger in MS governments and civil society. Some of the key developments in national responses in SADC over the last decade have included:

- *New structures and systems* to guide multi-sectoral responses.
- More *multi-sectoral approaches*, with integration of HIV and AIDS into planning around poverty, national development and other sectors such as education.
- Increasing consideration of *human rights, gender and concerns of PLWHA*.
- Availability of *better information and understanding* of the epidemic's, impact and effective responses, which allows for more evidence-based planning and management.

Strengthened national responses across the region have contributed to notable results. However, some important challenges still remain and the regional programme can assist in addressing them.

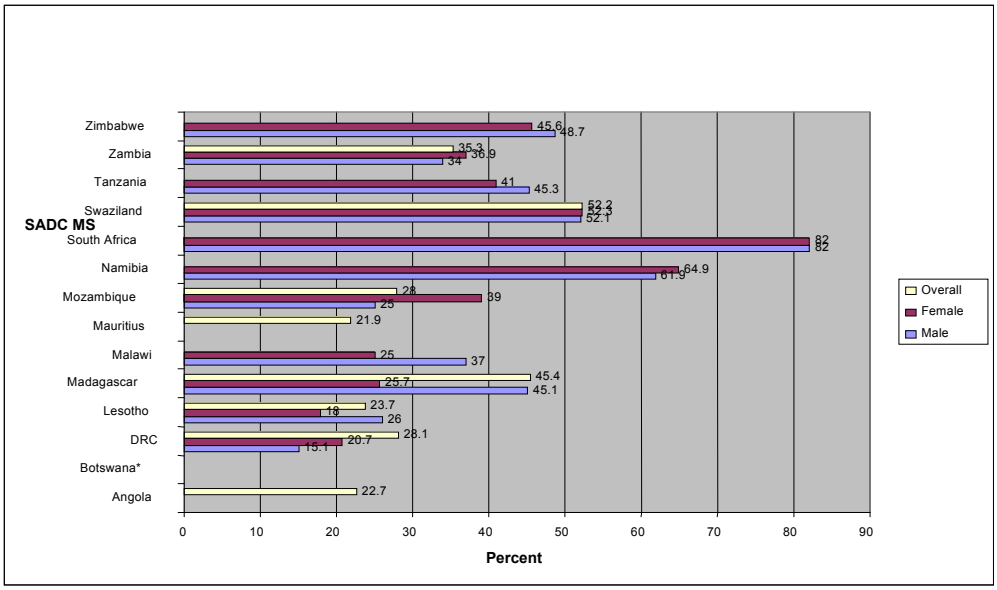
4.2.1 Prevention

There has been substantial progress in many areas of HIV prevention, but so far results are

still mixed across MS. Several key indicators of progress in prevention are being tracked by SADC MS and indicate the following achievements and limitations of responses.

- *HIV infection levels among 16-24 year olds* show some reduction in new infection rates, as discussed above. But MS are also at very different levels of response and outcomes, and much remains to be done to reach MS targets.
- Generalisations about regional trends in sexual risk behaviour are difficult to make due to limited data. However, behaviour change communication has facilitated *changes in behaviours* such as multiple partnerships, condom use and early sexual debut in some MSs, even if this has not always manifested clearly in HIV infection levels so far. But in others, it seems to have had marginal effects. Even *knowledge about HIV and AIDS seems limited.* Only three MSs reported that more than half of young adults could both correctly identify ways of preventing sexual transmission and reject major misconceptions about HIV transmission (
- Figure 1).
- *Condom access and use* have increased markedly in some MS. However, there is an ongoing challenge to improve levels and consistency of condom use, and reliable condom access.

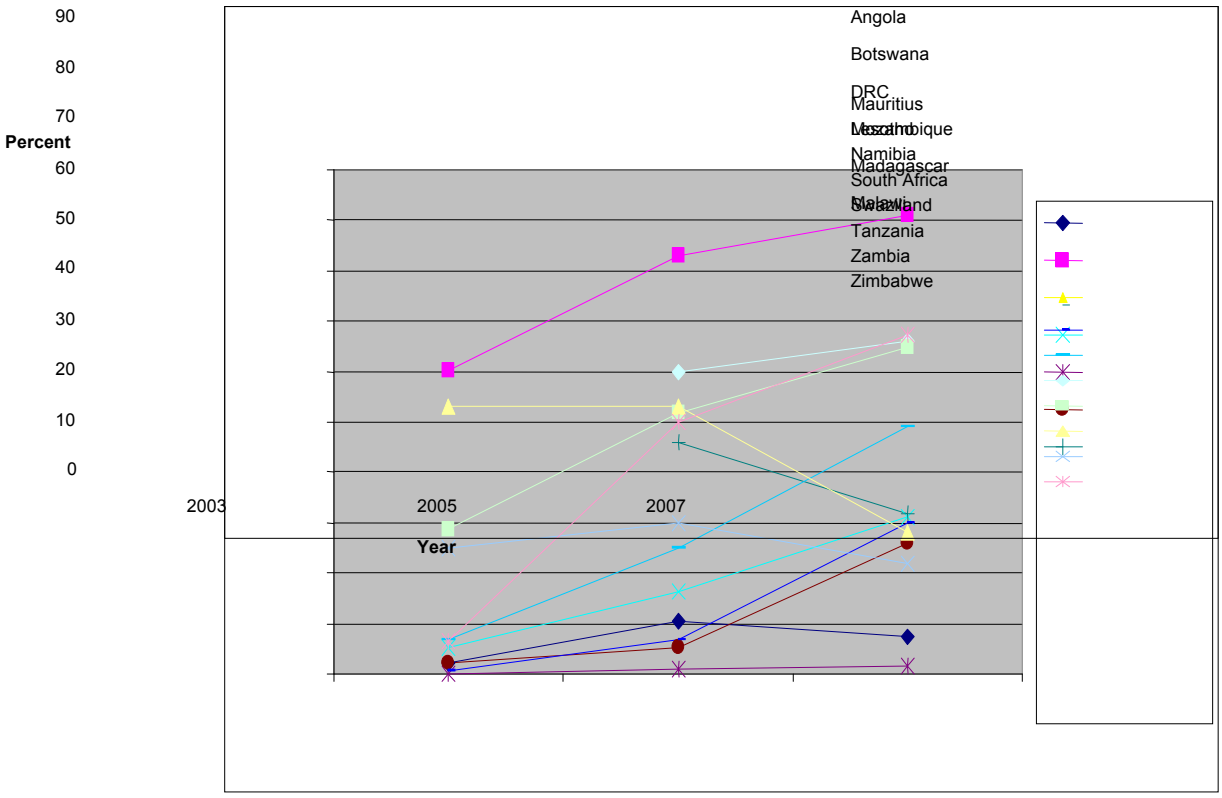
Figure 1: Percentage of men and women aged 15-24 who both correctly identify ways to prevent sexual transmission of HIV and who reject major misconceptions about HIV transmission in 2007.



*Source: SADC Member States HIV and AIDS Epidemic Reports, 2007; * Data not available*

PMTCT is one strategy that seems to have achieved clear results in MS. Nine reported increased coverage between 2005 and 2007 and the regional trend was upward. Universal Access targets seem to be attainable in several MS, despite quite ambitious targets and low coverage in some of them.

Figure 2: Uptake of PMTCT of HIV in the SADC region 2003-2007



Source: SADC Member States HIV and AIDS Epidemic Reports, 2007

HIV Testing and Counselling has expanded hugely, with over one in five adults testing for HIV in some MS in 2007. But access and uptake remains limited and uneven. Furthermore, recent studies suggest that testing and counselling may not lead reliably to safer behaviour, particularly among those who test HIV negative. So it may best be considered to be an intervention to boost treatment uptake.

Prevention responses - priority challenges and gaps

Progress in HIV prevention has been much more limited than in many other aspects of the HIV and AIDS response. This is a serious concern considering the human cost of new infections, and also the challenges for financing and sustainability if the number of people requiring therapy continues to climb unabated. Efforts must intensify if the region is to reach the MDG goal of halting and beginning to reverse the spread of HIV and AIDS by 2015. Additionally, the region must rise to the challenge of achieving the UNGASS target of a 25% reduction in HIV prevalence in young people, while also reducing infection rates in other at-risk groups.

The regional HIV Prevention Strategy identifies a number of areas for action and the Secretariat needs to act urgently to facilitate its implementation.[16] Prevention efforts need to adopt an evidence-informed, mutually reinforcing combination of approaches to the various drivers of the epidemic. These have to prioritise both proven strategies and adoption of new approaches.

[16] For details see: SADC Regional Strategy and Action Plan for Universal Access to Prevention 2008–2010.

Specific challenges of MS that are of particular relevance to regional action include the following:

- Comprehensive *social mobilisation* for HIV prevention, to address issues such as ongoing *denial, lack of openness and stigmatisation* in many MS. This requires leadership as well as other interventions to ensure effective advocacy and mobilisation on HIV and AIDS issues.
- More *evidence-based prevention* programming and *capacity to plan, manage and implement* evidence-based programmes. This also requires improved availability and use of strategic information on issues such as *drivers of the epidemic and effectiveness* of interventions.
- Need to incorporate *key emerging issues and knowledge* into MS responses. These include:
  - *Multiple and concurrent partnerships* (MCP) and *low rates of male circumcision* (MC). These need to be prioritised. However, continued emphasis on a comprehensive prevention package including behaviour change and social mobilisation is particularly important to avoid the potential complacency due to greater availability of ART and MC, and lack of understanding of the impact of MC on the risk of infection for women.
  - *Positive prevention* programmes to reach PLWHA and discordant couples more effectively
  - *Integration of prevention into other services*, including ART and reproductive health.
  - Developing appropriate responses for *specific groups at high risk* in MS. These may include young women, mobile and displaced populations, uniformed forces, IDU, sex workers, prisoners and sexual minorities. There is still limited information on marginalised and vulnerable groups, the nature of their vulnerability and how to develop appropriate policies and programmes at regional or MS level.

- Improving *quality assurance* of prevention, including managing external or ideological driven initiatives that conflict with key evidence-based messages or cultural contexts.
- Reducing *fragmentation of efforts*, competition for resources and limited sharing of learning.
- A limitation in the M&E framework is lack reporting of trends in children which needs to be addressed

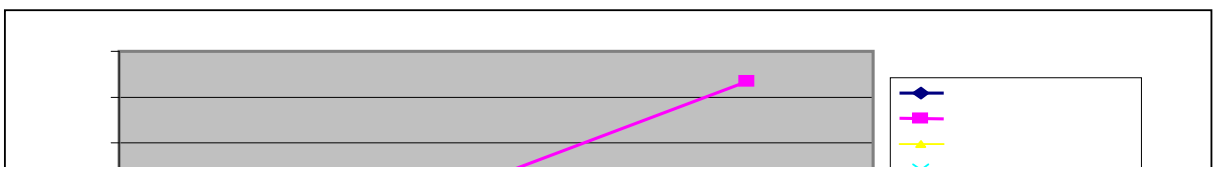
4.2.2 Treatment, care and support

There has been remarkably *rapid expansion of ARV treatment* in the region. In 2006, MS agreed to the UNGASS target of generalised access to treatment and care by 2010. Twelve MS reported an increase in coverage between 2005 and 2007 and the increase in coverage ranged from around 30% to about 114%. Four SADC MS reported ARV coverage above 40% in 2007, although ARV uptake in the region ranged from 11% to 83% (

Figure 3).

Improved access to ARV treatment and expanding PMTCT programmes has *sharply reduced HIV-related mortality*. Improved family sustainability and lower workplace impact have been reported, and it is estimated that achievement of universal access to ARV treatment by 2015 could reduce the number of AIDS orphans in sub-Saharan Africa by 4 million. Favourable cost-benefit outcomes of ART programmes have also been shown in countries such as Botswana.

Figure 3: ART Uptake in the SADC region 2003-2007



Source: SADC Member States HIV and AIDS Epidemic Reports, 2007

Despite great progress, many MS are expected to struggle to achieve the coverage required to meet their UNGASS targets for ART. Member states report that *paediatric AIDS treatment programmes* are still relatively under-developed, and that there are also significant *gender differences in access,* with women exhibiting higher uptake than men[17].

New challenges are emerging such as TB/HIV co-infection, multi- and extreme drug resistant TB, and increasing needs for more expensive and complex second or third line ARV therapies. Furthermore, even if coverage is high, HIV and AIDS and TB/HIV co-infection morbidity and mortality are expected to remain at significantly high levels in many countries, due to treatment failures and limited uptake.

Treatment, care and support - gaps and challenges

Treatment, care and support are rapidly evolving areas and weaknesses in any MS can have implications for others. Prominent challenges in the next 6 years, with which regional responses can assist, include the following:

- Scaling up coverage on a large scale, while maintaining adequate quality in the context of health systems that are already very stretched.
- Ensuring reliable, affordable *access to ART, Cotrimoxazole and other essential drugs* and commodities by MS including access for children. Regional roles will be essential to ensure implementation, monitoring, evaluation and refinement of the SADC Pharmaceutical Business Plan 2007-2013.
- Improving *Human Resources* capacity and *increasing financial resources* to tackle two key constraints on sustained scale up. SADC can build on its current regional HR capacity development initiative for HIV and AIDS and health, to address issues such as training, staff retention, and migration, efficient use of staff, and harmonising policies and programs across MS.
- Using the potential of HIV and AIDS resources for *health systems strengthening (HSS)*. For example, HIV and AIDS inputs can strengthen core system infrastructure such as laboratories, training for health workers, piloting of new staffing models, and procurement systems. There are opportunities for SADC to assist MS to identify and learn from innovative ways to tackle HSS, building on actions that were partially implemented under the previous Framework.

[17] Reasons probably include behavioural factors and more limited availability of service entry points for men.

- *Integrating HIV and AIDS "vertical programmes"* with other services. This is needed to improve access, and avoid negative effects of vertical programmes such as a skewed or inefficient use of resources. Key areas to consider include TB and Reproductive and child Health services.
- Coordination with other sectors, programmes and communities around issues such as *food security and nutrition* for people on ART, stronger *community based care and support of carers*
- Access to services for key groups such as *mobile and regionally displaced populations.* This has been recognised as a particular area for SADC action.
- Scaling up *treatment literacy and community mobilisation* to reduce stigma and discrimination and other obstacles to accessing effective care.

4.2.3 Accelerating development and Impact mitigation

Over the last decade MS have pursued a range of social and economic policies to accelerate socio-economic development, and tackle factors such as poverty, food insecurity and gender imbalances that make populations more vulnerable to HIV and AIDS. A number of MS have made progress in mainstreaming of HIV and AIDS into *non-health sector programmes*. Limited data is available to assess the scale or effects of this, but most MS have at least begun to integrate HIV and AIDS issues into key sectors such as education, welfare, labour and criminal justice. *Workplace programmes* have been implemented by many private and public sector employers across the region, but coverage is still limited in public services and small businesses in particular.

Some member states have also integrated HIV and AIDS into *national development plans and poverty reduction strategies*. Broader initiatives in areas such as social protection and food security, have simultaneously addressed HIV and AIDS vulnerabilities in various. Some of these initiatives have benefited from increasing interest and resources unlocked by HIV and AIDS.

Various large initiatives in recent years have targeted *orphans and other vulnerable children and youth (OVCY)*. The majority of member states have developed National Action Plans on OVCY. Responses have differed between MS, but have often included support in accessing education and health care, community based initiatives and social grant systems. Nevertheless, the 2007 SADC HIV and AIDS Epidemic Report found that, of the eight MS that submitted data, in only two did more than 50 % of OVCs' households report that they received free basic external support in caring for the child. Most MS are yet to fully address the problem of OVC. Social protection and social security will probably be built gradually, based on longer-term national action plans.

The picture at national level is therefore mixed. The humanitarian and development threat caused by HIV and AIDS in the region has not gone away, the developmental potential of children and youth is at particular risk, and access to social protection is low in most MS. The situation does however have many positive elements, including a spirit of leadership in many MS that is driving the national response.

Impact mitigation and accelerating development - prominent challenges and gaps

A number of issues need to be tackled by many MS in the years to 2015 in order to mitigate impacts of HIV, AIDS and TB/HIV co-infection, and support faster development.

A particular need affecting MS, and the region as a whole, is to *systematically consider the opportunities and risks related to the RISDP*. The pace of implementation of SADC's regional integration and other RISDP initiatives is expected to increase in the years to 2015.

The overall effects should be greater efficiency, human resources and economic development, and reduction in poverty and food insecurity, which can help to reduce HIV and AIDS vulnerabilities.

These opportunities have not yet been acted on by SADC Directorates and sectors. Furthermore, some RISDP initiatives could *increase* the vulnerability of certain groups in the short run. Some communities may, for example, face local poverty or pressure to migrate due to economic adjustments. Requirements for macroeconomic discipline, as well as greater mobility of skilled personnel, may also be a challenge for MS health programmes.

Other specific issues for consideration include the following:

- Need to *maintain adequate emphasis on multi-sectoral aspects of the response* in the face of renewed prominence of health sector and biomedical interventions (e.g. ART, CTX, PMTCT, MC).
- *Movement from policy to implementation* - there has not yet been large scale, quality implementation to follow social protection commitments, policies and plans in many MS.
- *Clearer definition of sustainable, effective and harmonised OVCY interventions.* Many responses in MS are fragmented, and social protection strategies are often not well defined. Most NPA's give inadequate guidance on standardised, systematic and adaptive approaches to OVC service delivery. The Framework and Plan of Action Plan on OVCY (2008) is a key opportunity to address the lack of a regional OVC programme and inconsistent MS approaches.
- *Community coping and care of carers for OVCY and the sick* have received limited attention, although over-extension of family, community and carer capacity is widely reported.
- Limited *financial and other resources, including welfare sector staff,* to ensure adequate coverage and sustainability of social protection on the scale that is required.
- Major constraints in p*rogramme management capacity*, which weakens programme and project at MS and regional level.
- *Stigma and discrimination.* Infected and affected people need protection within communities and when policies or legislation are being considered in areas such as testing, sex work and criminalisation of HIV transmission.
- Challenges to extend access to *workplace programmes* in the formal and informal sectors.
- Inadequate *monitoring and evaluation* of vulnerabilities and responses. Lack of standardised definitions in key areas of the OVCY response has been a particular impediment.

Several challenges and opportunities for impact mitigation arise specifically at the regional level, which include the following:

- *Integrating HIV, AIDS and TB/HIV co-infection with poverty reduction and food security initiatives under the RISDP.* The combination of HIV and AIDS with food insecurity due to other stresses threatens the livelihoods of many households and communities in MS.[18] People on ART need adequate food and nutrition for successful treatment. At the same time, poor access to food due to household impact of HIV and AIDS, or factors such rising food prices, also increases exposure to higher risk "survival" sex, thereby undermining prevention. The SADC Declaration on Poverty Eradication and Sustainable Development (2008) presents an opportunity to address this.
- *Action to address the needs of mobile populations including children*. Population mobility and migration between or within MS are key issues for SADC, as regional action has several advantages over individual MS initiatives. In addition, migration due to regional economic development, e*mergencies* due to natural and man-made disasters, and p*eacekeeping and electoral monitoring* activities can all increase vulnerability to HIV and AIDS.

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[18] Vulnerability Assessment Studies in some MS in 2003 confirmed that the most vulnerable households are those headed by children or grandparents when parents die of AIDS.

- *Stronger monitoring of vulnerabilities and responses related to HIV and AIDS* as part of the RISDP programme. There is a need to address limited information and systems for identifying the linkages between RISDP initiatives and HIV and AIDS-related opportunities and risks.
- *Integration of gender and HIV and AIDS mainstreaming*. The new Framework can use opportunities for pooling capacity and synergy between gender and HIV and AIDS mainstreaming at regional level, in order to be able to cover all relevant sectors and issues

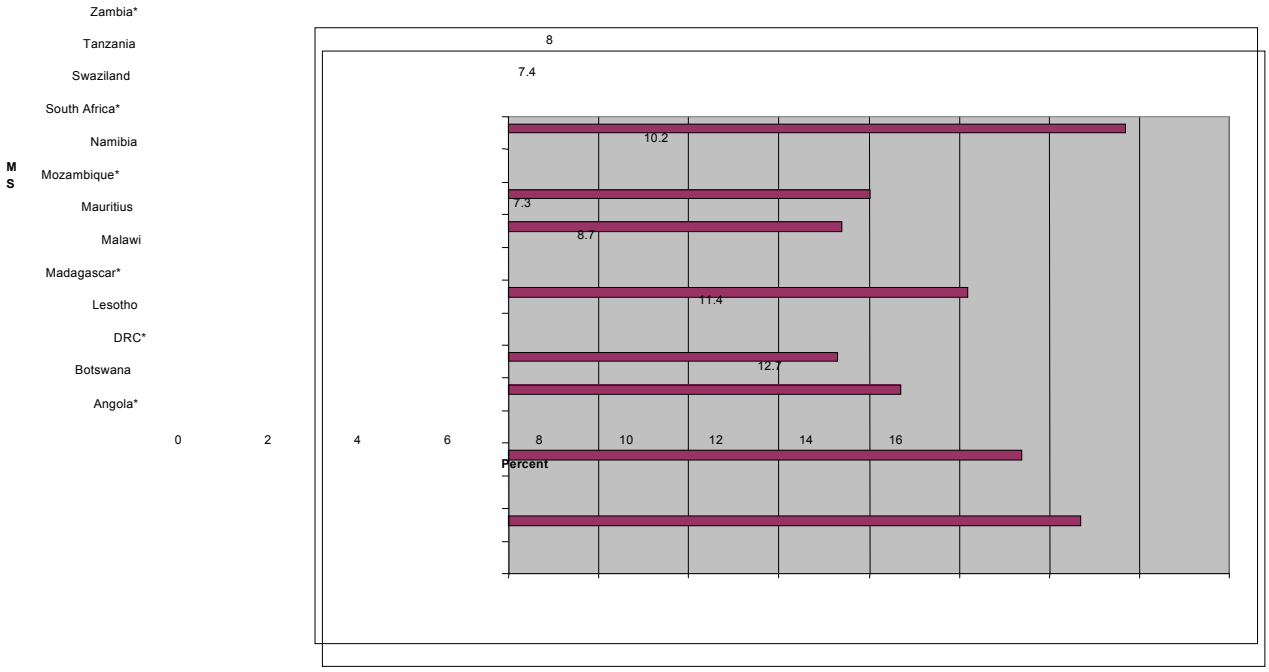
4.2.4 Resource mobilisation

Member states require very large financial and other resources to maintain and expand priority HIV and AIDS programmes. The 2008/9 global economic crisis has highlighted the central importance of resource mobilisation to sustain the response in the medium and longer term, and ensure that gains in prevention, treatment and impact mitigation are not reversed.

Tracking of the financial resources that are available to MS responses is still hampered by limited country-level information, but it is clear that total resources increased dramatically in the decade up until 2009. Increasing numbers of Member States have *raised national budgetary contribu*tions to health and HIV and AIDS. In countries such as Botswana and South Africa the national budget has been a major source of funding. However, data from SADC MS show that in 2007, many are still far below the target of 15% of national budgets going to health, to which they committed themselves in the Abuja Declaration in 2003. Two MSs reached this target in the past but they have not been able to sustain these levels. Zimbabwe has used an AIDS Levy to raise extra funding, and in some countries, the private business sector and faith based institutions have also made important contributions to resources for HIV and AIDS programme capacity.

International partners have played an important role in expanding access to HIV and AIDS services, as well as in developing models for treatment, and support to health care systems. Various bilateral and multilateral partners have provided assistance to SADC MS, including the Global Fund for AIDS, TB and Malaria, UN agencies, the World Bank's MAP Programme and the Presidents Emergency Plan for African Relief (PEPFAR). The importance of various partners to MS as well as the mechanisms and requirements for support, have changed over time and continue to evolve.

Figure 4: Percentage of national budget committed to the health sector by SADC MS (2007)



Source: SADC MS HIV and AIDS Epidemic Reports, 2007; * = data are not available

Resource mobilisation - priority challenges and gaps

Resource mobilisation and sustainability are areas of increasing urgency. The 2008 Framework on Harmonisation and Alignment identifies needs and opportunities for regional action to facilitate better resource mobilisation and use by MS. Implementation of the Framework and innovative support to MS will be critical to ensure that adequate resources are available, and that key ODA systems support MS HIV and AIDS responses as effectively as possible from 2010.

Challenges highlighted in relation to MS resource mobilisation for HIV and AIDS, include the following:

- Persistent *gaps in programme coverage; and between available resources and resource requirements* for HIV and AIDS and health, from both domestic and development partners.
- Need to ensure the *medium to longer term sustainability of programmes and funding* on the scale required by MS epidemics. MS need to consider how to ensure that HIV and AIDS remains a priority, that resource use is more efficient and prioritised; and that alternative and innovative sources of finance are sought.
- Limited *harmonisation and alignment of development partner systems* with each other or national systems. This has resulted in problems such as diluted national ownership and authority, duplication and inefficiency, and weaker M&E.
- Capacity and systems limitations that *impede efficient management and use of financial and other resources*, and broader difficulties of absorptive capacity
- Limited information on resource requirements and expenditure or resource use

Priority opportunities for SADC in the coming period will include fully operationalising the *Regional Fund for HIV and AIDS* new mechanisms such as the HIV Economic and Financial Reference Group, and developing resource mobilisation strategies for *hyper endemic middle income countries.*

4.2.5 Institutional capacity and M&E

The HIV and AIDS epidemic has required large scale expansion or development of programmes, structures and systems. This places huge new demands on institutional capacity in health and other sectors in MS, which was already limited and then eroded further by losing staff to AIDS.

Member States have committed to the principles of the "*three ones*"[19] and most have made progress in developing unified National Strategic Plans for HIV and AIDS, M&E systems and coordinated National AIDS Authorities. Most MS have established *increasingly effective NAA capacity* and ways to coordinate across key national stakeholders such as NACs, MOH's and CCMs. A feature of many national responses has been the increasing interaction between NAAs and *civil society organisations*.

Monitoring and evaluation systems have strengthened considerably and have allowed MS to track with increasing reliability the performance in key areas of their national programmes, and key commitments such as UNGASS and Universal Access. However, M&E is almost universally seen as an area where capacity and systems have to be strengthened and streamlined at national and decentralised levels in MS.

Monitoring and Evaluation Priority Challenges and Gaps

- Stronger *M&E systems and capacity* to track performance and promote MS adherence to national, continental and international commitments, enhance programme management and adequately reflect gender issues.
- Improved, *evidence-based planning* at NSP and other levels to enhance prioritisation and performance of programmes, and facilitate resource mobilisation
- Streamlining further the *structures and roles of National AIDS Authorities*, Ministries of Health and Country Coordination Mechanisms in order to optimise coordination and performance.
- Strengthening *technical and managerial capacity and leadership* to enhance programme performance and sustainability, and limit longer term requirements for external support.
- Streamlining of *partnerships with civil society and the private sector* to strengthen collaboration and facilitate optimal contributions of each sector in national responses.
- Regional action under this Framework can continue to facilitate ways to overcome *country level limitations* in institutional capacity, systems, M&E and coordination. However, within the *regional programme itself*, key constraints have also been highlighted.
- *Planning must be realistic and prioritise the achievement of key results.* Demands from partners and MS, combined with a large number of activities, made it more difficult for the previous SADC programme to be sure of achieving outcomes.
- *Institutional capacity limitations* must be addressed. The previous Framework encountered challenges in filling *technical positions*, and in capacity for *programme planning and management* in the secretariat and MS programmes. Particular limitations of the Focal Point system, and of *leadership, authority and systems,* undermined mainstreaming in other Directorates.
- *Improved M&E*. The SADC Surveillance Framework has already identified ways to improve quality of information. M&E of the SADC programme itself also needs to be consolidated.
- *Consistent tracking of the response among children*. The current M&E does not include children and this should be urgently addressed.
- *Improved use of information.* A particular challenge is to develop ways to use information and advocacy more effectively to improve performance of SADC and MS programmes.

5. Guiding Principles

[19] One national authority to coordinate a multi-sectoral response; One national action framework; One country M&E system

The regional response analyses, as well as emerging issues and trends in the region have informed the development of the following guiding principles.

5.1 Comparative advantage

In planning HIV and AIDS activities and programmes organisations should have regard to their respective comparative advantage. In particular, regional and development partners' actions should support and enhance national efforts and be in harmony with MS needs, priorities and responses. Regional actors such as the secretariat should focus on areas where MS action can support MS to achieve their goals, and should not replace MS action.

5.2 Multi-sectorality and partnerships

The policies and programmes will be based on a multisectoral response to HIV and AIDS, and will ensure effective collaboration between government, civil society, development partners and other sectors to use their comparative advantages to facilitate a stronger MS response.

5.3 Gender sensitivity

Gender sensitivity must be ensured in all HIV and AIDS policies and programmes. The majority of people living with HIV and AIDS in the region are women and the social and economic status of women increases their vulnerability to HIV and AIDS. Gender is important to address equality in access for males and females, and participation and control over resources for HIV and AIDS. Issues of gender are critical in understanding the key role that women play in the economies and societies of SADC countries, and how HIV and AIDS undermine their capacity. Women provide most of the agriculture labour, bring up and socialise children, and pass essential skills to the next generation. The role of men, and need to involve them in addressing these issues, is recognised.

5.4 Evidence based and contextual relevance

Responses by SADC and its member states should be based on evidence of what works and on sound data for designing more effective prevention and impact mitigation initiatives. The interventions should also fit the contexts of MS and their communities in order to be effective.

5.5 Respect for human rights

Policies and programmes must be based on the promotion, protection and respect for human rights of people who are infected and affected by HIV and AIDS; as well as those of uninfected people. Countries need to domesticate international and regional human rights norms and principles in national policy and legislation to provide the backbone of a rights-based response.

5.6 Participation

Meaningful participation, particularly by people living with and affected by HIV and AIDS, is imperative in policy development and programme delivery. Input of all MS, all relevant sectors and all segments of citizenry, particularly members of marginalised groups, is also essential for ensuring effective HIV and AIDS responses.

5.7 Transparency and accountability – transparency and accountability between MS, between SADC, international cooperating partners and the partnership forum when it comes to programming, resourcing, monitoring and evaluation of the national responses and cross border initiatives are imperative. This includes subjecting MS to peer pressure in

holding each other accountable for their national responses and domestic spending on AIDS.

6. SADC Vision, Goal and Objectives of the Strategic Framework on HIV and AIDS 2010-2015

Below are the vision, mission, goal and objectives of the SADC Strategic Framework for 2010– 2015. Based on gaps identified in regional and MS responses, priority outcomes and actions have been identified. Objectives are aligned with the priority areas of the Maseru Declaration. The desired outcomes and proposed actions have been prioritised by stakeholders in a consultative process; and are based on assessment of the regional comparative advantages in addressing them. Regional level priorities will be operationalised in the approved strategic intervention areas of the SADC Secretariat that include Policy and Strategy development and harmonisation; Mainstreaming HIV and AIDS; Capacity development; Facilitating a technical response and resource networks; and Research, and Monitoring and Evaluation of regional and global commitments. The SADC HIV and AIDS Business Plan 2010 – 2015 will detail how the priorities will be operationalised.

6.1 Vision

A common future with no threat of HIV and AIDS to public health and to sustained socio-economic development in the region

6.2 Mission

The SADC region controls and reverses the HIV and AIDS epidemic and its impacts as shown by the achievement of the Millennium Development Goals and Universal Access commitments by 2015

6.3 Goal

All member States demonstrate a 50% reduction in the rate of new infections to half of the 2008 levels and mitigate concomitant impacts by 2015

6.4 The five main objectives include:

1. *All member States deliver on their universal access to prevention targets by 2015*
2. *All member states deliver on their Universal Access targets to achieve access to quality treatment for people living with and affected by, HIV and AIDS and TB/HIV co-infection by 2015*
3. *Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.*

4. *Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response to HIV and AIDS in the SADC region that channels resources efficiently to operational and community level.*

5. *Enhanced institutional capacity in the region supports evidence-based programme design, implementation, monitoring, reporting and evaluation at regional and MS levels to ensure ongoing progress towards regional, continental and global commitments*

6.5 Outcome results

There are 12 outcome results spread across the five objectives defined by relevant thematic areas. These outcomes are tabulated below:

Table 7: Outcome results

Thematic area	Objectives	Outcome results
Prevention and social mobilisation	*1. All member States deliver on their universal access to prevention targets by 2015*	1.1 Strong and proactive political leadership and champions drive the HIV and AIDS response and social mobilisation around HIV prevention and other priorities from 2010. 1.2 All MS have in place effective, evidence-based and coordinated responses to HIV prevention needs of men, women, youth, children and other populations at particular risk by 2015.
Improved Access to Care, Counselling, Treatment and Support	*2. All member states deliver on their Universal Access targets to achieve access to quality treatment for people living with and affected by, HIV and AIDS and TB/HIV co-infection by 2015*	2.1 The SADC region is able to meet universal access to effective HIV, AIDS and TB treatment, care and support and MDG targets by 2015. 2.2 MS health systems and services are scaled-up to address HIV and AIDS, TB/HIV co-infection and other health priorities by 2015 2.3 Access to quality HIV and AIDS, TB and other essential drugs, medical supplies and technology is sustained from 2010
Accelerating development and mitigating impact of HIV and AIDS	*3. Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.*	3.1 An enabling environment that supports infected and affected people, including children, and that protects them against HIV and AIDS stigma and discrimination in place by 2015 3.2 HIV, AIDS and TB/HIV co-infection and gender issues are effectively integrated into initiatives under the Regional Integration Strategy by 2010 3.3 A coordinated, multi-sectoral, sustainable response to strengthen community coping and social protection in order to address the needs of children, OVCY and caregivers in place by 2015
Resource mobilisation	*4. Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response to HIV and AIDS in the SADC region*	4.1 SADC and MS able to increase alignment and efficient use of financial and other resources from 2010 4.2 All MS including hyper endemic middle income

Thematic area	Objectives	Outcome results
	that channels resources efficiently to operational and community level.	countries able to sustain financing for AIDS by 2015
M&E and Institutional Strengthening	*5. Enhanced institutional capacity in the region supports evidence-based programme design, implementation, monitoring, reporting and evaluation at regional and MS levels to ensure ongoing progress towards regional, continental and global commitments*	5.1 The region has in place effective systems for gender sensitive M&E, knowledge generation and management to inform the response 5.2 SADC and MS demonstrate stronger, evidence-based HIV and AIDS planning and implementation from 2010

7. SADC Strategic Intervention areas

In order to realise the five objectives and outcome results, the SADC secretariat has defined a number of strategic intervention areas that are consistent with the intervention areas of the previous strategic framework and business plan. These intervention areas are informed by a number of strategies that will be employed to help meet the objectives.

7.1 Policy development and harmonisation

A major focus of SADC action will be to enhance dissemination and facilitate implementation and monitoring of policies and frameworks developed under the 2003-2007 Framework. However, SADC will also continue to promote development and harmonisation of policies and legislation, and establishment of protocols and guidelines in the following priority areas:

- *HIV prevention*. Initiatives will address prevention among youth, young women, infants, and other populations at high risk of HIV infection. Priorities will include migrants and mobile populations, and integrating prevention into reproductive and child health, and PHC services.
- Provision of *quality treatment, care and support for HIV and AIDS and TB*. Issues to be covered will include:
  - Sustainable policies and strategies for quality treatment, care and support to meet the needs of women, men and children in the general population
  - Priority public health concerns such as ART, prophylaxis, TB and drug resistance
  - Ensuring access for vulnerable groups, particularly migrant and mobile populations and their children.
  - Coordinated approaches to strengthening HIV& AIDS and health systems in all MS.
  - Human resources policies and strategies in health and welfare to enhance production, retention and use of personnel
- Creation of an enabling environment to *protect individuals and communities against HIV and AIDS related stigma and discrimination*. SADC will, in particular, support the Parliamentary Forum in domestication and monitoring of the SADC Model Law on HIV, which can provide a framework to tackle stigma and discrimination in MS. Capacity

and processes will be developed to support MS to frame appropriate policies and laws in areas of ongoing or emerging concern. These include criminalisation of HIV transmission, as well as prevention, care and treatment for marginalised communities such as sex workers, prisoners, drug users and sexual minorities. Implementation of the Framework for Advocacy on challenges for PLWHA will also be supported.

7.2 Mainstreaming HIV and AIDS in SADC

SADC Member States should continue to protect human and economic development initiatives from being undermined by the effects of HIV and AIDS, and also use opportunities to address HIV and AIDS vulnerability through development initiatives. Mainstreaming and impact mitigation activities will target other Directorates as well as key Social and Human Development sectors such as health, education and skills, and labour and employment. The HIV and AIDS mainstreaming programme will focus on capacity development, sharing of information, and ways to monitor and evaluate mainstreaming and impact mitigation. A major emphasis will be to work closely with initiatives that mainstream gender, poverty reduction and food security issues in SADC sectors, in order to optimise use of available capacity and expertise.

A specific objective will be *effective integration of HIV and AIDS and gender issues into initiatives under the RISDP*. To achieve this, SADC will prioritise the following:

- Implementation of *systems to ensure active support from senior leadership* of Directorates.
- Development of *sufficient capacity in the SADC secretariat to facilitate mainstreaming* of HIV and AIDS, gender and poverty reduction in SADC programmes, with a particular focus on the issues of food security and mobile populations.
- Development and implementation of *plans by all SADC directorates* that effectively mainstream HIV, AIDS, gender and poverty reduction in their work, including *support to MS* mainstreaming.
- Strengthening the *workplace HIV and AIDS programme* for the SADC secretariat.
- Effective monitoring and evaluation *of HIV and AIDS vulnerabilities and responses in the RISDP*, including consideration in the mid-term review of the RISDP and subsequent revisions.

A second specific objective is to *address the needs of OVCY and caregivers* by developing a coordinated, multi-sectoral response to strengthen community coping and social protection. SADC will thus contribute to mitigation of the impact AIDS and poverty on development potential of OVCY and their communities. The programme will focus on producing the following outputs:

- *Dissemination of the OVCY Framework and advocacy* to ensure that SADC sectors and MS operationalise it.
- *Harmonised approaches and guidelines on social protection* to reduce vulnerability of OVCY and carers, particularly the elderly, to the impact of HIV and AIDS
- Facilitation of *stronger OVCY national action plans* and integration of OVCY issues in national *development, poverty and key sectoral plans* in all MS
- Facilitation of MS and SADC *capacity and systems development across sectors* that enables them to develop, implement, monitor and evaluate evidence-based OVCY responses by 2010

7.3 Capacity Development

Capacity development initiatives will focus on facilitating development of skills, systems and structures that are needed to achieve priority results in prevention, treatment, care, support and impact mitigation. Key strategies include the following:

- *Leadership* is recognised as a key requirement for an effective response to the epidemic. To reinforce active leadership capacity, a group of regional leaders will be supported to champion key issues at region and member state levels. Their role is expected to be a key contribution to social mobilisation to change norms and reinforce prevention, but may extend to advocacy on issues such as resource mobilisation or attainment of national and regional commitments.
- *Improvement in the quality of HIV and AIDS planning and programming*, as well as more *effective programme management,* are further priorities where the regional programme will facilitate capacity development for planners and managers, strengthening of quality assurance systems, and actions such as advocacy and sharing of lessons learned. These will promote evidence-based, prioritised and results-oriented practice in MS and the SADC programmes, as well as their key sub-components such as prevention, treatment and impact mitigation.
- *A review of national AIDS structures* and ways to streamline roles and functions of NAAs, MOHs, CCMs and other key stakeholders will be undertaken. SADC will also facilitate policy and actions to strengthen partnerships with civil society in line with the Partnership framework.
- *Systems and capacity development for implementation and monitoring of the SADC Pharmaceutical Plan* for AIDS, TB and Malaria will be facilitated. Strengthening of systems to monitor drug resistance to HIV AIDS and TB therapies will be another area for support.

Other capacity development activities will support mainstreaming, strengthening of health systems, M&E and development of resource networks, as indicated under other areas of focus.

7.4 Facilitating a technical response

SADC will continue to provide mechanisms to facilitate technical discussions, sharing of expertise and good practice, guideline development and planning and implementation. Priority areas include:

- *Promotion and support of coordinated, technically sound and evidence-based HIV prevention* by stakeholders at MS level. A particular focus will be regional synergy in planning, learning and action around new priorities such as male circumcision and multiple concurrent partnerships, as well as existing priorities such as PMTCT.
- *Support for MS to achieve Universal Access targets in treatment, care and support* by facilitating technically sound and up-to-date approaches on issues such as:
    - Planning and implementation of HIV and AIDS services scale-up.
    - Quality assurance of services.
    - Key areas of public health importance such as ART, TB/HIV co-infection and drug resistant TB, and testing and counselling policies.
    - Integrating vertical HIV and AIDS programs with reproductive and child health, reproductive health, TB and other services
    - Strengthening of health systems in coordination with HIV and AIDS programmes.
    - Implementation of the SADC HR Strategic Framework and coordinated human resource strategies for HIV and AIDS, health and welfare services.

- Community based care, support of carers, nutrition, and food security.

- More effective targeting of migrant and mobile populations and other vulnerable groups with prevention and access to services.
- Identifying HIV and AIDS-related vulnerabilities and effective responses in other SADC sector programmes.
- Strengthening the technical base to inform responses for impact mitigation.

7.5 Facilitating Resource Networks

SADC will continue to *identify and mobilise technical resources* at regional and MS level, in order to strengthen and leverage expertise and knowledge within the region. Activities will facilitate:

- *Increasing awareness and use of existing networks and other mechanisms* that generate manage and share information that can guide effective, gender sensitive planning and action.
- *Production of analyses and reports that provide accessible information.* These will be used to identify key needs, and improve planning and implementation of responses by SADC and MS.
- *Implementation and updating of the regional HIV Research Agenda*, to generate priority information to guide the region and MS.
- *Advocacy and information dissemination* to mobilise effective action in the region and MS,

7.6 Resource Mobilisation

The Framework recognises that there is an *urgent regional role to facilitating effective resource mobilisation at MS and regional level* to sustain and extend gains in prevention, treatment, care and impact mitigation. SADC can provide a common platform to explore innovative funding sources and mechanisms by facilitating dialogue with both national and international partners

SADC will aim to achieve increased alignment and efficient use of financial and other resources. Another critical objective is access to higher and sustainable levels of financing for regional initiatives and MS, including for hyper-endemic middle income countries with less access to donor funds. To pursue these outcomes, SADC will implement the SADC Alignment and Harmonization Framework for HIV and AIDS and other agreements. Specific regional initiatives will facilitate development of:

- *Harmonised and aligned financing mechanisms* for programmes at regional and MS level.
- *Harmonised medium and longer term financing strategies* for the SADC region, including strategies for hyper endemic, middle income countries.
- *Mechanisms to improve governance and management* of ODA and national resources.
- *Enhanced resource tracking and analysis of resource needs* to inform resource mobilisation.

- *Capacity building and sharing of good practice* for resource planning, mobilisation, management and tracking through operationalising the HIV Economics and Finance Reference Group and other mechanisms.
- *Advocacy for increasing national and donor allocations* to HIV, AIDS and health

In addition, SADC will continue to raise resources for the Regional Fund for HIV and AIDS, and facilitate effective use of those funds at MS and regional level.

7.7 Monitoring and evaluation

SADC will strengthen monitoring and evaluation of regional and global commitments by increasing the effectiveness of systems for gender sensitive M&E. This will both inform the response within the region and contribute to advocacy for achieving MS and regional goals. In order to contribute to this, the SADC programme will focus on the following:

- *Continuing implementation and updating of the SADC Surveillance Framework,* including capacity development and ongoing improvement in the quality of data and analyses.
- *Facilitating improvements in M&E systems* to track the regional response against regional and global commitments, and reflect gender dimensions of responses and impact as well as track the effect of the epidemic on children.
- *Collation and dissemination of strategic M&E information for regional planning and advocacy.*

The outline of the results framework to guide implementation of the Strategic Framework is shown in Figure 5 and is set out in more detail in the Operational Plan below.

A monitoring and evaluation framework and plan will be developed to define in detail the M&E activities in support of the Strategic Framework for HIV and AIDS, the Operational Plan and the Business Plan. This will include establishing indicators and targets to assess the performance of SADC. M&E will include quantitative and qualitative information, and also disaggregate it by gender. Ethical standards will be upheld in research arising from the Framework.,

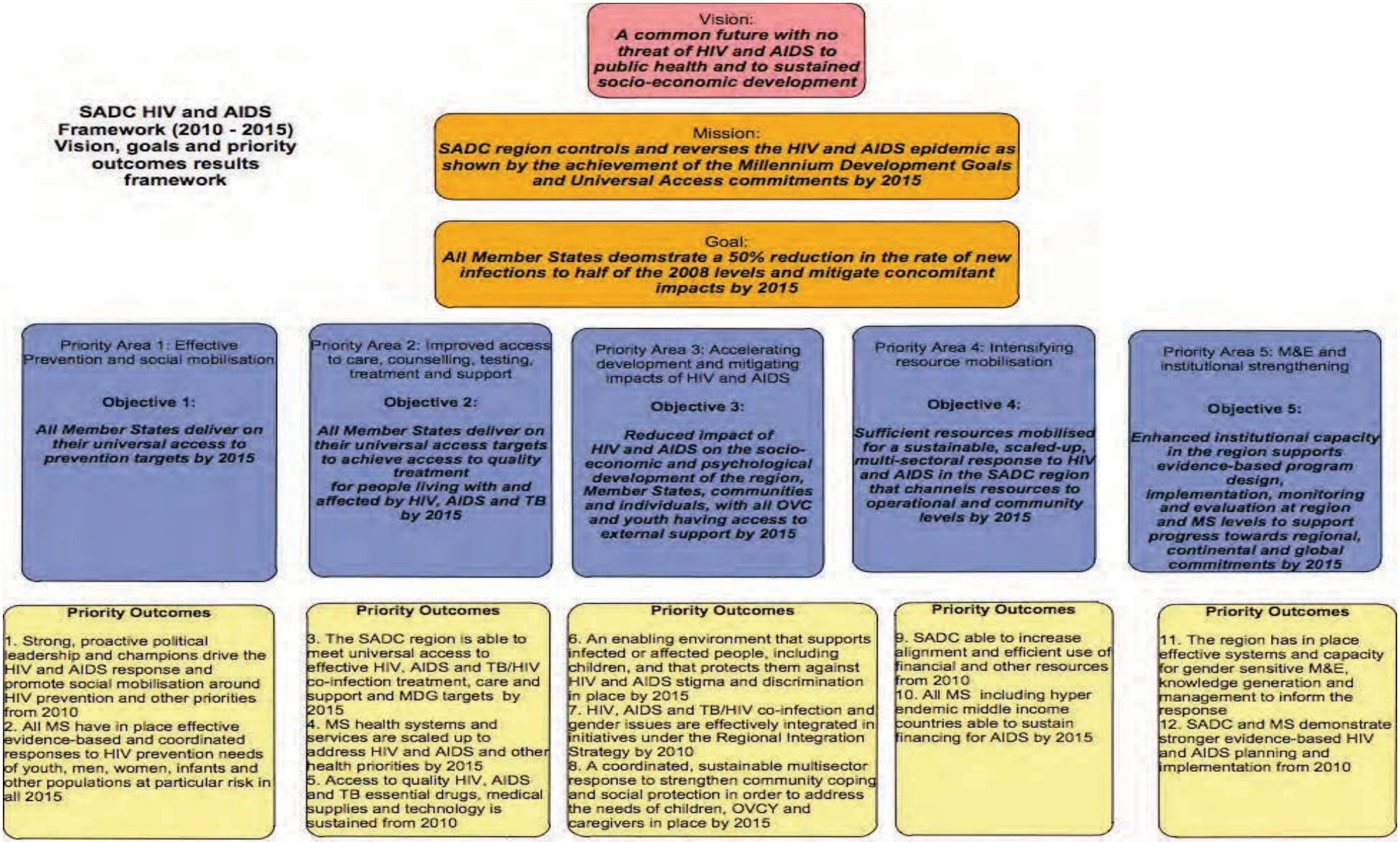
Capacity development is central to the response and it is essential that the SADC M&E Plan address this key concern. All monitoring and evaluation projects and programmes should incorporate a capacity development strategy that can ensure their feasibility and sustainability.

Objectives of the M&E plan

- Ensure that progress towards the Framework's targets is documented.
- Act as an early warning in cases where targets are unlikely to be achieved;
- Provide regular information to all stakeholders on progress in implementing the plan;
- Ensure the continuous sharpening and focusing of strategies and appropriate interventions.

Illustrated in figure 5 below is the vision, mission, goal, objectives and outcome results.

Figure 5: Results framework of the SADC HIV and AIDS Strategic Framework (2010 – 2015)



8. Institutional Framework

Management and coordination of the implementation of this Strategic Framework will use the approved SADC structures at the Political, Operational/ technical and Programme levels.

At the political level there is the SUMMIT that provides overall high level policy guidance. The Ministers in charge of HIV and AIDS provide policy guidance and leadership for implementation. The SADC Secretariat will provide regular progress reports to the Ministers for policy decision-making. The final policy approval will be through the Council of Ministers who will receive regular reports and recommendations through the Ministers in charge of HIV and AIDS. Where Ministers of other sectors meet in SADC fora, the DSHD and other Directorates will ensure that their agenda's consider HIV and AIDS issues relevant to their sectors.

At the operational and technical level the SADC Secretariat, through the HIV and AIDS programme in the Directorate of Social and Human Development and Special Programmes, will facilitate and coordinate the implementation of the Framework in collaboration with the NAAs, and Regional and International partners. The Secretariat will fulfil this function through planning and management of programmes, resource mobilisation and coordination and development of harmonised policies and programmes. These will be submitted to the Ministers in charge of HIV and AIDS for approval. The SADC Secretariat will also coordinate monitoring and evaluation of implementation of regional policies and programmes.

The NAA will ensure that the regional initiatives are integrated into their national plans. The NAA will monitor the implementation of programs at national level and provide feedback to the SADC Secretariat. In addition, they will identify and document emerging good practices, and share them during their annual forum.

The specific function of the SADC Technical Advisory Committee on HIV and AIDS is to provide technical guidance, direction and quality control. In addition, the committee will technically review and approve the annual work-plans. The Committee will also establish ad hoc technical groups to assist in fast tracking and guiding implementation. Currently, HIV Prevention and an M&E technical working groups have been established.

The Partnership Forum will provide a formal, representative structure for discussion, information sharing, consensus building and mutual support for all partners in the HIV and AIDS field at a regional level. In addition, the Partnership Forum will be used to broker coordination arrangements and identify and mobilize assistance. The Forum was created as a response to the growing complexity of the HIV/AIDS arena, due to the involvement of many sectors and regional actors from civil society, the public and the private sectors, and development partners.

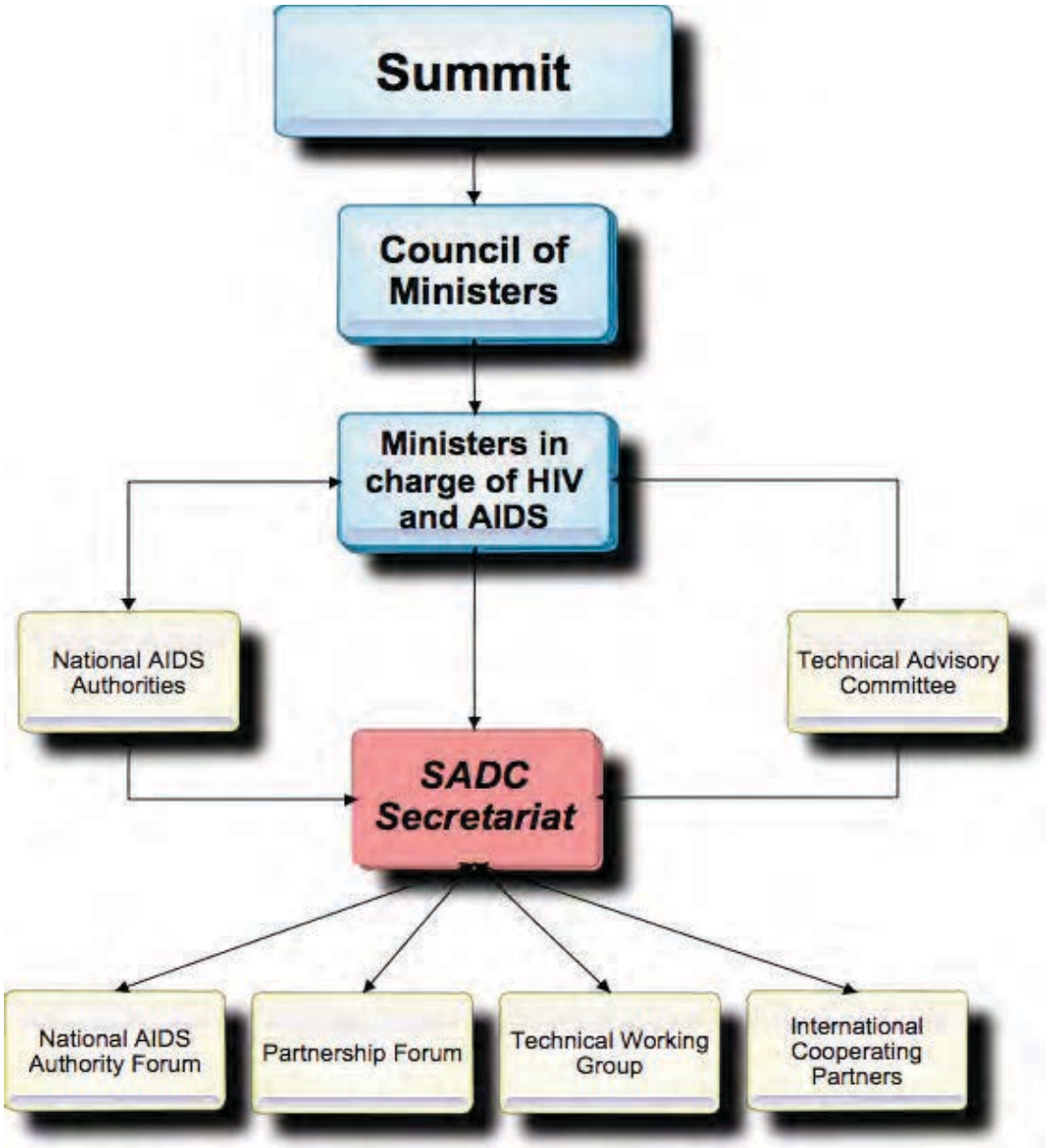
Regional Civil Society Organisations and research institutions will serve a dual role as both implementing partners and in some cases technical advisors. Comparative advantages of individual institutions will be considered in assigning responsibilities.

International Partners are expected to play a key role in providing technical assistance and resources for the implementation of the Strategic Framework.

At the programme level, the SADC Secretariat is responsible for strategic management of programmes and for ensuring that regional programmes deliver on their objectives, serving the interests of the region. The Secretariat mobilises funds for programmes and

therefore is responsible to International Cooperating Partners to ensure appropriate and efficient use of funds.

Figure 6: Institutional Framework for implementation of the SADC HIV and AIDS Strategic Framework



9. Operational Plan 2010 - 2015

The SADC Operational Plan is intended to put into action the Strategic Framework. It provides an overview of the crosscutting issues that have relevance to SADC and a brief description of the functions of the SADC Directorates and the Organ on Politics and Defence.

Responsibilities of each Directorate for implementing the HIV and AIDS plan of action are outlined in the form of a table and organised according to results which SADC wishes to achieve through the overall programme.

Specific activities to achieve results under each Maseru Declaration priority area fall under the general areas of SADC's mandate, namely: Policy and Strategy Development; Mainstreaming of HIV and AIDS; Capacity Building; Facilitating a Technical Response and Resource Networks; and Research and Monitoring and Evaluation. The HIV and AIDS programme and Directorate of Social and Human Development and Special Programmes (SHDSP) have particular responsibilities, not only for their direct functions but also to support other Directorates to discharge theirs.

9.1 Crosscutting issues

Five broad crosscutting issues have been identified which are relevant for the activities to be undertaken by SADC and by Member States, These are:

a) **Human Capital:** The HIV epidemic is concentrated in the working age population, and affects both men and women with all levels of education and skills. The loss of human resources affects all social, economic and political activities being undertaken by SADC.

b) **Public Goods:** The State in all countries plays a significant role in supporting growth and development. It does this through regulatory frameworks, the legal and judicial system and through the direct provision of key services. The HIV epidemic is eroding the resources and capacity of the public service upon which SADC and MS depend for public goods.

c) **Inter-sectoral relationships:** The economic and social system comprises of inter-dependent parts whose efficiency depends on the parts working more or less normally. The epidemic impacts across social, economic and political sectors and many of them have ability to address vulnerability to it. SADC policies and programmes must address these linkages to be effective.

d) **Economic and investment Strategies**: SADC programmes are promoting regional integration, and economic and social development under the RISDP. This is expected to increase resilience to HIV and AIDS over time. However, loss of human and financial capital due to HIV and AIDS undermines these aims. In addition certain strategies may exacerbate vulnerability to HIV and AIDS for reasons discussed above. At the same time, technology and increasing efficiency may also contribute to managing the impact of HIV and AIDS. SADC must ensure that investments in different programme areas are coordinated, and are supportive of each other in the response to the epidemic.

Integrating Gender: SADC is committed to mainstreaming gender in all its programmes and activities. The need to integrate gender issues is nowhere more essential than in the HIV and AIDS programme. But gender is also critical because women play a central role in the economy and maintaining social cohesion in SADC countries, and HIV and AIDS is undermining their capacity to do so.

9.2 Roles and responsibilities of each Directorate with reference to HIV and AIDS

An important reference in the operational plan (tables) is which directorate will be linked to the specific interventions and actions. In order to facilitate this understanding, tabulated below are the key responsibility areas of each directorate demonstrating possible roles in the HIV and AIDS response:

9.2.1 Directorate for Social and Human Development and special Programmes (SHD&SP)

The HIV epidemic affects all areas of responsibility of this Directorate particularly regarding issues of human resource development that includes education and training. The focus area of health has a prominent role in many aspects of the HIV and AIDS response. A major thrust will be to address the needs of OVC and youth in an holistic, multi-sectoral manner. HIV and AIDS cover the whole programme of the HIV and AIDS unit that will facilitate the implementation of various frameworks and policies, focus on monitoring and evaluation of agreements; and guide other components of the Directorate to mainstream HIV and AIDS both in the Secretariat and in key partner sectors in MS such as Ministries of Education, Labour and Health. Specifically in the context of HIV and AIDS, the Directorate will undertake the following:

- Integrate HIV and AIDS in the development, promotion and harmonization of policies and programmes in:
    - Sustainable human development
    - Gender strategies and programmes;
    - Human resources development, educational, skills development and training policies, strategies and programmes;
    - Social protection including welfare and preferential vulnerability reduction policies for vulnerable groups;
    - Health care policies and standards.
- Coordination of regional and national interventions to combat illicit drug trafficking, trafficking in persons especially women and children and substance abuse as they impact on HIV and AIDS;
- Promotion of employment creation and efficient human resources utilization; development, promotion and harmonization of employment policies and labour standards within the context of the HIV and AIDS epidemic;
- Harmonization and coordination of cultural, information and sports policies and programmes taking into account the implications of the HIV and AIDS epidemic;
- Promotion of economic empowerment for HIV and AIDS vulnerable populations, livelihoods development and linkages between rural and urban economies.
- Ensure women and men are participants and beneficiaries in all the above processes and programmes and at all levels.

9.2.2 Directorate for Trade, Finance, Industry and Investment (TIFI)

The industry and mining sectors play major roles in many of the economies in the region. Sustaining their human resources and productive capacity in the face of HIV and AIDS impact is critical. Other areas where the activities of this Directorate can help move forward the regional response to the epidemic include mainstreaming HIV and AIDS in key ministries such as Trade and Finance. Ministries of Finance need to be engaged in relation to ensuring financial sustainability of responses and strengthening management of financial resources. Trade liberalisation may affect the economic circumstances of some communities, making them more vulnerable to poverty, mobility and HIV and AIDS. This increases the importance of impact monitoring and pro-active employment creation or other initiatives for vulnerable populations. Customs and immigration reforms may affect risk on transport routes. Trade and industrial policies need to consider the drug and other material needs of programmes in the region.

The sector therefore needs to do the following:

- Develop effective mainstreaming responses and tools which include both an internal and external domain: workplace programmes for workers, and opportunities for outreach to family members and surrounding communities, to reduce HIV transmission and provide care, treatment and support;
- Advocate for HIV and AIDS mainstreaming in key ministries such as Trade and Finance;
- Facilitate access to trade and drugs including HIV and AIDS related ones;
- Advocate for policies on entrepreneurial and livelihood opportunities for vulnerable groups such as women and young girls and youth; and social corporate responsibility policies relating to support to PLWHAs, vulnerable /at risk children, youth and their communities;
- Facilitate the formulation and implementation of policies and strategies relevant to attaining market integration and sustainable economic growth and development taking into account the impact of mobility on HIV and AIDS;
- Mainstream HIV and AIDS impact on macroeconomic policy analysis and promoting macroeconomic convergence;
- Initiate policies to promote industrial development, particularly SMEs including workplace health promotion for staff;
- Promote the development of mining and beneficiation of mining resources;
- Promote functional, efficient and development-oriented financial sectors;
- Develop the application of science and technology to enhance competitiveness;
- Promote harmonization of economic policies with gender development taking into account HIV and AIDS

9.2.3 Directorate for Infrastructure and Services (I&S)

The transport sector is particularly vulnerable to the impact of HIV and AIDS and is threatened by losses of human resources. This requires that an effective mainstreamed response including workplace based policies and programmes be developed and implemented to minimise the impact of HIV and AIDS on this key industry. Water development has an important role to play both in terms of sustaining agricultural production and food supplies which are threatened by HIV and AIDS, and in improving the health status of the population. Activities for HIV prevention and treatment are also needed to ensure that investments do not lead to avoidable HIV transmission or inadequate treatment and care for workers or surrounding communities. Similarly with tourism where workplace programmes are essential for protecting the labour force. Large-scale infrastructure projects play a role in HIV transmission, and it is essential to integrate HIV and AIDS into environmental impact assessment methodologies.

- Conduct to HIV impact assessments, control policies and practices on major infrastructure development projects initiatives;
- Integrating HIV and AIDS /SRH particularly for young people in communication technologies and infrastructure;
- Integrating HIV and AIDS in the development, promotion and harmonization of transport and communications policies;
- Coordinating development and maintenance of health and wellness programmes for transport, water and energy infrastructure;
- Promotion of an enabling environment for investment and extending the principle of corporate social responsibility in the context of HIV and AIDS;
- Promoting development of physical and social infrastructure that assists poverty alleviation targeting vulnerable populations;
- Integrating HIV and AIDS in the coordination of the development of tourism infrastructure and related services.
- Monitoring and evaluation of the implementation of the above using gender disaggregated indicators (quantitative and qualitative).

9.2.4 Directorate for Food, Agriculture and Natural Resources (FANR)

Food security helps people to avoid situations that put them at risk of HIV infection, as well as combat a key impact of HIV and AIDS on individuals and households. Lack of food and poor nutrition is increasingly recognised as a major impediment to successful treatment of AIDS and TB in the region. There is now mounting evidence that HIV and AIDS affect agricultural production. In some settings commercial farm workers, including migrants, seem to be at high risk of HIV. The epidemic is thus threatening food security in the region, as well as raising the costs of commercial producers. Since Ministries of Agriculture are losing human resources to HIV and AIDS there is a need for policies and programmes to sustain their capacity. Integrating HIV and AIDS in Ministries of Agriculture is also an important area where SADC can help to facilitate policy and programme development. Other areas where HIV and AIDS can be mainstreamed:

- Develop sustainable food security and livelihood policies and programmes focused on vulnerable families and communities;
- Development, promotion and harmonization of bio-diversity, sanitary, crop and animal husbandry policies;
- Develop and promote gendered development strategies and programmes aimed at reducing vulnerability and impact of HIV and AIDS particularly among young women and older carers;
- Development of measures to increase agricultural output and develop agro-based industries;
- Promote production and consumption of foods rich in micronutrients that enhance immune systems for PLWHAs and general population including locally available foods.
- Empower vulnerable children and youth to participate in and take leadership in agro industry and livelihoods opportunities that reduce vulnerability
- Monitoring and evaluation of the implementation of the above, using gender disaggregated indicators (quantitative and qualitative).

9.2.5 Organ on politics, Defence and security

The structure, operations and functions of the Organ on Politics, Defence and Security are regulated by the Protocol on Politics, Defence and Security Cooperation. The Organ has a potentially very important role in respect of issues relating to security within SADC, and it is essential that security operations take into full account matters relating to HIV prevention, relating to the security services and in respect of populations affected by

insecurity, such as displaced people and refugees. Policies and programmes should be developed by the Organ to address security aspects of peace keeping and other related operations. The risks and treatment needs of election monitors and other SADC officials who travel frequently and for long periods should also be considered. Specific interventions include:

- Develop a SADC HIV Policy for the defence and security sector
- Capacity build on HIV and AIDS for the SADC Brigade
- Ensure access to treatment, care and support to the sector
- Monitoring and evaluation of the implementation of the above, using gender disaggregated indicators (quantitative and qualitative).

9.2.6 Information, Communication Technologies

- Electronic /internet communication technologies and innovations on HIV and AIDS and SRH particularly targeting young people

9.2.7 Communications and Publicity

Media monitoring and reporting on HIV and AIDS /SRH/ OVCY and encouraging a deeper understanding of the epidemic and responsible reporting among media practitioners

9.2.8 Administration and Human Resources

- HIV and AIDS policy for SADC staff (implementation)
- Contribute HR expertise to general HIV and AIDS workplace programming

9.3 Operational plan

The operational plan is attached and tabulates the objectives, associated outcome results and output results, actions, indicators and responsibility.

Annexure 1: Operational plan

Objective 1: All Member States deliver on their universal access to prevention targets by 2015			
Outcome results	**Output results**	**Actions**	**Responsibility**
1. Strong and proactive political leadership and champions drive the HIV and AIDS response and social mobilisation around HIV prevention and other priorities from 2010.	Identified champions committed to key sectors of SADC and MS by 2010 (Outcome 1)	Establish group of regional and MS champions and Set up functional secretariat for champions	HIV/AIDS Unit SHDSP, leaders
		Convene a SADC HIV and AIDS leadership and governance Conference	
	Leadership and advocacy programme of action implemented by 2010 (Outcome 1)	Develop advocacy and leadership agenda and strategy	
		implement advocacy and leadership agenda	
		Maintain the existing policy and coordination structures –Ministerial Committee on HIV and AIDS, NAA Forum , Partnership Forum, Technical Advisory Committee and Editors forum	
2. All MS have in place effective, evidence-based and coordinated responses to HIV prevention needs of men, women, youth, children and other populations at particular risk by 2015.	Mechanisms in place for information generation, research, management and sharing to guide effective child and gender sensitive targeting and planning of prevention strategies by 2010	Establish mechanisms for coordination, sharing of information and review of evidence and programs across MS including emerging issues e.g MC, MCP, IDU, MSM	HIV/AIDS Unit TIFI I&S MS UN Agencies, social partners and youth organisations
		Define and facilitate collection of key information needed for policy making on food security, agriculture and HIV and AIDS	
		Facilitate implementation of Regional Research Agenda and disseminate key research results through commissioning of studies on emerging	

Objective 1: All Member States deliver on their universal access to prevention targets by 2015			
Outcome results	**Output results**	**Actions**	**Responsibility**
		areas	
		Convene SADC Research Conference	
		Monitor types of policies formulated and level of usage	
	All MS have in place strengthened systems to monitor resistance to essential HIV and AIDS and TB drugs by 2012	Expedite development of effective drug resistance monitoring	
		Support MS to harmonise reporting systems and tools to monitor HIV and AIDS programmes and indicators Produce Annual Epidemic Report	
		Develop mechanisms to monitor HIV and AIDS, and TB co-infection	
	All MS have developed, resourced, implemented and monitored stronger and well coordinated evidence-based HIV prevention plans by 2011	Facilitate NAA leadership to share information through the Annual Forum	
		Strengthen stakeholder fora and other mechanisms to promote coordinated action on prevention at MS level (prevention conference)	
	Mechanisms in place for information generation, management and sharing to guide effective child and gender sensitive targeting and planning of prevention strategies by 2010	Gather and disseminate strategic information for planning	
		Facilitate and coordinate sharing of information and review of evidence and programs across MS including emerging issues such as MC, MCP, IDU,	HIV/AIDS Unit TIFI I&S

Objective 1: All Member States deliver on their universal access to prevention targets by 2015			
Outcome results	**Output results**	**Actions**	**Responsibility**
		MSM	MS UN agencies, social partners and youth organisations
		Support MS to document and disseminate best practice in community and national level responses	
		Facilitate and coordinate sharing of information and review of evidence and programs across MS including emerging issues such as MC, MCP, IDU, MSM	
		Facilitate expansion of comprehensive PMTCT services	
		Promote appropriate integration of indigenous and cultural assets into the HIV response	
	Regional Planners and Developers have the capacity to develop, implement, monitor and evaluate evidence-based HIV prevention by end of 2010	Design and implement prevention capacity development programmes including training, networks and regional resource centres	
		Develop coordinated plans to develop and retain prevention human resources in all MS	
		3.1.3 Advocate MS to conduct and share "know your epidemic" evidence and response analyses in the translation of knowledge into functional plans	
	In priority prevention areas there are in place harmonised policies, practice guidelines and standards including Paediatric care, SRH and PHC by 2011	Update and disseminate guidelines for harmonised policies, guidelines, standards in priority areas	
		Facilitate collaboration between MoH and NAA to accelerate integration of HIV prevention services	

Objective 1: All Member States deliver on their universal access to prevention targets by 2015			
Outcome results	**Output results**	**Actions**	**Responsibility**
	Children, youth young women, mobile and other populations at high risk of HIV infection benefit from policies, legislation and programmes addressing their prevention needs by end of 2010	Facilitate collaboration between MS in the development of harmonised policies on cross border and internal migrants; and mobile populations	
		Facilitate policies and programmes that respond to needs of other priority populations at high risk including young women, prisoners, sex workers, IDU, uniformed forces and other	
		Facilitate programmes for mobile populations to access prevention services in all MS regardless of legal status	

Objective 2: All member states deliver on their Universal Access targets to achieve access to quality treatment for people living with and affected by, HIV and AIDS and TB/HIV co-infection by 2015

Outcome results	Output results	Actions	Responsibility
3. The SADC region is able to meet universal access to effective HIV, AIDS and TB treatment, care and support and MDG targets by 2015.	Women, men and children benefit from harmonised and sustainable strategies and policies for quality, treatment, care and support by 2012	Finalise and disseminate , harmonised guidelines and minimum standards in areas of priority public health importance by end 2010 including routine testing of HIV positive patients for TB and vice versa; prophylaxis, ART, CTX, and MDR-TB including treatment of children and mobile populations	HIV/AIDS Unit MS UN agencies CSOs Private sector
		Develop communication and dissemination strategy of SADC guidelines and minimum standards	
		Facilitate development and implementation of quality assurance systems for key services in all MS	
		Support development of policy and strategy on nutrition and food security for infected and affected people	
		Develop guidelines and minimum standards for other key components of HIV/AIDS care and support for adults and children including nutrition, integration with SRH and MCH services, support of caregivers, counselling and testing	
		Facilitate sharing of learning and best practices in treatment, care and support	
		Document Best Practices in treatment, care and support	
4. MS health systems and services are scaled-up to address HIV and AIDS, TB/HIV co-infection and other	All MS have in place regional strategies and programming guidelines to maximise coordination between health systems strengthening and	Facilitate development and dissemination of region guidelines and minimum standards for Health systems Strengthening (HSS)	HIV and AIDS unit MS WHO ILO Education and
		Share learning and coordinate approaches to HSS and HIV and AIDS care	

Objective 2: All member states deliver on their Universal Access targets to achieve access to quality treatment for people living with and affected by, HIV and AIDS and TB/HIV co-infection by 2015			
Outcome results	**Output results**	**Actions**	**Responsibility**
health priorities by 2015	HIV/AIDS interventions by 2012		Labour USAID
	All MS have enhanced capacity to plan and implement systems that can achieve national targets for HIV/AIDS service scale-up by 2010	Harmonise strategies for expanding HIV and AIDS service capacity including relevant needs assessments	
		Share learning and approaches to sustainable, efficient models of AIDS care and task shifting	
		Develop good practice case studies	
	All hyper-epidemic countries implement coordinated, innovative human resources policies and strategies in health and welfare by 2012	Regional capacity development situational analysis	
		Develop coordinated regional and MS health HR strategies and guidelines to develop, retain and use human resources	
		Ongoing monitoring and sharing of information on trends in human resources and gaps	
5. Access to quality HIV and AIDS, TB and other essential drugs, medical supplies and technology is sustained from 2010	SADC Pharmaceutical Plan for AIDS, TB and Malaria implemented by 2015	Facilitate development of harmonised systems to regulate and use traditional medicines	SHDSP TIFI MS
		Facilitate rapid development of key systems and initiatives e.g. pooled purchase of essential drugs	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
6. An enabling environment that supports infected and affected people, including children, and that protects them against HIV and AIDS stigma and discrimination in place by 2015	Individuals and communities are protected against stigma and discrimination by 2012	Support domestication of SADC Model Law and address problematic and discriminatory legislation	SHDSP MS Parliamentary forum NGOs
		Develop, communicate and disseminate policies, guidelines and minimum standards to guide MS against stigma and discrimination	
		Build capacity in all MS to develop policies, laws to protect people and communities from discrimination	
		Commission assessment of the extent of stigmatization of PLWAs	
		Facilitate the implementation of Framework for Advocacy on challenges for PLHIV	
		Convene annual advocacy meeting on PLWA issues	
7. HIV, AIDS and TB/HIV co-infection and gender issues are effectively integrated into initiatives under the Regional Integration Strategy by 2010	Secretariat and key sectors have in place workplace programmes by end of 2010	Plan and operationalise an initiative to strengthen SADC leadership capacity and systems for HIV and AIDS, Human Rights, poverty alleviation and gender mainstreaming	
		Facilitate planning for coordinated HIV and AIDS and gender mainstreaming in SHD and SP sectors	All Directorates SHDSP sectors including education, labour, health and
		Initiate responses and/or risk monitoring in sectors.	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		Identify FANR sector policy initiatives and programs that may raise or reduce HIV&AIDS vulnerability	drug control HIV/AIDS Unit Gender programme MS Parliamentary forum NGOs
		Generate systems to share appropriate technology updates, lessons, guidelines and minimum standards in FANR and MS sectors	
		Facilitate planning for coordinated HIV and AIDS and gender mainstreaming in sector in sector in I&S	
		Identify I&S sector policy initiatives and programs that may raise HIV&AIDS vulnerability or opportunity Include HIV in environmental impact methodology	All Directorates SHDSP sectors including education, labour, health and drug control HIV/AIDS Unit Gender programme MS Parliamentary forum NGOs
		Identify TIFI sector policy initiatives and programs that may raise HIV&AIDS vulnerability or opportunity - Sector in TIFI	
		Review of the sectors that have been mainstreamed	
		dentify key policy initiatives and programs in directorates and sectors in FANR, TIFI, I&S, Politics, Defence and Security that may raise risks or opportunities to reduce HIV and AIDS vulnerabilities	
	All MS able to coordinate the mainstreaming of HIV and AIDS, gender and poverty from 2011	Develop capacity for mainstreaming in MS including regional centres of excellence and expert pools	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		Develop Secretariat HIV and AIDS workplace policy and programme	
		Review policies affecting migrant worker risk Promote, monitor and evaluate workplace programmes in key sectors incl. industry, mining, construction	
		Promote, monitor and evaluate workplace programmes in key sectors incl. transport, tourism, infrastructure projects	
	All national development, poverty and key sectoral plans have integrated OVCY issues and strengthened OVCY national action plans by 2011	Facilitate development of strong comprehensive national OVCY action plans	
		Facilitate integration of OVCY and carer issues in SADC and MS development, poverty and sector plans (e.g PRSP, education welfare)	
	SADC secretariat has sufficient capacity to facilitate the mainstreaming of HIV and AIDS, gender and poverty reduction in all sectors of SADC programmes by 2010	Strengthen capacity and systems in SADC Directorates for effective HIV and AIDS programming in regional and MS initiatives	
		Develop and implement minimum standards and guidelines for M&E in mainstreaming	
	MS use support provided for coordinated mainstreaming of	Develop capacity for mainstreaming in MS including regional centres of excellence and	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
	HIV and AIDS, gender and poverty from 2011	expert pools	
		Involve the private sector in Partners Forum and create a Private sector Forum	
		Commission a study to understand the operating modalities and models of the NBC in the SADC region	
		Develop guidelines on private sector engagement in the area of HIV and AIDS in order to establish modalities, linkages, functions and mechanisms for monitoring private sector contributions	
		Promote exchange programs among NBCs	
		Review the SADC / ILO code to take account of new emerging issues and the specific needs of business and facilitate its implementation and monitoring at national and regional levels	
		Support and monitor implementation of the SADC Gender Protocol	
		Monitor workplace mainstreaming in MS (by Labour)	
	All SADC Directorates mainstream HIV, AIDS, gender, Human rights and poverty reduction into their	Generate systems to share information, lessons, guidelines, minimum standards and M&E for mainstreaming in Directorates and MS	
		Facilitate responses and/or risk monitoring	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
	plans that are monitored with a particular focus on food security and population mobility issues by 2010	including monitoring of mobility and AIDS implications of Free Trade Agreement	
		Ensure integration of HIV during mid-term review of RISDP	
		Produce annual Epidemic Report	
		Convene M and E TWG	
		Develop and define disaggregated M&E indicators that track HIV and AIDS among mobile populations	
	Sectors have in place secretariat and key workplace programs by 2010	Develop monitoring framework for workplace programme	
	All MS have in place harmonised, enhanced capacity and systems for resource tracking and in management by 2011	Develop regional monitoring guidelines and systems for resource tracking	
8. A coordinated, multi-sectoral, sustainable response to strengthen community coping and social protection in order to address the needs of children, OVCY and caregivers	Develop regional monitoring guidelines and systems for resource tracking	Monitor and research the identification of priority vulnerable and target groups for OVCY intervention Convene inter-sector review meeting of SADC Senior Officials on OVCY	Secretariat; UNICEF; ILO; UN and partners Alliance; RHVP; Save UK; MS; Youth Orgs
		Convene inter-sector review meeting of SADC senior officials on OVCY	
		Establish mechanisms that monitor evidence based responses among MS	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
in place by 2015		Convene 1 regional technical working group meeting on OVCY	
		Convene inter sectoral review conference of Ministers on OVCY	
		Conduct a regional OVCY programme evaluation	
		Conduct at least 5 monitoring and technical support visits to regional OVCY activities	
		Engage consultancy to compile, translate and print annual status of OVCY in SADC report	
		Engage consultancy to prepare, translate and print progress reports for SADC policy meetings and donors	
	Children, OVCY and carers have reduced vulnerability to the impacts of HIV and AIDS and poverty by 2011	Commission situation assessment and draft the SADC social protection framework	
		Convene regional consultative meeting to review and finalise framework	
		Sensitise /train sector programme managers on the integration of the social protection framework into sectoral policies and plans	
		Develop capacity of policy and decision makers on integrating social protection in national development instruments	
		Training policy and decision makers on	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		integrating social protection in national development instruments	Secretariat; UNICEF; ILO; UN and partners Alliance; RHVP; Save UK; MS; Youth Orgs
		Convene regional policy conference to review on the status of social protection for OVCY and their families	
		Disseminate OVCY framework and advocate SADC sectors at MS levels to operationalise	
	The policy environment facilitates reduced deprivation and vulnerability of OVCY to the impact of HIV and AIDS and poverty in SADC	Develop regional policy guidelines for integrating social protection into national development policies and plans including PRSPs, HIV and AIDS strategies and NPAs	
		Convene regional consultative meeting to review and finalise guidelines	Secretariat; UNICEF; ILO; UN and partners Alliance; RHVP; Save UK; MS; Youth Orgs
		Sensitise /train sector programme managers on the integration of the minimum package and PSS	
		Sensitise /train sector programme managers on the integration of the minimum package and PSS	
		Engage consultants to conduct situation assessment and draft a regional framework on child and youth participation and leadership that includes volunteerism	
		Convene regional consultative meeting to	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		review and finalise framework on child and youth participation and leadership that includes volunteerism	
		Develop regional guidelines for promoting child and youth participation and leadership on HIV and AIDS strategies	
		Convene regional policy conference on the situation of child and youth participation and leadership that includes volunteerism	
		Convene inter-sectoral policy conference of Ministers on comprehensively addressing vulnerabilities of OVCY	
		Convene regional consultative meeting to review and finalise guidelines (piggy back conference)	
		Conduct regional activities to promote signing, ratification and implementation of the African Youth Charter	
		Convene regional review consultative forum on the implementation of the AYC	
		Convene regional conference on the implementation of the African Youth Charter	
		Develop regional guidelines on paediatric AIDS/TB/Malaria treatment	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		Convene regional consultative meeting to review and finalise guidelines	
		Convene regional policy advocacy conference on persons with disabilities	
		Convene regional conference on the implementation of policies and programmes to combat child trafficking	
		Develop and implement a regional campaign to combat trafficking of children and women	Secretariat; UNICEF; ILO; UN and partners Alliance; RHVP; Save UK; MS; Youth Orgs
	SADC Member States have enhanced capacities to implement comprehensive policies and strategies that reduce deprivation and vulnerability of OVCY to the impact of HIV and AIDS and poverty	Training planners on designing and coordinating national strategies for implementing minimum package of services	
		Training policy and decision makers from social welfare sectors of SADC Member States sensitized and trained on integrating social protection in NPAs	
		Training planners from social welfare sectors trained on designing and coordinating implementation of pro-social protection NPAs	
		Training MS on integrating PSS in sectoral programmes	
		Training policy and decision makers and planners from sectors responsible for children and youth on the implementation of the SADC	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		child and youth participation and leadership framework	
		Training child and youth leaders on the implementation of the SADC child and youth participation and leadership framework	
		Regional training workshop on child and youth leadership and governance	
		Sensitising planners and child and youth leaders of sectors and organizations for children and youth, to integrate health, HIV and AIDS /SRH into their strategies and programmes	
		Conduct regional training of MS health planners and managers on child and youth participation and leadership	
		Support child and youth led regional advocacy and communication activities	
	Evidence based OVCY interventions designed and implemented in SADC Member States	Assess status of MIS on OVCY in SADC	
		Develop and track a set of comprehensive regional OVCY indicators including PSS	
		Support MS to track and report on OVCY indicators annually	
		Engage consultants to prepare guidelines and tools for strengthening MIS in SADC MS	
		Train MS on MIS guidelines and tools	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		Commission specific OVCY vulnerability studies	
		Engage consultants to document best practices on comprehensive services for OVCY including paediatric HIV and AIDS/TB/Malaria	
		Convene regional consultative forum to review and approve best practices	
		Convene regional training workshops to support MS to adapt and implement best practices	
		Provide technical support to MS to adapt and implement best practices	
		Engage consultants to train MS on programming for OVCY in emergency /post conflict situations	
		Convene regional partnership coordination conferences on OVCY	
		Convene 1 annual learning and sharing forums for children and youth to enhance their participation and leadership on HIV and AIDS and development	
		Facilitate child and youth participation and exchange /learning visits at regional and international levels (for at least 10 youth leaders annually)	
		Participate in at least 5 international and	

Objective 3: Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.			
Outcome results	**Output results**	**Actions**	**Responsibility**
		regional partnership and learning forums and conferences	
		Disseminate publications on OVCY (at least 100kgs to each MS)	

Objective 4: Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response to HIV and AIDS in the SADC region that channels resources efficiently to operational and community level			
Outcome results	**Output results**	**Actions**	**Responsibility**

Objective 4: Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response to HIV and AIDS in the SADC region that channels resources efficiently to operational and community level			
Outcome results	**Output results**	**Actions**	**Responsibility**
9. SADC and MS able to increase alignment and efficient use of financial and other resources from 2010	All MS have in place harmonised, enhanced capacity and systems for resource tracking and in management by 2011	Capacity building for resource mobilisation and tracking	HIV and AIDS unit MS
10. All MS including hyper endemic middle income countries able to sustain financing for AIDS by 2015	SADC and MS have in place medium and long term resource and advocacy strategies by 2010	Mobilise resources for regional HIV and AIDS program including ongoing use of the Regional Fund for HIV and AIDS Advocate for increased ODA and national allocations to HIV and AIDS priorities	SHDSP; HIV and AIDS Unit; TIFI. MS
		Facilitate resource estimates, gap analyses and targets for all MS	
		Advocate for increased ODA and national allocations to HIV and AIDS priorities	
		Develop medium and long term resource strategies for MS including hyper-epidemic and middle income countries	
	SADC and MS harmonise and align the financing of HIV and AIDS by 2012	Develop mechanisms for dialogue between MS and partners on harmonization and alignment by 2010	
		Increase compliance to Paris and Windhoek Declarations, Alignment and Harmonization agenda. Facilitate other agreements and Code of Conduct.	

Objective 4: Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response to HIV and AIDS in the SADC region that channels resources efficiently to operational and community level			
Outcome results	**Output results**	**Actions**	**Responsibility**
		Implement cross border programmes through the SADC HIV Fund	
		Mobilise resources for the regional HIV and AIDS Programme including implementing the Regional Fund	
		Establish means across MS for learning and sharing good practice in resource mobilization	

Objective 5: Enhanced institutional capacity in the region supports evidence-based programme design, implementation, monitoring, reporting and evaluation at regional and MS levels to ensure ongoing progress towards regional, continental and global commitments			
Outcome results	**Output results**	**Actions**	**Responsibility**
11. The region has in place effective systems for gender sensitive M&E, knowledge generation and management to inform the response	Effective monitoring and evaluation systems to accurately an d reliably track the regional and MS response against regional and global commitments by end of 2010	Develop and implement capacity building programme for SADC and MS on M&E / HIS issues from 2010	HIV and AIDS unit MS
		Build capacity for M&E of implementation of SADC frameworks and disseminate annual M&E reports	
		Implement SADC HIV and AIDS Capacity Building Plan	
12. SADC and MS			All Directorates

Objective 5: Enhanced institutional capacity in the region supports evidence-based programme design, implementation, monitoring, reporting and evaluation at regional and MS levels to ensure ongoing progress towards regional, continental and global commitments			
Outcome results	**Output results**	**Actions**	**Responsibility**
demonstrate stronger, evidence-based HIV and AIDS planning and implementation from 2010			MS

Annex 2: selected references

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