



FINAL REPORT

**Strengthening African Engagement
with the Global HIV/AIDS Establishment:
Lessons and Strategies for Future Action**

Research Findings and Recommendations
Prepared for TrustAfrica by

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Abbreviations and Acronyms

ABC	=	Abstinence, Behavior Change, and Condom Use
AIC	=	AIDS Information Center
AIDS	=	Acquired Immune Deficiency Syndrome
API	=	AIDS Program Effort Index
ART	=	Anti-retroviral Therapy
ARV	=	Antiretroviral
BCC	=	Behavior Change Communication
BSS	=	Behavioral Surveillance Survey
CBO	=	Community-Based Organization
CEDAW	=	Convention on the Elimination of all Forms of Discrimination Against Women
CHAG	=	Christian Health Association of Ghana
CHBC	=	Community and Home-Based Care
CHRJ	=	Commission for Human Rights and Administrative Justice
CRC	=	Convention on Rights of the Child
CRIS	=	Country Response Information System
CSO	=	Civil Society Organization
DFID	=	(UK) Department for International Development
ECA	=	Economic Commission for Africa
FAMEDEV	=	Inter-African Network for Women, Media, Gender Equity, and Development
GAC	=	Ghana AIDS Commission
GAPP	=	Ghana AIDS Partnership Program
HIV	=	Human Immunodeficiency Virus
ICASA	=	International Conference on AIDS and STI in Africa
KAP	=	Knowledge, Attitude, and Practice
MICS	=	Multiple Indicator Cluster Survey
MSM	=	Men having Sex with Men
MTCT	=	Mother to Child Transmission
NACP	=	National AIDS/STI Control Program
NGO	=	Non-Governmental Organization
NSF	=	National Strategic Framework
PEPFAR	=	President's Emergency Plan for AIDS Relief
OVC	=	Orphans and other Vulnerable Children
PLWHA	=	People Living With HIV/AIDS
PMTCT	=	Prevention of Parent to Child Transmission
REC	=	Regional Economic Commission
STI	=	Sexually Transmitted Infection
SWAA	=	Society for Women and AIDS in Africa
TASO	=	The AIDS Support Organization
TOR	=	Terms of Reference
TSF/WCA	=	Technical Support Facility for West and Central Africa
UCC	=	UNAIDS Country Coordinator
UNAIDS	=	United Nations Joint Program on HIV/AIDS
UNFPA	=	United Nations Population Fund
UNICEF	=	United Nations Children's Fund
UNGASS	=	United Nations General Assembly Special Session
USAID	=	United States Agency for International Development
VCT	=	Voluntary Counseling and Testing
WHO	=	World Health Organization

Definitions

The following definitions summarize the way certain key words and expressions were used and understood in the research and for this report. While other meanings can be ascribed to these key words, the definitions used make the words more relevant to the research.

Research: The team defined “research” very broadly and perhaps loosely to cover gathering of especially qualitative information as the basis and context for its analysis, discussion, and recommendations.

African perspectives: African desires, preferences, aspirations, objectives, and targets are all manifestations of the “African perspective”. Given the focus and limited duration of the research, emphasis was placed on the perspectives that regional and national leaders expressed in relation to engaging the international community.

Engagement: To engage is to dialogue, to discuss with the aim of getting points and views across and accepted or to be taken into consideration in decision making and action. In the research and this report, “engagement” has to do with how Africa defines, presents and pushes its desires, aspirations, preferences, etc through the various forums and gatherings where decisions on strategy, policy, programs, activities and resource allocations are made. Engagement is at various levels: subnational, national, subregional, regional, and global.

Global HIV/AIDS establishment: Donors and international development organizations are included here. Bilateral and multilateral as well as foundation and corporate donors are included. Regional and national institutions and organizations involved in various areas of HIV/AIDS policy and program development and management are also included.

Executive Summary

I. INTRODUCTION

TrustAfrica commissioned this research through the Technical Support Facility for West and Central Africa as part of an initiative to increase the frequency and quality of African engagement with international institutions, initiatives, and funders that shape global responses to the HIV/AIDS pandemic in Africa. This study seeks to document gaps in Africa's engagement of the Global HIV/AIDS establishment in responding to the pandemic, and to identify specific strategies to fill them.

The research was conducted by a team of three investigators with expertise in HIV/AIDS and organizational development from mid-February through the end of March 2008. It involved fieldwork in four countries in three subregions: The Gambia and Ghana (Anglophone West Africa), Kenya (East Africa), and Niger (Francophone West Africa). The team conducted qualitative research to elicit the knowledge, views, and perspectives of selected key informants working in the public sector, academia, and the media as well as civil society organizations and international development organizations.

For background and context, the team conducted a literature review examining various dimensions of the pandemic in Africa, including its evolution and impact as well as government responses, policies, and programs. This desk work focused on the four countries visited (Ghana, Kenya, Niger, and The Gambia) as well as Botswana, South Africa, and Zambia. The latter group was added for comparative purposes.

The research conducted through this fieldwork and document review not only informs this comprehensive report, but will also help to develop a database that TrustAfrica can share with partner organizations and update regularly.

II. FINDINGS

From the document review and interviews with key informants, the team can summarize the current situation and gaps as follows:

General: There is a great deal of interest in the research topic, and many participants in the research saw it as relevant and important to Africa's aspirations in all development sectors, not just the response to HIV/AIDS. However, the research generated many more questions than answers, for example on issues such as definition of "African perspective" and whether Africa can really influence the international community. Also, the question arose as to who are "leaders" and what kind of knowledge leaders need in order to engage effectively? Respondents also drew attention to the need to consider engagement not only with the international community, but also within Africa at the local, national, subregional, and continental levels.

African perspectives: African perspectives in terms of desires, preferences, and goals and objectives are diverse and many—some known and others not. They manifest themselves in specific expectations (from the international community) such as space for the exercise of control and flexibility in making policy and programming decisions, setting local research agendas, and allocating resources.

Leaders: Most of the time, African leaders seek to influence the HIV/AIDS global agenda to reflect African perspectives through national, subregional, and Africa-wide

meetings in addition to the global settings. However, their knowledge and attitudes vary, with some outwardly supporting policies and programs and others in denial, hesitant, or lacking commitment and political will. Stephen Lewis, the UN Special Ambassador for AIDS, reported that when he urged Daniel arap Moi, Kenya's former president, to speak out about AIDS in Kenya, Moi replied, "We don't talk about nasty things." On the other hand, President Yoweri Museveni's determination to speak openly about the disease in Uganda, and about the changes in sexual practices necessary to prevent it, is credited with breaking through the stigma and silence surrounding the disease. Leaders' attitudes and practices continue to affect the allocation and use of resources.

Engagement: Africa has engaged the international community in various ways and with varying degrees of success. Overall, the engagement does not appear effective in fully ensuring that "African perspectives" are taken into account. There has been no purposeful engagement strategy, and consequently there is no purposeful effort to nurture an engagement process or documentation. A good (and sufficient) number of policies and policy frameworks exist (based on international and African regional agreements) that facilitate and support engagement. What is lacking is commitment to implementation and to more effective implementation. Many government officials and civil society figures plan, implement, and participate in activities that consciously or otherwise support engagement. The thinking is that the presence of Africans in international organizations helps to promote and enable engagement, but it is not clear to what extent this help facilitates the incorporation of African perspectives. There is no direct allocation of resources for engagement activities in terms of specific budget lines. However, resources (e.g. for travel, networking, and collaboration) made available to regional and subregional organizations invariably include portions that allow and support engagement activities.

Constraints: If effective and successful engagement requires robust and effective HIV/AIDS programs that show the desired clear impacts, then constraints to successful responses must also be accepted as constraints to effective engagement. Against this background, the team identified the following constraints: macroeconomic situation and unsustainable debt burden; often differing priorities of national governments and the international community; stigma, silence, denial, and discrimination; inadequate resources and capacity; politics of funding; inadequate coordination and partnerships; recurring conflicts and natural disasters; generally weak health systems; traditional attitudes and practices; and lack of political stability.

Case studies: The team identified a number of strategies that have worked well in fostering African leadership on HIV/AIDS and bringing it to global decision making processes. These include the Great Lakes Initiative on AIDS, the Abuja Declaration of 2001, the 2005 Gaborone Summit Declaration, the Brazzaville Declaration, the Lomé Declaration on HIV/AIDS in Africa, the Millennium African Renaissance Program, AIDS Watch Africa, efforts by Africa's First Ladies, and the African Development Forum. However, these cases need to be studied and analyzed further to sharpen and document lessons from them.

Opportunities: The team identified opportunities that are not well utilized for African engagement with global initiatives and forums. These include the New Partnership for African Development, the African Growth and Opportunity Act, AU annual summits, and forums supported by development partners such as SIDA, JICA, and the Korea International Cooperation Agency. These forums facilitate contact, dialogue, and planning, but they could be used more purposefully for engagement on global responses

to HIV/AIDS. Efforts to document and disseminate successful strategies for enhancing African engagement, such as the case studies noted above, could also go a long way in helping Africans shape global responses to the pandemic.

Information sharing: Information sharing depends on the documentation, monitoring and evaluation, and knowledge management systems in place as well as the culture of information use in each country. Information sharing is weak and not systematic. The main channels include: websites, radio (public and private as well as rural), television (both public and private stations, with coverage varying from country to country and within individual countries), workshops and conferences organized by government or civil society organizations, research reports, and newsletters and similar publications. There is a large and wide range of newspapers of varying strengths and frequency of publication, purposefully or partially addressing the response to HIV/AIDS. Some are university-based, while others are published by civil society organizations and journalist organizations, such as FAMEDEV, based in Senegal, and Journalists Against AIDS (JAAIDS) in Nigeria.

Lessons and good practices: Most of the lessons and good practices identified during the research relate to various components of HIV/AIDS programs, rather than directly relating to strengthening African engagement with the international community. They include: involvement of people living with HIV/AIDS; multisectoral approaches; understanding and accommodating socio-cultural and religious values; political commitment and government support at all levels; purposeful and streamlined coordination; and certain macroeconomic initiatives, such as the “debt for development” arrangement used to establish the Zambia HIV/AIDS Response Fund. With regard to engagement, lessons and good practices include convening and hosting preparatory meetings and related activities, commissioning and preparing background and working papers, and purposefully documenting and disseminating decisions and actions to build common platforms for discussion and negotiation with the international community.

Technical assistance and funding: Although countries may differ greatly in their capacity and resources, their needs are similar with respect to training, technical assistance, and funds for both HIV/AIDS programs and engagement with the international community. The needs expressed were many and varied. They include: sustaining the largely positive environment that currently exists; facilitating analysis and development of enabling policies and legislation; building human, program, and organizational capacity at all levels; and supporting implementing agencies to further define and fulfill their roles and responsibilities. A large number of local and international organizations, including intermediaries of donor and UN agencies, exist and assist with technical assistance needs. The three UNAIDS-funded Technical Support Facilities (TSF) located in Johannesburg (for Southern Africa), Nairobi (East Africa) and Ouagadougou (West and Central Africa) are significant in this regard

Accountability to African beneficiaries: Most respondents acknowledged that global policies, initiatives, and interventions have generally been responsive and sensitive to the basic needs of African beneficiaries. They also agreed that the international community has demonstrated its compassion, concern, and caring through resource mobilization and fundraising efforts. However, many respondents expressed the belief that developed countries are not always accountable to African beneficiaries and that a double standard is applied to beneficiaries and funders. Respondents offered thoughts on strategies for seeking greater accountability at the national and international levels. These include: recommending that African heads of state lead a social movement (e.g.

promoting and leading HIV/AIDS campaigns at all levels as part of their political platforms) to make a minimum package of services available within the context of a rights-based framework; developing and strengthening national monitoring and evaluation systems; and developing and applying a framework for self-accountability by the UN system and other development partners, including civil society organizations.

III. CONCLUSIONS AND RECOMMENDATIONS

General: From the key informant interviews, it is clear that successful engagement of the international community requires knowledge, preparation, participation, and institutional capacity. The first three can be considered from the standpoint of individuals, while all four can also be considered at the institutional or organizational level. Some respondents felt that “leadership” should be added to the person-centered requirements. It was not clear from the interviews and the document review to what extent, if at all, any of these requirements have been systematically identified, nurtured, or otherwise promoted among African institutions that are engaged in the HIV/AIDS response and that are in a position to engage the international community. Capabilities and resources for, and their impact on, each of the individual requirements differ from country to country. However, even in the national AIDS control agencies, the team did not find systematic attention to all the requirements.

The research findings show that African perspectives are a present but weak factor in the global community’s response to HIV/AIDS in Africa. Respondents acknowledged poor leadership and inadequate empowerment of leaders, insufficient capacity among regional institutions to engage Africa in the global response to HIV/AIDS, weak advocacy expertise among leaders and institutions, weak performance of HIV/AIDS interventions, weak monitoring and evaluation systems, low allocation of domestic funds (especially funding for needed policy-oriented research and “think tank-type” activities), and unfulfilled international commitments.

Many recommendations were made to address the challenges and constraints for a better HIV/AIDS response agenda. They are summarized here:

Leadership: Leadership of the HIV/AIDS response should be broadened. Leaders should come from all levels of society. African leaders should stop paying lip service and drive the HIV/AIDS agenda themselves. They should aggressively and persistently lobby with global partners to bring in more help, financing, and technical support. And they should set up a specific African body solely to tackle the HIV/AIDS pandemic. Given that some of these leaders have their own foundations, they should be encouraged to align themselves with this proposed new body and coordinate their funding priorities to minimize overlapping arrangements and competing agendas and to maximize impact.

Institutional capacity: African institutions and organizations, such as the African Union and ECOWAS, should strengthen their roles in the response to HIV/AIDS. Specific, purposeful steps should be taken urgently to further mainstream strategic and operational HIV/AIDS response needs and to operationalize them in the activities of regional and subregional institutions. Given the strategic and policy frameworks already available, African countries should incorporate the essential elements of these frameworks in their own development strategies and programs for fighting the pandemic. Governments should show political will and commitment by creating budget lines for HIV/AIDS in all sector ministries and encourage local fundraising at the decentralised

level to fund HIV/AIDS activities. This initiative has already begun in Ghana and with support of the AU and ECOWAS can be replicated in other countries.

HIV/AIDS programs: Improving the performance of HIV/AIDS programs is indispensable for advocacy, leadership, and empowerment. Countries that achieve good performance are more likely to be listened to.

Monitoring and evaluation: Obtaining reliable, high-quality data is an important step toward improving performance and gaining the trust of local, national, and international partners. Monitoring and evaluation systems need to be strengthened to become more effective and more efficient. The monitoring and evaluating of engagement strategies and activities, in particular, must receive greater attention. This action area is important if Africa really wants to strengthen engagement with the international community. There must be a systematic way to document engagement strategies and activities, assess their effectiveness, and learn from experience to inform planning for more effective strategies.

Local resources and commitment: African countries and institutions must mobilize more domestic funds for their HIV/AIDS response programs and keep their international commitments. Moreover, each government should institute a resource mobilization fund for HIV/AIDS. Each relevant ministry should have a specific budget line for HIV/AIDS and see that it is increased year after year as necessary. The modalities for fundraising should be based on local initiatives and drives. These should not be prescriptive.

Networking and exchanges: Some of the networks that can be strengthened and utilized include the African Network on Advocacy, West African Network on HIV/AIDS (WANOSO), African Network on HIV/AIDS, South African Network on HIV/AIDS, East African Network on HIV/AIDS, and the Regional AIDS Training Network, based in Nairobi. Africans should strengthen regional programs that involve participatory planning and develop action plans that are informed by similarities and differences. Africans can then share best practices. Africans should create an African database on HIV/AIDS that can be shared with all through networking.

I. INTRODUCTION

1. Background

No other region in the world has been hit harder by HIV/AIDS than Africa. Although the international community has marshaled significant resources and support to address the pandemic in Africa, it has not always taken into account African perspectives on the crisis when shaping its responses. Strengthening African engagement with the global HIV/AIDS establishment is consequently of significant concern to many leaders, institutions, and ordinary Africans.

The scale, manifestations, and impact of HIV/AIDS in Africa are now fairly well known. Around the continent, an impressive amount of work is being done at the community and national levels. Nearly every African country has a national AIDS control program, and community groups working on HIV/AIDS abound. At the global level, many developed countries have increased their funding for HIV/AIDS control in Africa in recent years, particularly through the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The U.S. Government has initiated the President's Emergency Plan for AIDS Relief (PEPFAR). Other major global programs that target Africa include UNAIDS, which brings together the efforts and resources of ten UN institutions, and the International HIV/AIDS Alliance.

While these global and international efforts are critical for the fight against HIV/AIDS in Africa, it is increasingly evident that Africa's own initiatives, experiences, lessons, knowledge, and perspectives are rarely taken into account. African participation in global forums, where experiences are shared and new initiatives are often born, is minimal. Within Africa itself, yawning gaps exist between local experiences and knowledge on one hand, and national and regional policy making on the other. Country successes and best practices are rarely shared, and yet the epidemic does not stop at national borders.

Against this background, TrustAfrica commissioned this research as part of its initiative to increase the frequency and quality of African engagement with key international institutions, initiatives, and funders that shape global responses to the epidemic in Africa.

2. Purpose and Objectives

The attached Terms of Reference (Appendix 1) spell out the purpose and objectives of the research. They note that the purpose was to document gaps in Africa's response to HIV/AIDS and identify specific strategies to fill them. The specific objectives were to:

1. Document the levels of interaction and collaboration among key African HIV/AIDS organizations and experts across disciplines and sectors and in ways that help to synthesize experiences and knowledge for concerted advocacy at the global level.
2. Identify the knowledge, attitudes, and practices of African leaders and key regional institutions vis-à-vis HIV/AIDS.
3. Document opportunities to promote learning and exchange among the HIV/AIDS community across sub-Saharan Africa.
4. Identify the funding and technical assistance needs of experienced actors in the field so as to sharpen their communication and advocacy skills.
5. Identify opportunities for African leaders to gain access to, and take center stage at, HIV/AIDS global forums and institutions.
6. Identify ways to stimulate global institutions and forums to create adequate space for African perspectives, lessons, knowledge, and initiatives to be presented and heard.

To meet these objectives, a number of specific research issues were identified to guide and focus the investigation. These issues were:

1. Knowledge, attitudes, and practices of African leaders and key regional institutions vis-à-vis HIV/AIDS;
2. Factors that impede African actors' global outreach and engagement;
3. Innovative ideas and perspectives that provide useful contextual insights which global initiatives ought to incorporate;
4. Case studies of strategies that have worked well in fostering and bringing African leadership to global decision making on HIV/AIDS;
5. Opportunities that exist, but are not well known, for African engagement with global initiatives and forums; and
6. Strategies and opportunities for seeking greater accountability by global initiatives to their African beneficiaries.

From the research, two deliverables were envisaged. The first is a research report outlining recommendations for strategic approaches and activities to achieve the purpose and objectives listed above. The second is a database containing information from the comprehensive scan, which TrustAfrica can share with partner organizations and update on a regular basis.

3. Methodology

The study adopted a qualitative research approach, making extensive use of consultations with knowledgeable persons, in-depth interviews with program managers, observations of PLWHA in hospitals and institutions, case studies of initiatives, and secondary information on individual countries. Details of the entire process of soliciting information for the study are outlined in the planning, consultation, secondary review, fieldwork processes, and limitations sections outlined below. The instruments developed for the study, mainly In-depth interview guides are presented in Appendix 2. The research team interviewed key informants in five pertinent categories presented in Table 1 below.

1. Public sector, including parliamentarians and national AIDS control agencies, focusing on ministries responsible for education, women and gender, and health;
2. Civil society organizations focusing on women and youth and networks of people living with HIV/AIDS (PLWHA);
3. Academia, including universities and relevant research institutions;
4. The media; and
5. International development partners.

Box 1: Key Informants Interviewed	
Category	N°
Public Sector	18
Civil Society	10
Academia	7
The media	2
International Development Partners	14
Total	51

In each case, the plan was to interview the chief executive officer or his or her deputy. The information and knowledge gained from these discussions was supplemented with findings from literature review, including review and consideration of information and documentation available online. Responses from key informants were recorded, added to information and knowledge gathered from document review, and synthesized to produce country reports. The country reports were later merged to produce this consolidated report.

The research process involved the following main stages:

3.1. Planning meeting

The research team met in the TrustAfrica office in Dakar (18–21 February) with the TSF/WCA assignment manager and the executive director and staff of TrustAfrica. These meetings were used to review the TOR and to discuss and gain common understanding of the assignment by sharing the thinking and perspectives of the TrustAfrica staff. They also provided an important opportunity for the research team to get to know one another better, to jointly discuss and develop the research approach and instrument, and to discuss and agree on respective roles and responsibilities.

3.2. Preliminary consultations in Dakar

While the consultants were in Dakar for the planning meeting, TrustAfrica arranged for them to meet with the Society for Women and AIDS in Africa (SWAA)–Senegal and SWAA International, the UNAIDS regional advisor on technical support platforms and networks for West and Central Africa, representatives of the Association for the Promotion of Traditional Medicine (PROMETRA), the president of the December 2008 International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA), and the Inter-African Network for Women, Media, Gender Equity, and Development (FAMEDEV), an organization of media professionals working to give voices to disadvantaged groups in the response to HIV/AIDS. Although Senegal is not a focus country for this research, the meetings provided useful and important insights on the country's efforts and achievements. Some of the meetings also helped inform and clarify the research team's understanding of African and particularly West African perspectives. Moreover, some of the meetings helped to validate, test, and refine the research questionnaire.

3.3. Literature review

Although it started during the planning meeting, document review was undertaken throughout the research process. Key documents reviewed include national HIV/AIDS strategic frameworks, national HIV/AIDS monitoring and evaluation plans, mid-term evaluation reports for the World Bank's Multi-country HIV/AIDS Program for Africa (MAP), annual reports and activity reports for national HIV/AIDS programs, and an assortment of other publications and documents from civil society organizations, government agencies, academia, and international development partners. The reference section of this report lists the general as well as country-specific documents reviewed. From these materials, the research team gleaned relevant knowledge and information about the current situation and needs as well as about learning and good practices.

3.4. Fieldwork

Each team member spent approximately one week conducting fieldwork in one of the two assigned focus countries, in addition to fieldwork in the second country in which he/she is based. Fieldwork consisted mainly of key informant interviews and collection and review of documents. In Senegal, a field observational visit was made to the Laboratory of Bacteriology and Virology at Le Dantec Hospital in Dakar. The visit and the information gathered very well illustrated how African collaboration and partnership with international counterparts (e.g., in clinical and other research, publication, and advocacy) has helped and continues to help convey African perspectives to the international community.

The mix of key informants differed from country to country, variously including officials of national assemblies (one in Gambia and one in Niger); national AIDS control programs (one each in Gambia, Ghana, and Niger and two in Kenya); the Presidency (three in Gambia and one in Niger); organizations of people living with HIV/AIDS (one in Niger); ministries responsible for education, health and social affairs (three in Gambia, one in Ghana, and two in Niger); representatives of the Global Fund country coordinating mechanisms; and staff from WHO, UNICEF, UNDP, UNFPA, and UNAIDS. Appendix 3 lists the persons contacted or interviewed in each of the focus countries.

Each member of the research team was allowed a combined 15 days for the two assigned countries (an additional five days were approved for the team leader). This timeframe inevitably limited the scope and depth of the research, especially with respect to probing for additional information or obtaining supporting details.

4. Limitations

The research focused on Africa's involvement with the international community in initiating, designing, and implementing interventions responding to HIV/AIDS in Africa, including policies, programs, and resources. However, since the quality and effectiveness of HIV/AIDS programs are important in Africa's ability to influence international policies, programs, and resources, it was necessary to pay attention to and assess the programs on the ground in the focus countries.

The analysis and recommendations presented in this report are based on information and knowledge gleaned from document review and responses of the key informants identified in the Appendices. Although fieldwork in seven countries was originally envisaged, the research team was not able to visit three of them (Cameroon, Morocco, and Zambia) due to logistical and other constraints. However, the research team believes that the four countries it visited represent a balanced geographic spread and that the information and knowledge obtained from this field work, when supplemented by the output from document review, forms a reasonably valid basis for generalizing the situation and needs found and discussed in this report.

II. THE HIV/AIDS EPIDEMIC IN AFRICA

1. Overview

Sub-Saharan Africa remains the region most affected by the global AIDS epidemic. Although just over 10% of the world's population live in this region, it is home to more than two out of three (68%) adults and nearly 90% of children infected with HIV. In 2007, more than three out of every four (76%) global deaths due to an AIDS-related illness occurred in sub-Saharan Africa. Estimates indicate that the number of people living with HIV/AIDS in this region grew from 24.9 million in 2003 to 25.8 million in 2005. New HIV infections rose from 3 million to 3.2 million during this same period, although the prevalence rate among adults fell from 7.3 to 7.2. The number of deaths due to HIV/AIDS also rose from 2.1 to 2.4 million in 2005¹. In 2006, an estimated 24.7 million people in sub-Saharan Africa were living with HIV/AIDS, while 2.8 million people were newly infected with HIV and 2.1 million people died due to AIDS². HIV/AIDS is increasing the demand for vital health services at the same time that it is taking the lives

¹ UNAIDS/WHO, AIDS Epidemic Update, December 2005.

² Regional HIV/AIDS Statistics and Feature 2004–2006.

of health providers whose services are more critical than ever. The Global Health Council estimates that 44% of nurses in southern Africa are HIV-positive.

2. Situation in Selected Countries

The following paragraphs summarize the HIV/AIDS situation in several countries in sub-Saharan Africa.

Gambia: The first case of AIDS in Gambia was diagnosed in 1986. Subsequently, two population-based seroprevalence surveys were conducted among the sexually active age group, defined as 15 years and above. Results from the first of these surveys, in 1988, showed infection rates for HIV-1 of 0.1% and for HIV-2 of 1.7%. By the time of the second survey, in 1991, the HIV-1 infection rate had increased to 0.5%, while the rate for HIV-2 remained stable at 1.7%. A countrywide survey of 30,000 pregnant women conducted from 1993–1995 found a prevalence rate of 0.6% for HIV-1 and 1.2% for HIV-2. In 2000 and 2001, surveillance data from four sentinel sites revealed a continued rise in the prevalence of HIV-1, now reaching 1.2%, and a mild reduction in the rate of HIV-2, reported at 0.9%³.

For the period from 2000 to 2004, the NSS studies showed a steady increase in the prevalence of HIV-1 from 1.3% in 2000/2001 to 2.1% in 2004, while the prevalence of HIV-2 declined from 0.9% to 0.8%. During this period, HIV-1 drove the HIV epidemic in Gambia. However, the 2005 NSS findings revealed that the prevalence of HIV-1 and HIV-2 had declined to 1.1% and 0.6%, respectively. This was the first documented decline in national HIV prevalence rate since the initial NSS in 2000/2001 (see Table 1). In contrast to previous reports, the highest rates were recorded in urban settings. However, further analysis of the 2005 findings by site reveals a complex situation: the prevalence of HIV-1 was extremely low at the newest sentinel sites, Essau (0%) and Soma (0.2%), making them markedly different from other sites. This contributed in part to the marked overall observed decline in HIV-1. Excluding the two new sites results in an overall HIV-1 prevalence of 1.4%⁴.

In 2004, Gambia's National AIDS Control Program reported that more than 15,000 Gambians were living with either HIV-1 or HIV-2 and that more than 1,400 had died from the disease.⁵ People aged 15–49 are most affected.

Ghana: The first case of AIDS in Ghana was diagnosed in 1986. By 2004, an estimated 380,000 adults and 14,000 children were HIV-positive (UNAIDS, 2004a), and the cumulative number of people diagnosed with AIDS was 36,000. Prevalence rates rose from an estimated 2.6% in 2000 to 3.6% in 2003, and dropped to 3.1% in 2004 (National AIDS/STD Control Program, GHS, 2005)⁶. It appears to have declined to 2.6% in 2007. Evidence from the National AIDS Control Program (NACP 2008) shows that the HIV prevalence rate in 2008 so far has further declined to 2.1%, with most (86.8%) of the cases officially reported found among individuals aged 20–49 years. These figures show

³ NSF: 2003:16.

⁴ MRC presentation at Kairaba Beach Hotel, Gambia, NSS 2005. See also CCSI 2007:13.

⁵ HIV/AIDS Sentinel Survey Report 2004. Government of The Gambia National AIDS Control Program (NACP) and Medical Research Council (MRC).

⁶ In contrast, prevalence rates in Southern and Eastern Africa expanded much more rapidly over the same period, exceeding 25% in some countries. Neighboring Côte d'Ivoire has shown still another pattern, generally maintaining a rate between 10% and 15% for most of the period.

that the epidemic has spread much differently—and much more slowly—in Ghana than it has in Eastern and Southern Africa, where prevalence rates rapidly exceeded 25%.

Kenya: According to the National AIDS Control Council, 1.5 million people had died of AIDS in Kenya by June 2000. By the end of 2003, it was estimated that 1.2 million people in Kenya were living with HIV/AIDS; Kenya's HIV/AIDS prevalence rate of 6.7% was just slightly below the 7.5% rate for the sub-Saharan African region. An estimated 150,000 died due to HIV/AIDS in Kenya, compared to 2.2 million in the sub-Saharan Africa region and 2.5 million worldwide. Most infections in Kenya occur among young people, especially young women aged 15–24 and young men below the age of 20. Women account for approximately two-thirds (65%) of adults living with HIV/AIDS in Kenya, a higher percentage than the sub-Saharan African region (57%). Major transmission mechanisms in Kenya, as in Uganda, are heterosexual and mother-to-child transmissions⁷. Recent statistics show that the number of people living with HIV/AIDS in Kenya has increased from 1.2 million in 2003 to 1.3 million by the end of 2005, with 6.1% of the adults living with the virus⁸.

Niger: Two major surveys conducted in Niger in 2006—the demographic and health survey (DHS) and the Multiple Indicator Cluster Survey (MICS-III)—found an HIV prevalence of 0.70%, a rate that seems to have stabilized. However, there were differences between genders: women aged 20–29 years were more likely to be infected than men of the same age (0.8% versus 0.4%). Conversely, men over 30 were more likely to be infected than women. Prevalence rates also varied according to geography; the virus was three times more prevalent in urban areas, where the rate was 1.5%, than in rural ones, where it was 0.5%. Routine data collection by Niger's health management information system showed that the HIV prevalence among sex workers was 33.98% in 2006. The prevalence among women attending antenatal clinics at the country's 129 PMTCT centers was 1.5%. Unfortunately, that surveillance has not been regular through time, due to a lack of resources and a shortage of trained personnel.

Botswana: The first AIDS case in Botswana was reported in 1985. At that time, AIDS was seen as a disease that affected male homosexuals in the West and people from other African countries. In 2005, an estimated 270,000 people were living with HIV in Botswana, a country with a population of less than 2 million. Botswana has an adult HIV prevalence rate of 24.1%, the second highest in the world after Swaziland⁹. Life expectancy at birth fell from 65 years in 1990–1995 to less than 40 years in 2000–2005, a drop of about 25 years that is primarily attributed to HIV/AIDS¹⁰. An estimated 120,000 children have lost at least one parent to the epidemic.¹¹ Most funding for HIV/AIDS programs comes from the national government, which spent around \$150 million in 2005 (6% of the national budget).

South Africa: By the end of 2005, five and a half million people were living with HIV in South Africa, and almost 1,000 AIDS deaths occurred each day.¹² Average life expectancy in South Africa is now 54 years; without AIDS, it is estimated that it would be

⁷ HIV/AIDS Policy Fact Sheet 2005.

⁸ UNAIDS Report, 2006.

⁹ UNAIDS/WHO, Report on Global AIDS Pandemic, 2006.

¹⁰ United Nations, (2004), The Impact of AIDS.

¹¹ UNAIDS/WHO (2006), Report on Global AIDS Pandemic.

¹² UNAIDS/WHO (2006), *Report on the Global AIDS Pandemic*.

64. Over half of 15-year-olds are not expected to reach the age of 60.¹³ Almost one of every five adults is infected. Between 1990 and 2003, a period in which HIV prevalence in South Africa increased dramatically, the country fell 35 places in the Human Development Index. In 2006 a leading researcher estimated that HIV-positive patients would soon account for 60-70% of medical expenditure in South African hospitals¹⁴.

Zambia: This southern African nation has one of the world's most devastating HIV/AIDS epidemics. One in every six adults in Zambia is living with HIV, and life expectancy at birth has fallen below 40 years¹⁵. This is low compared to South Africa, which has a life expectancy of 54 years¹⁶, and has compounded Zambia's existing economic problems.

3. Current Landscape of Africa Regional and Subregional Responses to HIV/AIDS

A rather large number of strategies and initiatives that enable and enhance engagement with the international community in response to HIV/AIDS has been implemented, and many are ongoing. The following are culled from various sources, as referenced.

1. The Great Lakes Initiative on AIDS: This intergovernmental partnership is oriented to civil society, private sector, and development partners in six countries: Burundi, the Democratic Republic of Congo, Kenya, Rwanda, Tanzania, and Uganda. The aim of the initiative is to help reduce HIV infections and mitigate the socioeconomic impact of the epidemic in the Great Lakes Region by developing regional collaboration and implementing interventions that can add value to the efforts of each individual country. The initiative began in 1997 and seeks to establish HIV/AIDS prevention, care, treatment, and mitigation programs for mobile and vulnerable groups such as refugees, transport sector workers, and highly affected/infected populations within the participating states. It also seeks to enhance prospects for coordinated approaches addressing HIV/AIDS prevention, care, treatment and mitigation among these countries. The initiative has four components: (1) support for refugees and displaced persons, which provides services to a limited number of such populations and could include the full range of prevention, care, treatment, and mitigation through provision of services and goods; (2) support for HIV/AIDS related networks; (3) support for regional health-sector collaboration; and (4) support for management, capacity strengthening, monitoring and evaluation, and reporting of activities.

2. The Abuja Declaration of 2001¹⁷: Signed by African heads of state, this landmark declaration described AIDS as a state of emergency on the continent and proclaimed the fight against the pandemic to be the highest priority issue in their respective national development plans. Its signatories laid the foundations for intensifying and accelerating bold actions to stem the tide of HIV/AIDS in Africa. Significant progress has since been made toward combating the pandemic. A majority of the countries in Africa have established national coordinating bodies for HIV/AIDS, and several have accessed funds

¹³ Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa (2006), [The Demographic Impact of HIV/AIDS in South Africa - National and Provincial Indicators for 2006](#).

¹⁴ Inter Press Service News Agency (2006, May) 'Health South Africa: a burden that will only become heavier'.

¹⁵ UNAIDS/WHO Report 2006.

¹⁶ The National Demographic Impact of HIV in South Africa: National and Province Indicators for 2006.

¹⁷ OAU, Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, Abuja, Nigeria, April 2001.

from the Global Fund, the World Bank's Multi-country HIV/AIDS Program (MAP), PEPFAR, the Bill & Melinda Gates Foundation, and other bilateral and multilateral sources.

3. The 2005 Gaborone Summit Declaration¹⁸: At this summit, African Union member states committed themselves to achieve universal access to treatment and care by 2015 by developing an integrated health-care delivery system that incorporates essential health services and responds to the needs of the poor. The summit participants also committed themselves to strengthening primary health care; scaling up treatment of AIDS, tuberculosis, and malaria with proven effective drug combinations; strengthening health systems to promote universal access (by implementing the Abuja Declaration and allocating at least 15% of national budgets to health); preparing and implementing costed human resources for health development plans; and strengthening partnerships for improving access to treatment and care with communities, local governments, youth networks, civil society, RECs, development partners, and other stakeholders.

4. The Brazzaville Declaration¹⁹: Arising from a consultation in March 2006, this declaration contains a set of recommendations and commitments for scaling up toward universal access to HIV/AIDS prevention, treatment, care, and support in Africa by 2010. The participants at the consultation developed key principles for the expansion of health, social, and development programs and services. They also identified the main obstacles to rapidly and sustainably scale up existing national programs and services and made recommendations to overcome the identified obstacles to universal access. Participants further recommended actions to be carried out in the following areas: financing, human resources and systems, building and strengthening systems, affordable commodities, technology and essential medicines, human rights and gender, and accountability.

5. Lomé Declaration on HIV/AIDS in Africa²⁰: This declaration made in July 2000 reiterates the government's need to employ a holistic approach to combat the spread of HIV/AIDS in Africa. At its 36th Ordinary Session, members of the Assembly of Heads of State and Government of the OAU pledged to consider the issue of HIV/AIDS in their overall socioeconomic policies and to establish effective partnerships with regional and international organizations in the fight against HIV/AIDS. They also endorsed similar resolutions and declarations combating the grave consequences of the pandemic *and* committed to allocate resources within the framework of national budgets for HIV/AIDS activities, particularly prevention, epidemiological studies, and public education on HIV/AIDS and its prevention and care, recognizing the needs of HIV-positive people and people living with AIDS, their rights and roles in the containment of the epidemic.

6. The Millennium African Renaissance Program: This partnership for African renewal brought together several African heads of state. The leaders were not only concerned with reducing poverty levels and improving the quality of life in Africa, but also referred to the prevalence of infectious diseases, including HIV/AIDS. In the African-led and Africa-driven response expressed in the Program of Action, the leaders were asked to take responsibility for revitalizing and expanding education, technical training, and health services and urged that high priority be given to tackling HIV/AIDS.

¹⁸ 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana, 10–14 October 2005.

¹⁹ Brazzaville Commitment on Scaling up Towards Universal Access to HIV and AIDS Prevention Treatment, Care and Support in Africa by 2010, Brazzaville, Republic of Congo, 8 March 2006.

²⁰ OAU, The Assembly of Heads of State and Government of the OAU, 36th Ordinary Session, Lomé Declaration on HIV/AIDS in Africa.

7. AIDS Watch Africa (AWA): This advocacy platform comprises the heads of state and government of Botswana, Ethiopia, Kenya, Mali, Nigeria (chairperson), Rwanda, South Africa, and Uganda. It was established in April 2001 in Abuja, Nigeria, during the African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. AWA aims to accelerate efforts by heads of state to implement their commitments to fight HIV/AIDS by mobilizing the required national and international resources. It also seeks to spare future generations from infection, ensure the provision of care and treatment to the infected, improve management of the orphans' crisis, and strengthen human capacity.

8. Efforts by Africa's First Ladies: There have also been efforts by Africa's first ladies to fight HIV/AIDS on the continent. For example, a meeting in Kigali, Rwanda, brought together African first ladies to discuss preventing the spread of HIV/AIDS and searching for solutions to problems of children in difficult circumstances. Similarly, at a forum of African first ladies on women's economic empowerment and the fight against HIV/AIDS, Kenya's first lady, Lucy Kibaki, said that winning the war against HIV/AIDS would require paying particular attention to interventions that target women, who are more vulnerable to the disease than men due to their lack of socioeconomic empowerment. There is therefore a need for economic empowerment among girls and women.

9. The Medical Assistance Program (MAP): This program has worked with Christian hospitals, mission organizations, and churches throughout Africa to promote total health. It is especially credited with mobilizing African Christians in the fight against HIV/AIDS. It currently covers four African countries (Kenya, Tanzania, South Africa, and Zambia), although plans are underway to expand it to reach Angola, Botswana, Malawi, Namibia, Nigeria, Rwanda, Uganda, and Zimbabwe. The program has been notably effective in fighting HIV/AIDS due to its faith-based approach and its ability to bridge denominational gaps. Its focus in Africa has been on building HIV networks, engaging in church and AIDS policy advocacy, training pastors to counsel parishioners on HIV/AIDS, training people for home-based HIV/AIDS care, and training peer educators to engage youth on issues related to HIV/AIDS. The initiative has been very influential in the fight against HIV/AIDS in Africa, particularly in the development of the Africa HIV/AIDS Theological Initiative.

10. Efforts in Academia: The Workshop on Higher Education Science and Curriculum Reforms: African Universities Responding to HIV and AIDS, held in Nairobi in 2006, brought together deans of faculties of science and engineering and coordinators of AIDS Control Units at 22 African universities in five countries: Botswana, Eritrea, Ghana, Kenya, Rwanda, and Uganda. The workshop was jointly organized by UNESCO's Regional Bureau for Science in Nairobi and African Women in Science and Engineering. The aim was to share experiences, learn about mainstreaming in the context of HIV/AIDS and the university environment, and identify specific entry levels for mainstreaming HIV/AIDS into engineering, physical, and biological sciences as a way of enhancing prevention efforts for HIV/AIDS and responding to its impact. The workshop emphasized interactive learning through the presentation of HIV/AIDS activities at the institutions, compulsory university HIV/AIDS courses, and the process of mainstreaming HIV/AIDS into curricula with a focus on integrating HIV/AIDS into courses on physical and biological sciences and engineering.

11. African Development Forum (ADF) 2000: The ADF is a unique, innovative, annual event led by the ECA. It brings together government, civil society, private sector, and development partners to focus on specific strategies, policies, and programs on a selected development issue in Africa and establish an African-driven response. The ADF presents a unique regional environment for Africans and their development partners to

meet once a year to discuss critical development challenges and agree on African-led, African-owned responses that could be delivered, with impact, at country level. In 2000, ADF organized a forum where it considered AIDS as the greatest leadership challenge. According to ECA, Africa is the only continent so mortally affected by the pandemic. That year it convened activists and leaders to sharpen perspectives on AIDS and chart a new course for the future. The forum aimed to promote policies and mechanisms that harness the effort of government, civil society, and the private sector in the design and implementation of intervention programs. It also aimed to influence policy shifts at the national level and sought to impress upon leaders the urgency of advocacy and action on HIV/AIDS. The forum enabled the ECA to look at the role and responsibility of civil society, private sector, and external partners in the fight against HIV/AIDS in Africa.

12. United Nation General Assembly Special Session—Declaration of Commitment: UNGASS noted that by the end of 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 percent of them in developing countries and 75 percent in sub-Saharan Africa. UNGASS deemed HIV/AIDS a state of emergency that threatens development, social cohesion, political stability, food security, and life expectancy and imposes a devastating economic burden. It resolved that HIV/AIDS needs urgent and exceptional national, regional, and international action. However, it was at the Abuja special summit in April 2001 that the African heads of state and government committed to fighting HIV/AIDS. They pledged to allocate at least 15 percent of their annual national budgets for improvement of the health sector to address the HIV/AIDS epidemic. The declaration has succeeded in increasing total financing for HIV programs in developing countries by more than fourfold between 2001 and 2005. Consequently, the number of people on antiretroviral therapy has increased fivefold, and a comparable rise has occurred in the number who choose to learn their HIV serostatus. The prevalence rate has declined in most countries in sub-Saharan Africa due to these increased prevention efforts.

13. International Partnership Against AIDS (IPAA): Formed in 1999, IPAA is a coalition of actors who, based on a set of mutually agreed principles, have chosen to work together to achieve a shared vision, common goals and objectives, and a set of key milestones. This powerful initiative aims to establish and maintain processes by which the partners, also called the five constituencies (African governments, the United Nations agencies, donors, the private sector, and the community sector), are enabled to work more effectively together to stop the spread of HIV, sharply reduce its impact on human suffering, and halt the further reversal of human, social, and economic development in Africa. IPAA has mobilized unprecedented leadership and commitment among African leaders and organizations to intensify their response to HIV/AIDS. Many presidents have broken the silence that previously surrounded HIV/AIDS in their countries and have established high-powered commissions. IPAA has mobilized financial and technical resources from co-sponsors and donors, who have significantly increased their support. There is growing commitment among African governments, resulting in a realignment of funding priorities at the national level. Substantial grants have been made by private-sector organizations such as the UN Foundation and the Bill & Melinda Gates Foundation. The UNAIDS Secretariat is also working closely with the World Bank, UNDP, and UNICEF to maximize benefits for HIV/AIDS programs in debt-relief accords.

III. FINDINGS AND DISCUSSION

1. General

The researchers found a great deal of interest in the research topic. Many participants felt that the issue of engagement with global responses was not only relevant to HIV/AIDS, but also important to Africa's aspirations in other development sectors. However, the research generated many more questions than answers and in some cases sharpened and heightened controversies. While most respondents expressed the belief that African perspectives played little role in the response to HIV/AIDS in Africa initiated by the international community, many were at a loss to define these "African perspectives". Also, some respondents asked whether Africa, given her generally weak situation, can effectively engage the international community and influence interventions in response to HIV/AIDS. Even if the answer is yes, they wondered at what stage the engagement would occur: initiation (policy decision, program identification, conceptualization and design) and/or implementation.

Some respondents felt that policies and programs often originate in situations where Africa cannot be a player. These situations can be deliberate constructs ("some sections of the international community do not want to be engaged"—they want to retain the flexibility and freedom to take action as they see fit) or unintentional, for example due to national policy direction in a donor country. If this is all true, and Africa in fact cannot influence the initiation and design of policies and programs, should efforts therefore be channeled more productively towards influencing implementation?

In analyzing the role of leaders, the question arose as to who the "leaders" are when it comes to engaging the international community: obviously political party leaders (especially those in government and the ruling party), government and other policy makers, ideological leaders (e.g., faith-based), journalists, business leaders, and other opinion leaders are involved. All of these groups can shape opinion and policies on HIV/AIDS and play major roles in engaging with and representing African perspectives to the international community. How best should the differing situation and need of leaders in this broad definition be determined and addressed?

With respect to the knowledge, attitudes, and practices of leaders, what are or should be the necessary knowledge contents in relation to efforts at equipping leaders for effective engagement: knowledge of the biology of HIV/AIDS, knowledge of how to avoid HIV/AIDS, knowledge of how to present HIV/AIDS as a public health agenda or a governance issue, or focusing on knowledge of the impact of the epidemic?

While the research TOR appear to focus on interest in African engagement of the international community (i.e., the international or global level), it is relevant and important to consider engagement also at the Africa regional level and the various national and local community levels. For example, how do the various national levels (local communities, districts, provinces, regions, states, etc.) engage with one another horizontally and vertically, and how do the products or outputs of this engagement impact on engagement within the Africa region and with the international community?

Overall, the key findings of the research can be summarized as follows:

1. Africa has in various ways and with varying degrees of success engaged the international community on the response to HIV/AIDS in Africa. In all countries studied, civil society organizations—including community- and faith-based organizations and organizations of people living with HIV/AIDS—have played and continue to play major roles in advocacy, social mobilization, and fundraising to facilitate and support various levels of the response. In many instances, the

advocacy and “activist” activities of CSOs (such as KANCO in Kenya, and TASO and AIC in Uganda) have been critical for national level engagement to catalyze or strengthen the response.

2. Overall, the engagement has been *ad hoc* and does not appear fully effective in communicating and advocating “African perspectives”. Clearly, Africans have been involved in the development of some international initiatives that focus on or include the response to HIV/AIDS. However, there has been no purposeful engagement strategy, and consequently no effort to nurture an effective engagement process. Nor have these limited forms of engagement been purposefully documented.
3. A good (and sufficient) number of existing policies and policy frameworks facilitate and support engagement. What is lacking is effective implementation.
4. Many government and civil society executives and officials plan, implement and participate in activities that consciously or otherwise support engagement.
5. The presence of Africans in international organizations helps to promote and enable engagement. However, it is not clear to what extent this help facilitates incorporation of African perspectives.
6. There is no specific allocation of resources for engagement activities. However, resources made available for activities at the regional, subregional, and national levels invariably include portions for engagement.

Two particularly important points emerged strongly. These concern the need for leadership recognition of the socioeconomic magnitude of the HIV/AIDS pandemic and commensurate commitment to effective action, including allocation of the needed resources. One respondent in Kenya felt strongly that in view of its devastating impact, “Africa should be lining up its best brains to fight the pandemic”. On the need for domestic funding, one question continued to reverberate: how can one talk about a national response that is funded from abroad? Equally important was the view that if resources must come from the international community, then there must be coordinated strategic approaches to engaging with the international community to ensure that funded interventions more fully incorporate African perspectives.

2. African Perspectives

The general view among most respondents was that there is a unique overall African perspective on HIV/AIDS because Africa is hardest hit by the pandemic and HIV/AIDS can lead to a social catastrophe. But what is/are the African perspective(s)? In Niger, respondents defined the “African perspective” as “African global vision to address HIV/AIDS”, “African long-term goals and objectives to address HIV/AIDS”, and “African cultural, economic, social and political approaches to HIV/AIDS”. Respondents in Ghana and Gambia placed great emphasis on poverty, seeing it as a critical factor in the response to HIV/AIDS. In their view, since poverty is multifaceted, an African perspective is one that has an integrated approach to dealing with the HIV/AIDS problem.

As defined above (see page 5), the “African perspective” includes the various desires, preferences, aspirations, objectives, and targets that Africa would like to fulfill, in this case with regard to the response to HIV/AIDS in Africa. Prof. Souleymane Mboup of the University of Dakar, who has been extensively involved with HIV/AIDS research since 1985, believes that the African perspective is “very diverse and in many aspects, some known and some not so”. He places great importance on belief in the capability of Africans in collaboration and partnership with one another and with international counterparts to drive various aspects of the response. His research network, in partnership with international counterparts, has generated much of the knowledge of

HIV-2. Such networks and research facilities that help to promote and enable African influences need to be strengthened. In this regard, Prof. Mboup asked two questions: how do we create environments that are attractive to African professionals who contribute to strengthening the voice of Africa, and how can African professionals at the international level help to strengthen the voices of Africa? He felt strongly that it is important to target the professionals in the Diaspora.

In practical and specific terms, the African perspective as expressed by respondents may be summarized in the following African expectations from the international community:

1. Allow more African involvement and say in the conceptualization, design, implementation, and evaluation of policy, programs, and allocation and use of resources;
2. Refrain from micro-managing executives, other officers, and activities;
3. Involve executives, managers, and other officers more often and more fully in decision-making; keep them in the loop on decisions made outside Africa;
4. Integrate programs and activities with other development programs, such as those focused on poverty alleviation; promote and support more integrated rather than vertical programs and activities;
5. Allow control and flexibility in the allocation and use of resources;
6. Recognize and accommodate traditions and sociocultural practices as well as concerns; allow time for education and behavior-change programs;
7. Increase resources for initiatives to build human and organizational capacity and increase organizational effectiveness;
8. Share data and documentation (from research, activities, and accomplishments) with local nationals; publish more on Africa;
9. Reduce the number of different officers and reporting requirements to respond to or be accountable to; simplify and harmonize reporting requirements as much as possible; and
10. Enable more involvement of, and provide more support to, people and communities affected or infected by HIV/AIDS.

Respondents agreed that the African perspective (in terms of voice and space) is more often than not present but weak in the international response to HIV/AIDS in Africa. Africans attend most of the international conferences and other forums on HIV/AIDS. However, in most cases they do not engage effectively in the decision-making processes. Many respondents acknowledged that most of the time, they participate in Africa regional as well as international conferences and other events and activities without providing input into the agendas. Asked to explain, some respondents felt that the selected participants often lack the required expertise and qualifications. This is the case reported in Niger, for example. However, despite the lack of involvement in the decision-making process, leaders from Niger commit themselves to regional and international HIV/AIDS initiatives although their political will is not always fulfilled.

The African perspective includes bringing Africans together to deal with their own problems. African leaders at all levels should have a unified response, determine their own HIV/AIDS agenda, and direct the funding. The African perspective also includes keeping in view the vulnerability of its youth and making visible attempts to safeguard their wellbeing. The African perspective ensures that the population is sensitized and informed about the impending crisis on the youth and seeks to redress the problem,

taking cognizance of African socio-cultural backgrounds and their influences, one that involves all stakeholders especially traditional healers and opinion leaders.

3. African Leaders and the Global HIV/AIDS Agenda for Africa

Most of the time, African leaders seek to influence the HIV/AIDS global agenda to reflect African perspectives through national, sub-regional, and Africa regional meetings. At the national levels, the set-up of national AIDS control programs chaired by the head of state is the main strategy used to advance an African HIV/AIDS agenda. At the Africa level, the HIV/AIDS initiatives developed through the New Economic Partnership for Africa (NEPAD), the African Union (AU), the Economic Community of West Africa States (ECOWAS), the International Conference on AIDS and STI in Africa (ICASA), and the African Heads of State Abuja conference, have been strategies and approaches used to influence the HIV/AIDS global agenda. The recommendations of these regional consultations have been presented to the global HIV/AIDS establishment during the United Nations General Assembly Special Session (UNGASS, June 2001), the millennium declaration (September 2000), the 3 by 5 initiative, the 'Three Ones', and the joint UNAIDS/WHO political declaration on HIV/AIDS testing.

O.Z. Kwena (2004), J. Putzel (2003), J. Parkhurst (2001), and B. Rau, S. Forsythe, and T.M. Okeyo (1996) have written about the HIV/AIDS pandemic in Africa, including the style and attitude of leaders. Many African leaders are not sensitized enough about the HIV/AIDS pandemic to drive an appropriate response. This is partly because, in spite of the declarations political leaders sign, such as *The Abuja Declaration*, there is not enough commitment and political will. There is a "deep sense of shame about AIDS" and a "reluctance of everyone from head of state to the local clergy to talk about the issue". Situations differ across Africa, and changes of attitude and commitment appear to have taken place in some cases. A few African leaders have attempted to change the mindset of their people and have improved knowledge, attitude, and practice themselves. The often-cited examples of Kenya, South Africa, Uganda, and Senegal illustrate some of these different and changing situations.

Some African leaders, however, are still in denial about the existence and magnitude of the effects of HIV/AIDS, particularly in some countries with lower prevalence. Denial arises from many causes, such as the fact that AIDS touches on many taboo topics, including adolescent sexuality, sexual infidelity among married couples, homosexuality, and prostitution. Many political, religious, and cultural leaders would like to believe, or have others believe, that these things do not happen in their countries, and this tends to pull them backwards in responding to HIV/AIDS.

3.1. Government leadership on HIV/AIDS in The Gambia

In The Gambia there was a high level of political will from 1986 to 2007 (based on interviews with government officials and program managers), with a lot of advocacy using the media, the country coordinating mechanism, and the World Bank's Multi-country HIV/AIDS Program for Africa (MAP). President Yahya Jammeh took a lead in all activities related to HIV/AIDS, chairing the Council and holding a series of meetings with PLWHA. The Vice-President, First Lady, and cabinet ministers were physically involved in working with PLWHA to champion the fight against the disease. There was a high level of media coverage on HIV/AIDS, and this informed the general population and helped promote improvements in knowledge, attitudes, and practices (KAP).

Gambia's political will peaked in 2000–2001, when it received extensive funding from the donor community and held its first National AIDS Forum. The government led a concerted effort to combat stigma and discrimination against people living with HIV/AIDS. Meanwhile, specific NGOs and CSOs, such as the Alliance for Democracy in Africa, have been empowered to build the capacity of local people, educating them about HIV/AIDS and the management of treatment and care for PLWHA. Workshops have been held for religious leaders, parliamentarians, imams, and heads of villages—the “Alikalos”. According to the National Behavioral Sentinel study, knowledge about HIV/AIDS by the people of Gambia is very high, at about 95%.

Gambian parliamentarians are now pushing for enactment of a model law on HIV/AIDS and Human Rights drafted by SWAA and promoted through consultations with legislators. A certificate of urgency is being sought to speedily facilitate the process. The National AIDS Secretariat has met with the Speaker of the House to discuss ways to make inroads with parliamentarians. Specific actions taken by the government are also instrumental in changing the attitudes of Gambian leadership and the public at large. People in Gambia are not being dismissed from work because of their HIV/AIDS status. The President has made a specific statement on this issue.

Nevertheless, the political climate in Gambia changed dramatically on 17 January 2007, when President Jammeh announced at a Cabinet meeting—and a subsequent press conference—that he had found a cure for HIV/AIDS. He then launched a new treatment regimen involving herbal remedies, massages, ritual baths, and *Koranic* and spiritual incantations.

Those who wish to be cured are told to report to the Royal Victoria Hospital for a blood test to prove that they are HIV-positive. The results of the screening are read on national television; there is no confidentiality. Those who test positive are directed to the President's clinic inside the statehouse, where they are confined for treatment. Male patients may report to the clinic of their own volition, while female patients are expected to get permission from their husbands. There are specific instructions on conduct and expectations while undergoing treatment:

- Patients are encouraged to bring along their spouses for treatment;
- Patients should not take food from outside the statehouse;
- Patients should eat nutritious and well-balanced meals, including lots of fruits and vegetables;
- Patients should not consume alcohol or smoke cigarettes;
- Patients should abstain from sex;
- Patients should stop taking all other medications, including antiretroviral drugs;
- Treatment is free;
- Patients should partake in media sensitization programs, especially TV advocacy programs with the President; and
- Patients deemed ‘cured’ receive start-up capital for income-generating activities.

Patients are confined for three to six months, and their viral load must be cleared before they are discharged. Testing has been conducted in laboratories in Senegal and Morocco. Often there have been improvements in CD 4 counts, which are also announced on TV, and significant reductions in viral loads. Three results were found to be undetectable, and this was widely publicized in the print and electronic media.

This created a rift between the laboratory in Dakar and the President's program. The lab was not happy with how the results were interpreted, noting that the machine it used cannot detect viral loads less than 25,000 and that results that register as "undetectable" should not be interpreted as a 'cure'. Blood samples were subsequently sent to Morocco for screening, but the President's treatment program has now stopped revealing the source of its screening and results.

After treatment, patients are tested again; if found to be free of the virus and fit, they are discharged as a group. The President calls a rally at the statehouse and advises the patients on follow-up regimens and procedures. A key message after treatment is that one should not have unprotected sex. "Cured" patients become part of the team supporting the drive to cure.

So far five sets of patients have taken part in the President's treatment regimen. The first set comprised 11 patients, the second 32, the third 39, the fourth 48, and the fifth 90. Progressively more and more Gambians are undergoing treatment. Foreign patients are accepted through their embassies in Gambia. People from Guinea, Senegal, Malawi, and Uganda have participated in the program, with noticeable improvements in weight gain and general appearance.

Many Gambians believe the "cure" for HIV/AIDS found by their President is the best thing to ever happen for their country. Gambians generally patronize traditional herbal treatment, and the President's treatment regimen fits very well into their own health-seeking behaviors. It is welcomed even by some intellectuals, although a majority of intellectuals and educated people in Gambia view the President's "cure" with a measure of skepticism. Indeed, many intellectuals live in fear, afraid they will lose their jobs and positions if they say anything negative about the President's herbal treatment.

All respondents for this study, however, see some wisdom in the nutritional promotions in the president's treatment regimen and stress that it is a lesson worth learning. All agree that there are usually marked differences in the physical appearance of patients before and after treatment and that patients improve tremendously. "President Yahya Jammeh is restoring hope to the hopeless".

The President has become aware of some of the lapses in this treatment, especially his claim to cure HIV/AIDS, and in recent time the message has changed. He now says he simply flushes the "viruses out of one's system". The program is currently institutionalized with a director general and medical staff comprising trained nurses, doctors, and support staff—mainly PLWHA who have undergone treatment and are now advocates. The treatment is being extended to other diseases and is now known as the President's HIV/AIDS, Asthma, and Infertility Treatment Programme.

To most HIV/AIDS program managers, however, the initial gains are being derailed. Some say that the greatest mistake was the president's claim of a cure. Some patients have grown emaciated after an apparent recovery. The Minister of Health, Dr. Tamsir Mbowe, was sacked by the President in November 2007 for questioning the treatment's efficacy. He has since been reappointed as the Director of Health Services and Director General of the President's program, but his redeployment sent a message that one dare not question the efficacy of the President's treatment. Thus, a culture of silence and fear has emerged. Since January 2007, Gambian radio and TV programs have limited their coverage of HIV/AIDS to programs focusing on the president's own initiatives.

International civil society organizations are likewise frustrated because they are unable to carry out advocacy and sensitization programs. Gambian CSOs complain about a lack of funds for their HIV/AIDS programs because they lack access to donor funding. The president's response is essentially: "Why look for funds if there is a cure?" The environment created by his claim for a cure has derailed other HIV/AIDS programs in Gambia. Most CSOs are denied access to the media to educate the public about the transmission of HIV/AIDS and the management and care of PLWHA.

Some patients are compelled to testify on air that ARVs have side effects and are not good for HIV/AIDS patients; that ARVs are another imperialistic tactic to annihilate the black race; that Gambians have become guinea pigs; that the worst drugs are reserved for blacks and the best are reserved for whites. Yet PLWHA who appear in the president's television programs face a lot of stigma in their communities.

For his part, the President denigrates the international community and its response to the epidemic in Africa. He seems to be fighting with global leadership, saying that world leaders in health, especially pharmacists, are making a lot of money from HIV/AIDS in Africa. Gradually the government or political leadership is trying to indoctrinate the masses against Europe and America. The message is that the Western countries are trying to destroy Africans by sending untested antiretroviral drugs and that Africans are becoming guinea pigs for Western experiments. The Gambian President has found a cure, and Western countries are not ready to support his claim.

3.2. Government leadership on HIV/AIDS in Ghana

In contrast to Yahya Jammeh, a number of African leaders have demonstrated exemplary leadership. This is the case in Ghana, where there is continuing political commitment and support to campaign against HIV/AIDS. The country's favorable sociopolitical environment inspired the development of NSF I and NSF II. The 1992 Constitution recognizes and affirms the basic rights of citizens. The President serves as chairman of the Ghana AIDS Commission (GAC), providing it the highest mandate. The commission's members also include up of 15 Ministers and other stakeholders, including members of the private sector, traditional and religious leaders, and civil society organizations that have helped to create a favorable response to the epidemic.

A steering committee provides the technical backstopping for the activities of the Secretariat. The GAC regularly conducts its work through technical committees composed of experts and representatives from stakeholders, including MDA, development partners, NGOs, and civil society organizations. Prof. Fred. Sai, a renowned physician and reproductive health advocate, serves as presidential advisor on HIV/AIDS and reproductive health issues (2001-2008). Coordination and management of the national response through the decentralized system constitute key components of HIV/AIDS program implementation.

As the national coordinating body, the GAC blends political focus and technical dimensions to ensure a harmonized national response. It has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation, and research. It has also provided strategic vision for the coordination of the national response. Many of these achievements have been realized through strong political support, the establishment and use of decentralized institutional structures, the enactment of supportive policies and legislation, and widespread participation of civil society (NSF 11, 2005:2 & 11).

3.3. Government leadership on HIV/AIDS in Kenya

Writing in *African Development* in 2004, Kwena identifies four phases in the Kenya government's policy response to the AIDS pandemic. The first phase (from 1984, when the first AIDS case was diagnosed in Kenya, to around 1987) was characterized by an official view "that HIV/AIDS was not a serious problem" for Kenya (Rau *et al.*, 1996: 3) since it was associated with homosexual lifestyles, which were not officially acknowledged in the country. Hence, although the National AIDS Council was created in 1985, it did not become operational until 1987, when it was transformed into the National AIDS/STD Control Programme (NASCOP), and only then did it initiate HIV/AIDS awareness campaigns in the mass media and through interpersonal channels.

The next phase of government response (from 1988–1991) was characterized by a more realistic appraisal of HIV/AIDS as a potentially harmful health issue, although the perception persisted that AIDS was no more harmful than other diseases. In addition, influential religious leaders virulently criticized condom use in the media, suggesting that they were "a Western solution" inappropriate for Kenyans.

The third phase of government response (1992–1998) marked a significant departure, and official surveillance data were released and a national conference on AIDS held in 1993. The Minister of Health acknowledged that AIDS had become a national crisis (*Africa Confidential*, 1993), while government and international donors made socioeconomic impact assessments of the pandemic. From then on, NASCOP assumed a stronger coordinating role in the field activities of nongovernmental organizations (NGOs) and religious groups working in the HIV/AIDS field.

In the fourth phase, President Daniel arap Moi declared HIV/AIDS a national disaster and appealed officially to the international community, local communities, and individuals to assist in the fight against the disease (Kwena 2004). During this phase (1999–2002), various suggestions and approaches taken by institutional research, NGOs, and individual effort raised many issues about their effectiveness as well as legal, ethical, and human rights concerns. These debates addressed on a wide range of issues, among them the importation and use of condoms, the introduction of sex education in the formal schooling system, and the criminalization of spread of HIV/AIDS.

Kwena (2004) notes that, "In all these issues, the hand of politics has been quite conspicuous, thereby shaping people's responses to these issues. Political utterances on some of the interventions suggested have resulted in a strong undercurrent of skeptical opposition among the public without due considerations of the facts available". The methods and approaches taken in the fight against AIDS in Kenya have been met with considerable controversy. "Every method suggested has met heated debates from various quarters, with hardly any compromises reached" (Kwena, 2004).

3.4. Government leadership on HIV/AIDS in Niger

In response to the HIV/AIDS pandemic, Niger has developed a national strategic framework which has two goals: 1) to prevent the extension of sexually transmitted diseases (STIs) and the HIV/AIDS pandemic through information, education, and communication (IEC), sensitization, and advocacy activities; and 2) to support and care for people living with HIV/AIDS and people affected by the pandemic. The HIV/AIDS

response is based on four components, which are 1) prevention, 2) care and counseling, 3) socio-economic support to reduce economic precariousness of people living with or affected by HIV/AIDS, and 4) the coordination of the fight.

Niger's HIV/AIDS political environment is characterized by a number of features: the political will of the highly ranked leaders; availability of an institutional framework; Niger's adherence to the social objective of universal care; multi-sectoral and decentralized approach to combating the pandemic; and strengthening of the national HIV/AIDS legal framework. To show its leadership, the Republic of Niger allocated \$1,316, 304 annually for HIV/AIDS in the national budget for the period 2007-2011. In addition, there is Niger's engagement with international commitments, such the UNGASS declaration on HIV/AIDS (June 2001), the African heads of States Abuja Declaration (April 2000), the Millennium Declaration (September 2000), the "3 by 5" initiative, the "Three Ones", and the joint UNAIDS/WHO political declaration on HIV/AIDS testing.

The policy environment is poor, due to the sensitivity of HIV/AIDS issues. Two major policies are well known. The first policy criminalizes the voluntary transmission of HIV/AIDS. The second policy, supported by USAID AWARE HIV/AIDS project protects HIV positive people's rights.

The decision making structures are the National AIDS Council presided over by the President of the Republic; the eight regional HIV/AIDS councils presided over by the respective regional governors; thirty nine sub-regional HIV/AIDS councils presided over by the respective prefects, a large number of communal HIV/AIDS councils presided over the respective mayors, and twenty three sectoral HIV/AIDS committees in the various ministries chaired by the respective secretary general in each ministry.

The coordination structures 1) HIV/AIDS inter-sectoral coordination managed by the national coordinator; 2) the eight regional HIV/AIDS coordinating structures each led by the regional HIV/AIDS coordinator; and the twenty-three sectoral HIV/AIDS structures chaired by the respective secretary general of the ministries.

4. Engagement of the Global Community

4.1. Prerequisites

Many respondents shared their thoughts on how Africa might effectively engage the international community. They enumerated many conditions that could help African leaders (not only political, but also civic, religious, and other leaders) to effectively engage and influence the global HIV/AIDS agenda. At a minimum, these include:

1. Education and empowerment of leaders regarding the magnitude and impact of the HIV/AIDS epidemic in all its dimensions;
2. Purposeful involvement of knowledgeable, respected, and outspoken current and former leaders and first ladies;
3. African leaders must initiate, nurture, and sustain purposeful and coordinated region-wide strategies and strategic partnerships for fighting the epidemic and to underline and support their engagement of the international community;
4. Despite grave resource constraints, African leaders and governments must demonstrate commitment to fighting HIV/AIDS by setting aside and progressively increasing domestic (national) allocations for HIV/AIDS programs;

5. In line with the popular adage “in unity lies strength”, African leaders should establish or strengthen common institutional and management structures for researching, analyzing, and defining the strategic issues and considerations to inform Africa’s position when engaging with the international community, on an ongoing basis. These structures must receive adequate and continuous funding;
6. Active involvement and participation of different levels and segments of the media.

All the respondents agreed that African leaders and institutions are invited to the relevant international conferences. However, in most cases, African participation is dependent on funding from the international community. Also, many felt that decisions are often made ahead of time by developed countries and international organizations.

4.2. The Current Situation

Many of the respondents have been involved in actions that have strengthened Africa’s influence on the international community’s response to HIV/AIDS in Africa. The range of actions includes:

1. Researching and documenting needs, accomplishments, and issues;
2. Preparing and presenting papers for educational, advocacy, and resource mobilization purposes;
3. Defining desired positions and communicating and mobilizing support for them;
4. Identifying, tapping, and utilizing resources to support engagement needs; and
5. Providing leadership and preparing representatives to engage international partners at global meetings.

SWAA-Niger and SWAA-Senegal are examples of CSOs that have been involved in engaging the international community. SWAA-Niger has been involved with the Africa first ladies’ organization, Synergy Africa. Niger participated in the sub-regional youth network aimed at advocating youth involvement in HIV/AIDS issues. People living with the virus have been involved in many regional conferences, such as meetings of the Network of African People Living with HIV/AIDS. Also, Niger’s parliamentarians, through the African Parliamentarians’ Network, have been very active in enacting an HIV/AIDS law.

Representatives of the government of Niger have been attending the aforementioned Africa regional and international conferences. However, many respondents were negative about how government officials engage the international community on the response to HIV/AIDS. Representatives of Niger attend most of the international conferences and meetings but often without preparing, coordinating, networking, and developing partnerships. Thus, participants become spectators rather than actors at these gatherings. They are typically chosen through nepotism and favoritism rather than on merit and expertise. As a result, participants often develop a complex of inferiority during such meetings and do not dare to share their views.

The availability of national funding is important for African leaders and institutions to effectively engage the international community. Yet most African countries contribute very little of their national resources to HIV/AIDS and related programs. For instance, the government of Niger allocates only \$300,000 for the HIV/AIDS response. A Centre for Global Development study on funding of HIV/AIDS programs in Mozambique, Uganda, and Zambia (*A Comparative Analysis of PEPFAR, the Global Fund and World Bank MAP*) found that national government contributions towards HIV/AIDS programs in 2006 amounted to only 2% for Mozambique and 5% for Uganda. The corresponding amount

for Botswana was 6% in 2005. It is not clear how much of these amounts are spent on activities that enhance Africa's ability to engage the international community.

African countries receive funding from international sources for their responses to HIV/AIDS. Some, like Ghana, have benefited from international technical cooperation and funding. Like most other countries, Ghana has benefited from the AIDS Response Project (GARFUND) and the Global Fund. Its Ministry of Health accessed \$15 million from the Global Fund. The International Partnership against AIDS in Africa (SIPAA), a collaborative project with ActionAid, is receiving technical support from UNAIDS and £2 million from DFID. UNDP, GTZ, USAID, and DFID have all supported the HIV/AIDS programs in Ghana, but as in most other African countries, the amounts involved are meager considering the enormity of the pandemic.

Respondents suggested that as long as developed countries pay the bills for HIV/AIDS programs, they will continue to impose their viewpoints. Many African countries have little or no HIV/AIDS budget. There is a huge gap between the status quo and what ought to be in place for Africa to be effectively engaged.

According to a 2005 UN report, success in the response to HIV/AIDS will require an unprecedented willingness on the part of all actors in the global response to fulfill their potential, embrace new ways of working with each other, and commit to sustaining the response over the long term. If this does not happen, the world will not achieve Millennium Development Goal number 6 (combating HIV/AIDS and malaria) nor will it attain the 2010 targets laid out in the UN's Declaration of Commitment. The implication of this is that other Millennium Development Goals for reducing poverty, hunger, and childhood mortality will not be met.

African leaders have signed several declarations committing to actions and allocation of resources responding to the HIV/AIDS pandemic. Yet some respondents felt that these declarations, such as the Abuja Declaration, are merely lip service.

African countries can further stimulate global institutions and forums to create space for African perspectives by tackling issues of local governance in terms of transparency and accountability and by earmarking resources for HIV/AIDS. Also, there is a need to combine resources with political will, democratic processes, and human rights.

The key to stimulating global institutions is advocacy. African leaders should speak for the voiceless and marginalized. African leaders should be advocates to eradicate poverty and lobby for more funds to fight the disease.

4.3. Constraints and Impeding Factors

If effective and successful engagement requires robust and effective HIV/AIDS programs showing the desired clear impacts, then constraints to successful responses must also be accepted as constraints to effective engagement. Constraints to successful national responses are well documented. Some of them are summarized below.

One major factor hindering an effective HIV/AIDS response in Africa is the unfavorable macroeconomic situation, including low GDPs, high inflation rates, high interest rates, and unsustainable debt burdens. These factors lead to tight fiscal constraint, as revenues fall below targets and expenditure pressures increase. This situation is a major hindrance and prevents many African countries from implementing HIV/AIDS prevention

and control programs as expected by the richer countries. If the developed countries do not give financial assistance, the global initiatives on HIV/AIDS cannot succeed.

Governments usually have different priorities than those set by the global response to HIV/AIDS. For instance, in 1999 the government of Zambia allocated a very minimal amount to HIV/AIDS, citing economic reform as more important. This is a clear impediment to the global initiative, since its priority of prevention and control of HIV/AIDS differed from that of the Zambian government. However, this changed in 2004, when President Levi Mwanawasa declared HIV/AIDS a national emergency. In 2006 his government allocated US\$203,824,914, reflecting a commitment to fight AIDS.

Stigma, silence, discrimination and denial, as well as a lack of confidentiality are some of the factors that undermine prevention, care, and treatment efforts and increase the epidemic's impact on individuals, families, communities, and nations. These issues undermine efforts to control and prevent the spread of HIV/AIDS. There is a need for increased efforts to raise awareness.

There are inadequate resources and capacity for the HIV/AIDS response in the face of competing development priorities. In many African countries, such as Kenya and Uganda, the growth of HIV/AIDS to epidemic proportions coincided with the introduction of a slate of macroeconomic and development reform initiatives driven in large measure by external donors and development agencies. Important as they are, decentralization, health-sector reform and other sector-wide approaches (SWAPS), privatization, and other initiatives to improve governance and economic performance compete for the attention of leaders and the scarce resources of countries. In Tanzania, one committed leader in HIV/AIDS prevention noted that the government's tackling of various reform initiatives simultaneously strains the capacity of the bureaucracy, as civil servants are shuffled from one reform workshop or seminar to another, leaving inadequate time and attention to HIV/AIDS needs.

Coordination and partnerships at regional and national levels remain weak, making it difficult for countries to come together and influence global decisions on HIV/AIDS. For instance, in the East African region there have been very limited partnerships to fight the pandemic. There are a few exceptions, such as the Great Lakes Initiative on AIDS.

Recurring conflicts and natural disasters result in massive displaced populations and the degradation of infrastructure and social fabric. This presents difficulties in planning intervention programs. A good example is the post-election violence in Kenya. This sudden and totally unexpected development disrupted activities and plans in many respects and many areas.

Health systems are generally weak on the African continent. Inadequacies in skilled human resources due to the absence of appropriate human resource development plans and policies to train, motivate and retain available human resources (further complicated by the brain drain of professionals) are major concerns. Also, monitoring and evaluation systems are still weak in most African countries. This makes it difficult for African countries to engage in the fight against HIV/AIDS.

Traditional attitudes and practices, such as widow inheritance and the subordination of women's interests to those of men, play a role in the further spread of the virus. Lack of concrete and up-to-date biomedical, epidemiological, and impact-related information also limits the response by African leaders. At the same time, it must be said that African

leaders have either not been convinced or have refused to allocate resources for research and analytical work necessary to generate the required knowledge.

A lack of political stability in some African countries has contributed to the failure to generate an effective public-sector response to HIV/AIDS. The World Bank reported that in 1999, one out of every five Africans lived in a country that was severely disrupted by war or civil conflict. How could countries such as Burundi or Congo be expected to mount an effective response to HIV/AIDS in the face of protracted civil war and lawlessness? Quite the opposite: roving armies, refugees, and other migrating populations have fed the epidemic.

It has been shown that individuals who are personally affected by the epidemic exhibit greater commitment. For example, a leader who has witnessed the death of a close colleague or family member is more likely to act on HIV/AIDS policies or programs. Zambia's former president, Kenneth Kaunda, has frequently acknowledged the 1986 death of his son Musugo from AIDS. In a speech at the United Nations, President Robert Mugabe of Zimbabwe admitted that ministers in his cabinet and close family members had succumbed to AIDS. On the other hand, hard-hit communities may feel a sense of helplessness arising from the notion that AIDS is an insoluble problem.

There is a big difference in funding mechanisms, and a large variation in the degree to which donors want to have control over the content of programs and projects. Some donors have technical departments that specialize in HIV/AIDS and finance projects according to their own policies. Also there is little coordination among donors: most are not aware of other donors in the same country, which leads to overlaps. There is a tendency to fund many small projects, or parts of projects for short periods, which leads to scattered projects with many actors all doing little things and no one fully accountable. Also although budgets for humanitarian aid have increased significantly over the last years, they are still subject to the political views of the donor in respect to the conflicting parties, and funds are disbursed in an ad-hoc fashion, with short-term commitments of overfunding of long-term programs.

5. Information Sharing and Exchange

Information sharing depends on the documentation, monitoring and evaluation, and knowledge management systems in place, as well as the culture of information use in the different countries. Although specific situations and capabilities differ, many countries lack good monitoring and evaluation systems. Respondents acknowledge that at the national level, information sharing is weak and not systematic. In many instances, more information is available from international organizations in the countries than from the government. At the regional level, institutions such as USAID-PEPFAR, UNAIDS, ECOWAS, and ICASA provide significant opportunities for sharing HIV/AIDS information. However, it appears that information is shared in an *ad hoc* manner in many African countries.

The following are the main channels for sharing information on progress and challenges of the national responses. Preparatory meetings as well as dissemination of commissioned research and other reports are channels of information sharing related to engagement.

- 1) Websites: Where access is possible, the Internet is a rich source of information and knowledge. The Africa Regional Sexuality Resource Centre in Nigeria and the Africa

Gender Institute in South Africa are acknowledged as very good sources of information to aid preparation for engagement events. Yet in countries like Niger, not all international organizations have websites. Also, Internet connectivity is low, and only small numbers of people have access to information posted on websites.

- 2) Radio: Many national, private, and rural radio stations help to disseminate HIV/AIDS messages in local and national languages. This medium is the most effective in most countries.
- 3) Television: National and private television stations broadcast HIV/AIDS messages in national and local languages. TV coverage varies from country to country and within individual countries (in Niger, for example, it is limited to the capital city for the private stations). While television availability and viewing have increased, especially in urban areas, television coverage in most countries is still limited. As a result, not many target populations are reached.
- 4) Workshops and conferences: Organized by both government and civil society organizations, these meetings constitute important channels to share information. Unfortunately, attendees often do not give feedback about what they have learned at these gatherings.
- 5) Newsletters and other publications: Many organizations use such channels to share HIV/AIDS information. There is a large and wide range of newspapers of varying strengths and frequency of publication, purposefully or partially addressing the HIV/AIDS response. Many are university-based, but many others are published by civil society organizations and journalist organizations, such as FAMEDEV, based in Senegal, and JAAIDS in Nigeria.

Established in 2001 and operating in Central and West Africa, FAMEDEV conducts research, training, advocacy, and production of materials with the general aim of giving voice to women and other disadvantaged groups on issues of gender and HIV/AIDS. One of its initiatives is Alternative Voice, a community radio project with programs in English and local languages.

6. Lessons and Good Practices

Most of the lessons and good practices identified during the research relate to various components of HIV/AIDS programs, rather than directly relating to strengthening African engagement with the international community. The lessons and good practices are presented below, since effective and successful HIV/AIDS programs are important in achieving the objectives of engagement—influencing policies and allocation of resources with evidently effective and successful initiatives.

They are the following:

- The involvement of people living with HIV/AIDS has contributed greatly to the prevention and reduction of HIV/AIDS in Uganda. PLWHAs participate in sensitization and sharing activities as a way to reduce stigma, denial, and discrimination.
- The multisectoral approach to HIV/AIDS control has helped governments to provide services extensively, showing that a holistic approach to the epidemic is important and works.
- Understanding the socio-cultural and religious values of various communities is essential for any successful strategy.
- The involvement of civic, cultural, and religious leaders has helped the government of Uganda to deliver its HIV/AIDS message to many more Ugandans.

- The political support and commitment by government and the president of Uganda is very well known. These factors created a great impact on the Ugandan public. The poor and illiterate have accessed information about HIV/AIDS through HIV/AIDS campaigns and debates.
- A proper and streamlined coordination system is necessary to fight HIV/AIDS. Uganda has succeeded because of this kind of system, which is regarded a best practice.
- Sharing experiences and scaling up successful interventions through training workshops, conferences, and seminars is an important factor in the transfer of knowledge and skills to the different parts of the country to fight HIV/AIDS.

Ghana's sociopolitical environment, which provides the framework for policy development and implementation, contains essential elements for successful programming to combat the epidemic. The president serves as chairman of the Ghana AIDS Commission, providing the highest level of leadership in creating a supportive environment. One of the important sociopolitical structures in the country is chieftaincy—a popular institution that has the potential for effective social mobilization to combat HIV/AIDS at the community level. Some important chiefs have identified themselves with HIV/AIDS campaign, while some queens have taken up HIV/AIDS issues, especially the care of orphaned children. Within this supportive environment, the multisectoral national HIV/AIDS response has accumulated political capital.

PEPFAR has focused on fostering host-country leadership in the governmental and nongovernmental sectors, especially among people living with HIV/AIDS. Such leadership is critical in combating the stigma that continues to inhibit the fight against HIV/AIDS. PEPFAR supports numerous activities that engender leadership among PLWHA. A few examples include:

- South Africa's Mothers to Mothers-to-Be program has received international attention for achieving striking results. This program employs, trains, and supports HIV-positive women who have received prevention of mother-to-child HIV transmission (PMTCT) interventions. It enables pregnant women to learn the importance of knowing their HIV status, gives them information about how to access PMTCT programs, and instructs them about ways to prevent mother-to-child transmission.
- In Kenya, PEPFAR supports a number of efforts to link PLWHA who have similar interests. For example, a growing network of HIV-positive educators provides care for its members and works to improve the educational environment. Similar networks of HIV-positive religious leaders, Muslim women, and disabled people have also been effective within their communities.

With regard to engagement events, lessons and good practices include convening and hosting preparatory meetings and related activities (prior to the commencement of international events), commissioning and preparing background and working papers, and purposefully documenting and disseminating agreed-upon decisions and actions to build common platforms for discussion and negotiation with the international community. These activities are essential for defining, debating, and deciding common platforms and strategies during engagement with the international community. However, they have tended to be *ad hoc* in organization and coordination, often depending on the availability of funding allocated from other budget lines.

7. Technical Assistance and Funding

Although countries may differ greatly in their capacity and resources, their needs are similar with respect to training, technical assistance, and funds for both HIV/AIDS programs and engagement with the international community. Some countries, such as Niger, require further training to help them implement rights-based approaches, cultural approaches, and gender-based approaches to implementing HIV/AIDS programs.

Gambia needs technical support and assistance in developing and writing proposals to obtain funding. The country could not access the last round of support from the Global Fund because it lacked the capacity to write strong proposals. Respondents there also noted the need for technical assistance to support financial management of the HIV/AIDS program. This should be coordinated by the National AIDS Secretariat, but is currently outsourced to Deloitte and Touché at an enormous cost to the Secretariat. Gambia also needs to develop one main database on HIV/AIDS for the whole country. Current data, including Sentinel data, are scattered in heaps in offices and are used as and when needed without proper storage.

The need to expand and strengthen monitoring and evaluation systems, including CRIS, was emphasized. For example, in Gambia, there is currently no systematic mechanism to narrow response to the key drivers of the epidemic at all levels. Resources invested in HIV/AIDS should be measured in term of effectiveness, but this is not available.

Some countries need technical assistance to develop and implement their National Strategic Plans. Gambia, for instance, faces a skills gap that requires it to collaborate with experts from outside the country, instead of developing its own capacity. Since 1994, the Gambian government has created a very insecure work environment, and a lot of skilled personnel have left the country. People without the requisite skills are currently managing key positions.

Capacity building is essential. There is lack of capacity in sharing of information in terms of Internet technology, including development of websites and search engines. Updates on recent innovations in IT are needed.

In Niger, respondents articulated a need for technical support for planning, implementation, and monitoring and evaluating (M&E) HIV/AIDS programs. M&E is very weak, and there is the need for a South-South partnership and collaboration due to similarities in cultural beliefs and needs.

In Ghana, certain essential, uncompleted tasks, such as eliminating stigma and discrimination and empowering women and marginalized groups, may require using some of this capital. Since the implementation of NSF I, new dimensions of the management of the epidemic and priorities have emerged in such diverse areas as ARV, care and support for PLWHA and OVC, prevention of MTCT, deepening of BCC activities, and provision of more VCT centers. These emerging priorities have enormous resource implications for the national response, requiring significant increases in resources committed to HIV/AIDS activities. For instance, 750,000 women become pregnant each year. The annual cost of providing nevirapine to all pregnant women who are HIV-positive in order to prevent MTCT has been estimated at US\$1.2 million (NACP/GHS, 2004). It is also estimated that about 71,000 PLWHA require ART, yet only a small number of them are currently receiving treatment. The estimated annual cost of extending ART to all PLWHA who need treatment is between \$47 and \$80 million

(NACP/GHS, 2004). These priorities, together with others related to blood safety, BCC, infrastructural development, equipment, institutional development, training and capacity development, research and development, and monitoring and evaluation have extremely large resource implications for the national response.

Technical assistance and funding will be needed to:

- Sustain the existing positive environment;
- Facilitate the enactment and enforcement of policies and legislation relevant to stigma, discrimination, prevention, treatment, care, and support regarding HIV/AIDS;
- Sustain the interest of civil society in social mobilization;
- Ensure a focus on changing high-risk sexual behaviors;
- Operationalize a management framework that ensures efficient and effective implementation of the decentralized multisectoral response;
- Build the capacity of key agencies to develop and implement their policies and programs;
- Develop human capacity to sustain implementation of the HIV/AIDS response at all levels;
- Support implementing agencies to fulfill their defined roles and responsibilities; and
- Mobilize adequate resources to meet the demands of the expanded response at national, regional, district, and community levels.

A large number of local and international organizations, including intermediaries of donor and UN agencies, assist with technical assistance needs. The three Technical Support Facilities (TSFs) funded by UNAIDS are significant in this regard. The TSFs provide a mechanism for responding to technical assistance needs. In addition to improving access to technical assistance in prioritized areas, they also help to strengthen local capacity to deliver technical assistance, including professional development of national and regional consultants.

8. Accountability to African Beneficiaries

8.1. Current Situation

Respondents unanimously acknowledged that global policies, initiatives, and interventions have in many respects been sensitive to the needs of African beneficiaries. The international community has demonstrated compassion, concern, and caring through international mobilization and fundraising efforts. Many citizens of developed countries have been at the forefront of the HIV/AIDS fight by volunteering their time and sacrificing their lives to help.

However, some respondents also criticized the international community for making unilateral decisions about HIV/AIDS strategies and priorities and failing to reckon sufficiently with African perspectives on the response to HIV/AIDS. Thus, the social, cultural, and sociological aspects of the underlying roots of the pandemic are sometimes not fully taken into consideration. Respondents also believe that a big amount of the funds raised goes into administration, logistics, salaries, and per diems of experts.

Many respondents expressed the belief that developed countries are not always accountable to African beneficiaries. A double standard exists between beneficiaries and fund providers. Fund recipients are always required to explain their expenses, whereas

the donors and other funders fail or are unwilling to do so. There is a lack of transparency with regard to international organizations' bureaucratic expenses.

Many respondents in Niger, for example, felt that only the Global Fund is accountable to beneficiaries, as beneficiaries have ownership of their programs. Since accountability is an ethical issue, the status quo should change. Other fund providers should imitate the Global Fund's approach by involving beneficiaries during the whole process of the HIV/AIDS response. Beneficiaries should be responsible and gain ownership of their programs. They should be empowered.

Developed countries have committed to financial aid to developing countries. UNGASS should urge the developed countries to meet the agreed-upon targets—namely, allocating 0.7% of their gross national product (GNP) for overseas development assistance (ODA) and earmarking 0.15% to 0.20% of GNP for ODA to least developed countries—as soon as possible, taking into account the urgency and gravity of the HIV/AIDS epidemic. This is a platform that helps to ensure that developed countries keep their financial commitments.

8.2. Some strategies for seeking greater accountability by global initiatives to their African beneficiaries

The following strategies are some of the ways that the international community and global initiatives can improve their accountability to African beneficiaries:

- Recommend that African heads of state lead a social movement in their respective countries to provide accurate and reliable information and to make a package of services available within the context of a rights-based framework.
- Recommend that the Pan-African Parliamentary Committee on Health, Labor, and Social Affairs provides advocacy, oversight, and accountability for the implementation of the commitment to universal access. This group should work within the framework of the African Union making use of the AIDS Watch Africa and NEPAD peer review mechanisms, among others.
- Develop and strengthen national monitoring and evaluation systems with support from Regional Economic Commissions, UNAIDS, WHO, and the World Bank, in line with the Three Ones, which would produce an annual report on progress. The Three Ones is an initiative that was conceived during the 13th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA 2003), whose main aim is to promote universal coordination in the fight against AIDS.
- Set national targets inspired by regional targets for prevention, treatment, care, and support for 2008 and 2010 to aid Africa's development and be on track for Millennium Development Goal 6 (combat and reverse the spread of HIV/AIDS by 2015).
- The UN system and other development partners, including civil society, should develop a framework under which they are held accountable.

The UN has a key role to play in mobilizing resources for an intensified response to HIV/AIDS among women, girls, and the general community, ensuring greater coordination of donor requirements and processes and finding innovative ways to get these resources down to community level. The UN can therefore help ensure that funds issued through its various institutions are accounted for by institutional leaders so that the public benefits.

The Global Fund ensures transparency of funds it receives and spends by detailing them on its website. This promotes accountability and reduces the risk of corruption. It also helps ensure that money given to the Global Fund can be tracked to the projects and that, as a result, the Global Fund is held accountable to its African beneficiaries.

IV. CONCLUSIONS AND RECOMMENDATIONS

1. General

From the key informant interviews, it is clear that successful engagement of the international community requires knowledge, preparation, participation, and institutional capacity. The first three can be considered from the standpoint of individuals, while all four can also be considered at the institutional or organizational level. Some respondents felt that “leadership” should be added to the person-centered requirements (knowledge, preparation, participation)

The need for *knowledge* relates not only to the HIV/AIDS epidemic and its impact, and the issues and concerns to be addressed, but also to trends and developments associated with the policies, programs, and resource flows of national institutions and donor and international development partners. This knowledge is critical to the ability to prepare and participate effectively. *Preparation* involves a number of important actions: anticipating and planning for the issues to be raised; determining and deciding between/among alternative approaches or methods to use; and researching or otherwise gathering the information necessary to support positions to be advocated. Effective *participation* requires careful selection of representatives and spokespersons, balancing the required expertise and credibility with the ability and skill to communicate and negotiate. Acquiring, documenting, retrieving, and effectively utilizing knowledge, as well as tapping and allocating resources to support engagement actions, are all functions of *institutional and organizational capacity*.

What was not clear from the key informant interviews and the document review is to what extent, if at all, any of these requirements has been systematically identified and nurtured or otherwise promoted among African institutions that are engaged in the HIV/AIDS response and are in a position to engage the international community. Capabilities and resources for, and their impact on, each of the individual requirements differ from country to country. However, even in the national AIDS control agencies, the team did not find systematic attention to all the requirements.

The research findings show that African perspectives are a present but weak factor in the global community’s response to HIV/AIDS in Africa. Respondents acknowledged poor leadership and inadequate empowerment of leaders, insufficient capacity among regional institutions, weak advocacy expertise among leaders and institutions, weak performance of HIV/AIDS interventions, weak monitoring and evaluation systems, and low allocation of domestic funds. Many recommendations were made to address these challenges and constraints to a better global HIV/AIDS response agenda.

There is a need for a comprehensive development agenda that addresses the broad spectrum of underdevelopment as an issue in its own right and as the context within which HIV/AIDS flourishes. Success in responding to HIV/AIDS will come only through the implementation of such an agenda. Dealing with each one of the developmental factors that enhances vulnerability to HIV infection is, in effect, dealing with the AIDS epidemic. The UNAIDS Scenarios Project for AIDS in Africa took account of this

perspective when it stated that “the shape and extent of the AIDS epidemic is determined by a range of powerful forces, outside of the areas in which HIV and AIDS programs normally respond. Addressing HIV and AIDS may act as a catalyst for addressing these broader socioeconomic and political dynamics. Equally, addressing HIV and AIDS effectively requires a consideration of these broader forces” (UNAIDS). AIDS and development issues are so closely intertwined that the promotion of development almost automatically implies action against the epidemic.

HIV/AIDS prevention efforts need to be grounded in the broader struggle for social and economic rights for the poor. But international trade relations currently do not favor poor countries in Africa or elsewhere in the world. Instead they are heavily weighted in favor of the wealthier countries, while simultaneously creating barriers that prevent goods from poorer countries from accessing markets. This unfair global process serves to maintain countries in their poverty and thereby fuels the AIDS epidemic. The same holds true for debt, with many countries spending as much or more on debt servicing as they do on health services. The never-ending servicing of debts limits developing countries’ ability to pull themselves out of poverty as well as their ability to respond to the AIDS epidemic.

2. Leadership

African leaders should set up a specific African body solely to tackle the HIV/AIDS pandemic. There should be a standard African strategy that dwells on various experiences from African countries. This can then be used to define the African approach or strategy. Once the African strategy is defined, African leaders from a common platform can then share these strategies on a global platform and stimulate global institutions and forums to create space for African knowledge and initiatives on HIV/AIDS to be presented and heard. African leaders should aggressively and persistently lobby global partners to bring in more help, financing, and technical support.

Leadership of the HIV/AIDS response should be broadened. Leaders should come from all levels of society, comprising political as well as community and religious leaders, opinion leaders, and people living with HIV/AIDS. Charismatic, visionary, and articulate leadership should be encouraged. Leaders need to strive to acquire or strengthen good knowledge of HIV/AIDS and must improve their attitude to and perception of HIV/AIDS.

African leaders should stop paying lip service and drive the HIV/AIDS agenda themselves, allowing the international community to take them seriously. Africa leaders should be more visible in their campaigns. There is an abundance of policy frameworks; what is now needed is policy implementation and operationalization of action plans. There is a need to combine resources with political will, democratic processes, and human rights. In this regard, African leaders should take the first step by providing ‘seed money’ for their own HIV/AIDS programs and then others would follow. The fight against HIV/AIDS should not be donor-driven. African leaders should demand cancellation of debts, with proceeds going into a common fund for tackling HIV/AIDS on the continent.

African leaders should ensure South-South cooperation on issues of HIV/AIDS since Africans have similarities in cultural beliefs and needs. African countries should develop a common platform, suitably adapted to each country situation and needs, to articulate their concerns about HIV/AIDS. Allegiance should not be to former colonial masters, but to Africans. Taking cognizance of the varied historical and cultural influences, African leaders should utilize colonial connections as benefits in creating a common African agenda.

There should be strong regional and continental collaboration where African leaders would create a forum to discuss and agree upon strategies that are appropriate for solving the HIV/AIDS problem. Current programs are donor-driven and do not in many cases reflect national priorities and needs. There is a need for strategies that deal with Africa-specific situations rather than building on Western examples. Programs on HIV/AIDS should be driven by beneficiaries rather than by donors, and this can only be achieved when African leaders see the pandemic as a continental problem rather than a set of national problems. All African leaders should create a common platform and approach to tackling the HIV/AIDS problem.

3. Institutional capacity

African institutions and organizations such as the African Union, ECOWAS, NEPAD, ICASA, and others should strengthen their roles in the mission. Specific, purposeful steps should be taken urgently to further mainstream strategic and operational HIV/AIDS responses and implement them within the activities of regional and sub-regional institutions. The related capacities need to be strengthened with the aim of creating centers of excellence for African engagement in the global response to HIV/AIDS.

Given the strategic and policy frameworks already available on the continent—such as NEPAD, MDGs, and the Abuja Declaration—it is recommended that all African countries should incorporate the essential elements of these frameworks into their development strategies and programs for fighting HIV/AIDS. Issues regarding HIV/AIDS should be captured into the poverty reduction strategies of all African countries.

All African leaders should empower their National AIDS Control Programs (NACPs) by:

- Ensuring the regular supply of Anti-Retroviral Therapy drugs.
- Ensuring that each NACP has the specific technology, analyzers and other machines to deal with CD4 counts.
- Ensuring that all NACPs have guidelines for treatment.
- Ensuring that laboratory services are regularly supported and updated with new technologies.

Both leaders and institutions must be skilled and trained in advocacy, lobbying, and social marketing. Leaders should know how to win over developed countries to their HIV/AIDS agenda. Institutions such as Futures Group International have a presence in Africa as well as the ability to train leaders and institutions and share their expertise in advocacy. Futures Group has proven its competencies during its partnership with Family Health International on the USAID-funded AWARE HIV/AIDS program.

African leaders should create a forum for capacity building and networking among the various countries. They should build capacity for sharing information through websites, search engines, and other Internet technology.

African leaders should ensure training in various approaches to implementing HIV/AIDS programs, including rights-based, cultural, and gender-based approaches.

4. HIV/AIDS Programs

Improving the performance of HIV/AIDS programs is indispensable for advocacy, leadership, and empowerment. It is irrefutable that countries that achieve good

performance are more likely to be listened to and more likely to advance their agendas. The international community frequently cites strategies and approaches developed by Uganda and Senegal, for example. The Global Fund approach, based on performance, should be encouraged. Other international organizations should foster such an effective approach. The various technical support facilities (TSF) supported by UNAIDS are qualified to help countries improve the performance of their HIV/AIDS programs.

5. Monitoring and Evaluation

Obtaining reliable, high-quality data is an important step toward improving performance and gaining the trust of local, national, and international partners. Monitoring and evaluation systems must be strengthened to become more effective and more efficient.

The national AIDS control agencies visited during the research continue to take action in various ways and at different levels of commitment to build the capacity for monitoring and evaluation. What is not receiving attention is monitoring and evaluating of engagement strategies and activities. This action area is important if Africa really wants to strengthen engagement with the international community. There must be a systematic way to document engagement strategies and activities, assess their effectiveness, and learn from experience to inform planning for more effective strategies. Local or other funding must be found and used to fund local research and think-tank activities.

With regard to the monitoring and evaluation of HIV/AIDS control programs, African leaders should make use of the decentralized governance systems already in place. Some AIDS control agencies, such as the National AIDS Control Council in Kenya, have facilitated and supported the operationalization of decentralized structures that can also serve as monitoring and evaluation points. These structures also facilitate participatory approaches. The challenge is to make them work and work effectively. Outputs of the participatory monitoring and evaluation activities will help to incorporate local perspectives in engagement activities at the national and international level.

6. Local Resources and Commitment

Most of the time, in many international conferences and forums, countries that allocate substantial domestic funds to the HIV/AIDS response are well respected and listened to. Countries that abide by their international promises are more credible. African countries and institutions must mobilize more domestic funds for their HIV/AIDS response programs and keep their international commitments.

African countries do not reflect reality of the African situation and because of this, their proposals are often not convincing and therefore they do not gain access to global forums and institutions. African leaders should argue for the cancellation of debts, with proceeds to go into a common fund for tackling HIV/AIDS on the continent. Too many strings and conditionalities are attached to money provided by the Global Fund and other donors. Release of funds is often delayed because of these conditionalities, but AIDS is a disease that cannot wait.

Each African government should institute a resource mobilization fund for HIV/AIDS. Each relevant ministry should have a specific budget line for HIV/AIDS and see that all it is well managed and directed specifically toward HIV/AIDS programming.

7. Networking and Exchanges

Africans should develop regional programs that involve participatory planning. Africans can thereby share best practices, draw up action plans based on similarities, and learn lessons from the differences. Africans should create a broadly accessible African database on HIV/AIDS. There are currently a few networks that can be strengthened and utilized, including:

- African Network on Advocacy
- West African Network on HIV/AIDS (WANOSO)
- African Network on HIV/AIDS
- South African Network on HIV/AIDS
- East African Network on HIV/AIDS
- Regional AIDS Training Network

Language barriers seem to divide Africans, and this should create space at the various international forums to share their experiences. For example, during various regional forums (such as meetings of ECOWAS), African leaders should make it mandatory to devote at least one day to discussions on challenges and lessons on HIV/AIDS faced by individual countries. HIV/AIDS should become a core agenda item during these forums.

There should be strong regional and continental collaboration through which African leaders could create a forum to discuss and agree upon strategies that are appropriate for solving the HIV/AIDS problem. Current programs tend to be donor-driven and do not always reflect national priorities and needs. There is a need for strategies that will deal with Africa-specific situations rather than building on Western examples. Programs on HIV/AIDS should be driven by beneficiaries rather than donors, and this can only be achieved when African leaders see the pandemic as a continental problem rather than a set of national problems. All African leaders should create a common platform and approach to tackling HIV/AIDS.

APPENDICES

Appendix 1: OTHER STRATEGIES AND INITIATIVES

I. Current Regional and Sub-regional Responses to HIV/AIDS

A rather large number of strategies and initiatives that enable and enhance engagement with the international community to respond to HIV/AIDS has been implemented and many are ongoing. The following are culled from various sources, as referenced.

1. The Great Lakes Initiative on AIDS: This intergovernmental partnership is oriented to civil society, private sector, and development partners in six countries: Burundi, the Democratic Republic of Congo, Kenya, Rwanda, Tanzania, and Uganda. The aim of the initiative is to help reduce HIV infections and mitigate the socioeconomic impact of the epidemic in the Great Lakes Region by developing regional collaboration and implementing interventions that can add value to the efforts of each individual country. The initiative began in 1997 and seeks to establish HIV/AIDS prevention, care, treatment, and mitigation programs for mobile and vulnerable groups such as refugees, transport sector workers, and highly affected/infected populations within the participating states. It also seeks to enhance prospects for coordinated approaches addressing HIV/AIDS prevention, care, treatment and mitigation among these countries. The initiative has four components: (1) support for refugees and displaced persons, which provides services to a limited number of such populations and could include the full range of prevention, care, treatment, and mitigation through provision of services and goods; (2) support for HIV/AIDS related networks; (3) support for regional health-sector collaboration; and (4) support for management, capacity strengthening, monitoring and evaluation, and reporting of activities.

2. The Abuja Declaration of 2001²¹: Signed by African heads of state, this landmark declaration described AIDS as a state of emergency on the continent and proclaimed the fight against the pandemic to be the highest priority issue in their respective national development plans. Its signers laid the foundations for intensifying and accelerating bold actions to stem the tide of HIV/AIDS in Africa. Significant progress has since been made toward combating the pandemic. A majority of the countries in Africa have established national coordinating bodies for HIV/AIDS, and several have accessed funds from the Global Fund, the World Bank's Multi-country HIV/AIDS Program (MAP), PEPFAR, the Bill & Melinda Gates Foundation, and other bilateral and multilateral sources.

3. The 2005 Gaborone Summit Declaration²²: At this summit, African Union member states committed themselves to achieve universal access to treatment and care by 2015 by developing an integrated health-care delivery system that incorporates essential health services and responds to the needs of the poor. The summit participants also committed themselves to strengthening primary health care; scaling up treatment of AIDS, tuberculosis, and malaria with proven effective drug combinations; strengthening health systems to promote universal access (by implementing the Abuja Declaration and

²¹ OAU, Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, Abuja, Nigeria, April 2001.

²² 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana, 10–14 October 2005.

allocating at least 15% of national budgets to health); preparing and implementing costed human resources for health development plans; and strengthening partnerships for improving access to treatment and care with communities, local governments, youth networks, civil society, RECs, development partners, and other stakeholders.

4. The Brazzaville Declaration²³: Arising from a consultation in March 2006, this declaration contains a set of recommendations and commitments for scaling up toward universal access to HIV/AIDS prevention, treatment, care, and support in Africa by 2010. The participants at the consultation developed key principles for the expansion of health, social, and development programs and services. They also identified the main obstacles to rapidly and sustainably scaling up existing national programs and services and made recommendations to overcome the identified obstacles to universal access. Participants further recommended actions to be carried out in the following areas: financing, human resources and systems, building and strengthening systems, affordable commodities, technology and essential medicines, human rights and gender, and accountability.

5. Lomé Declaration on HIV/AIDS in Africa²⁴: This declaration made in July 2000 reiterates the government's need to employ a holistic approach to combat the spread of HIV/AIDS in Africa. At its 36th Ordinary Session, members of the Assembly of Heads of State and Government of the OAU pledged to consider the issue of HIV/AIDS in their overall socioeconomic policies and to establish effective partnerships with regional and international organizations in the fight against HIV/AIDS. They also endorsed similar resolutions and declarations combating the grave consequences of the pandemic *and* committed to allocate resources within the framework of national budgets for HIV/AIDS activities, particularly prevention, epidemiological studies, and public education on HIV/AIDS and its prevention and care, recognizing the needs of HIV-positive people and people living with AIDS, their rights and roles in the containment of the epidemic.

6. The Millennium African Renaissance Program: This partnership for African renewal brought together several African heads of state. The leaders were not only concerned with reducing poverty levels and improving the quality of life in Africa, but also referred to the prevalence of infectious diseases, including HIV/AIDS. In the African-led and Africa-driven response expressed in the Program of Action, the leaders were asked to take responsibility for revitalizing and expanding education, technical training, and health services and urged that high priority be given to tackling HIV/AIDS.

7. AIDS Watch Africa (AWA): This advocacy platform comprises the heads of state and government of Botswana, Ethiopia, Kenya, Mali, Nigeria (chairperson), Rwanda, South Africa, and Uganda. It was established in April 2001 in Abuja, Nigeria, during the African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. AWA aims to accelerate efforts by heads of state to implement their commitments to fight HIV/AIDS by mobilizing the required national and international resources. It also seeks to spare future generations from infection, ensure the provision of care and treatment to the infected, improve management of the orphans' crisis, and strengthen human capacity.

8. Efforts by Africa's First Ladies: There have also been efforts by Africa's first ladies to fight HIV/AIDS on the continent. For example, a meeting in Kigali, Rwanda, brought

²³ Brazzaville Commitment on Scaling up Towards Universal Access to HIV and AIDS Prevention Treatment, Care and Support in Africa by 2010, Brazzaville, Republic of Congo, 8 March 2006.

²⁴ OAU, The Assembly of Heads of State and Government of the OAU, 36th Ordinary Session, Lomé Declaration on HIV/AIDS in Africa

together African first ladies to discuss preventing the spread of HIV/AIDS and searching for solutions to problems of children in difficult circumstances. Similarly, at a forum of African first ladies on women's economic empowerment and the fight against HIV/AIDS, Kenya's first lady, Lucy Kibaki, said that winning the war against HIV/AIDS would require paying particular attention to interventions that target women, who are more vulnerable to the disease than men due to their lack of socioeconomic empowerment. There is therefore a need for economic empowerment among girls and women.

9. The Medical Assistance Program (MAP): This program has worked with Christian hospitals, mission organizations, and churches throughout Africa to promote total health. It is especially credited with mobilizing African Christians in the fight against HIV/AIDS. It currently covers four African countries (Kenya, Tanzania, South Africa, and Zambia), although plans are underway to expand it to reach Angola, Botswana, Malawi, Namibia, Nigeria, Rwanda, Uganda, and Zimbabwe. The program has been notably effective in fighting HIV/AIDS due to its faith-based approach and its ability to bridge denominational gaps. Its focus in Africa has been on building HIV networks, engaging in church and AIDS policy advocacy, training pastors to counsel parishioners on HIV/AIDS, training people for home-based HIV/AIDS care, and training peer educators to engage youth on issues related to HIV/AIDS. The initiative has been very influential in the fight against HIV/AIDS in Africa, particularly in the development of the Africa HIV/AIDS Theological Initiative.

10. Efforts in Academia: The Workshop on Higher Education Science and Curriculum Reforms: African Universities Responding to HIV and AIDS, held in Nairobi in 2006, brought together deans of faculties of science and engineering and coordinators of AIDS Control Units at 22 African universities in five countries: Botswana, Eritrea, Ghana, Kenya, Rwanda, and Uganda. The workshop was jointly organized by UNESCO's Regional Bureau for Science in Nairobi and African Women in Science and Engineering. The aim was to share experiences, learn about mainstreaming in the context of HIV/AIDS and the university environment, and identify specific entry levels for mainstreaming HIV/AIDS into engineering, physical, and biological sciences as a way of enhancing prevention efforts for HIV/AIDS and responding to its impact. The workshop emphasized interactive learning through the presentation of HIV/AIDS activities at the institutions, compulsory university HIV/AIDS courses, and the process of mainstreaming HIV/AIDS into curricula with a focus on integrating HIV/AIDS into courses on physical and biological sciences and engineering.

11. African Development Forum (ADF) 2000: The ADF is a unique, innovative, annual event led by the ECA. It brings together government, civil society, private sector, and development partners to focus specific strategies, policies, and programs on a selected development issue in Africa and establish an African-driven response. The ADF presents a unique regional environment for Africans and their development partners to meet once a year to discuss critical development challenges and agree on African-led, African-owned responses that could be delivered, with impact, at country level. In 2000, ADF organized a forum where it considered AIDS as the greatest leadership challenge. According to ECA, Africa is the only continent so mortally affected by the pandemic. That year it convened activists and leaders to sharpen perspectives on AIDS and chart a new course for the future. The forum aimed to promote policies and mechanisms that harness the effort of government, civil society, and the private sector in the design and implementation of intervention programs. It also aimed to influence policy shifts at the national level and sought to impress upon leaders the urgency of advocacy and action

on HIV/AIDS. The forum enabled the ECA to look at the role and responsibility of civil society, private sector, and external partners in the fight against HIV/AIDS in Africa.

12. United Nation General Assembly Special Session—Declaration of Commitment: UNGASS noted that by the end of 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 percent of them in developing countries and 75 percent in sub-Saharan Africa. UNGASS deemed HIV/AIDS a state of emergency that threatens development, social cohesion, political stability, food security, and life expectancy and imposes a devastating economic burden. It resolved that HIV/AIDS needs urgent and exceptional national, regional, and international action. However, it was at the Abuja special summit in April 2001 that the African heads of state and government committed to fighting HIV/AIDS. They pledged to allocate at least 15 percent of their annual national budgets for improvement of the health sector to address the HIV/AIDS epidemic. The declaration has succeeded in increasing total financing for HIV programs in developing countries by more than fourfold between 2001 and 2005. Consequently, the number of people on antiretroviral therapy has increased fivefold, and a comparable rise has occurred in the number who choose to learn their HIV serostatus. The prevalence rate has declined in most countries in sub-Saharan Africa due to these increased prevention efforts.

13. International Partnership Against AIDS (IPAA): Formed in 1999, IPAA is a coalition of actors who, based on a set of mutually agreed principles, have chosen to work together to achieve a shared vision, common goals and objectives, and a set of key milestones. This powerful initiative aims to establish and maintain processes by which the partners, also called the five constituencies (African governments, the United Nations agencies, donors, the private sector, and the community sector), are enabled to work more effectively together to stop the spread of HIV, sharply reduce its impact on human suffering, and halt the further reversal of human, social, and economic development in Africa. IPAA has mobilized unprecedented leadership and commitment among African leaders and organizations to intensify their response to HIV/AIDS. Many presidents have broken the silence that previously surrounded HIV/AIDS in their countries and have established high-powered commissions. IPAA has mobilized financial and technical resources from cosponsors and donors, who have significantly increased their support. There is growing commitment among African governments, resulting in a realignment of funding priorities at the national level. Substantial grants have been made by private-sector organizations such as the UN Foundation and the Gates Foundation. The UNAIDS Secretariat is also working closely with the World Bank, UNDP, and UNICEF to maximize benefits for HIV/AIDS programs in debt-relief accords.

II. Government Leadership

1. Malawi

In 2003, Malawi's minister for land, housing, physical planning, and surveys, Mr. Thengo Maloya, disclosed that three of his children had died of HIV/AIDS when he addressed his staff at an HIV/AIDS sensitization workshop in the capital, Lilongwe. He decided to go public about his family tragedy to show the seriousness of the pandemic.

"They would have taken care of me and buried me but instead I have buried them at such an early age".

The following year, President Bakili Muluzi urged Malawians to break the stigma attached to AIDS as a first step in fighting the disease, which has infected more than 14% of the country's 11 million people. To help change attitudes, break the silence, and initiate open talk about sex and AIDS, he announced that his own brother had died of HIV/AIDS.

2. Rwanda

In Rwanda, all of the political leaders are involved in the fight against HIV/AIDS, from the President on down. There is a cabinet minister in charge of the fight against HIV/AIDS, as well as a parliamentary commission charged with sensitizing the masses about HIV/AIDS at the village level. A substantial part of the national budget is devoted to the fight against HIV/AIDS.

The office of the First Lady, Jeannette Kagame, advocates for HIV/AIDS patients and supports local associations of AIDS victims. At a 2007 conference in Kigali sponsored by the United States President's Emergency Plan for AIDS Relief (PEPFAR), along with the Global Fund, the World Bank, and three United Nations agencies, Ms. Kagame urged participants to continue to fight HIV/AIDS and not to discriminate against people living with the disease. "Too often, we are elaborating our efforts to protect the reputation of the wealthy and say they died or are suffering from ailments other than AIDS," she said. "But at the same time, we are quick to judge the poor as irresponsible when they become victims of this scourge. AIDS does not make social judgments, so why do we? AIDS does not affect families based on their economic wealth, so why should we?"

3. South Africa

The Nelson Mandela Children's Fund was established in 1995 to address the needs of young people facing homelessness, joblessness, and poverty in South Africa. However, the scourge of AIDS has given new meaning to the phenomenon of children in need, and the Fund is now focusing its energy on AIDS orphans and the many "child-headed households" around the country. In the Fund's 2002 annual report, Mr. Mandela wrote:

"The effects of HIV/AIDS demand a more sustained approach involving the community and the primary unit of care and nurturing, namely the family. A solid family environment is essential in paving the way for the realization of future dreams and aspirations of children".

He also stressed the need for a global approach in fighting the pandemic, and emphasized the importance of strengthening relationships with UNICEF, Save the Children, and other nongovernmental organizations.

In 2005, upon losing his eldest son, Mr. Mandela announced the cause of death as HIV/AIDS. He called for renewed efforts to fight AIDS, challenging the taboo that surrounds the disease in Africa:

"Let us give publicity to HIV/AIDS and not hide it because it's the only way to make it appear like a normal illness".

Since stepping down in 1999, Mr. Mandela has campaigned for greater awareness of AIDS issues.

Other South African leaders have sown more confusion. Jacob Zuma, the former South African Deputy-President (now leader of the African National Congress and President of the country), went on trial in 2006 for allegedly raping an HIV-positive woman. As reported in the South African and international media, he argued that she had consented to sex and was eventually found not guilty, but sparked controversy when he stated that he had showered after sex in the belief that this would reduce his chances of becoming infected with HIV.

The slow provision of treatment by government of South Africa has been linked to unconventional views about HIV and AIDS within the government. Former President Thabo Mbeki frequently questioned whether HIV really causes AIDS and the efficacy of antiretrovirals such as AZT. On the other hand, while announcing a partnership against AIDS in 1998, he urged South Africans to recognize that HIV/AIDS is everyone's problem. He noted that it spreads mainly through sex, and although he acknowledged that people have a right to choose how to live their lives, he encouraged abstinence or the use of condoms by those who don't abstain.

Mr. Mbeki's health minister, Manto Tshabalala-Msimang, promoted nutrition rather than antiretroviral drugs as a means of treating HIV. She resisted the use of antiretroviral drugs in the state health sector on cost and safety grounds, even though close to five million people in the country are living with the virus. Tshabalala-Msimang has been criticized for causing further confusion by talking about the value of garlic, the African potato, and traditional healers in treating the virus. These views have drawn widespread criticism, both within South Africa and among the international community.

4. Uganda

It is well documented that Uganda was one of the countries hit "earliest" and "hardest" by the HIV/AIDS epidemic in Africa. The first cases of HIV were identified in 1983, where after the number of reported cases expanded exponentially. Prevalence, as measured by surveys of women attending antenatal clinics, appears to have peaked in the early 1990s and declined through the decade, and has remained stable from 2000 until now.

Swidler (2003) notes that Uganda's limited "no-party" democracy initially provided a stimulating environment for the operation of a wide variety of NGOs and for an array of international collaborations. She writes that the state-building strategy of President Yoweri Museveni, following a brutal civil war, "recognized that government couldn't do everything, but that it could encourage a wide variety of local and international initiatives". One Ugandan observer (Nyago, 2003) notes that the country's success in slowing the spread of HIV/AIDS hinged on the "democratic reforms that characterized the post-1986 period. This new political climate unleashed people's creative energies to respond to this pestilence. This occurred through free debate in the media and the broader public realm, which helped demystify the disease, in addition to the formation of people-centered NGOs such as TASO and the Aids Information Centre."

Nyago also credits the "decentralization and the introduction of the Local Council system," noting the kind of collaboration that was encouraged between community groups and local-level party officials:

The women, youth and people with disabilities were particularly targeted for empowerment. This meant that scientifically proven information would smoothly flow from the top to the Local Council leadership, who would in turn disseminate

it to a receptive population. It's this local coalition of the LCs, clan head, local imam and pastor, or bwana Mukulu [parish priest] together with Community Based Organizations that helped change the tide through community ownership of the anti-AIDS campaign.

Box 2: Important Themes in Uganda Leadership
<ol style="list-style-type: none">1. He listened to and valued scientific and medical knowledge.2. He favored public delivery of health care and the regulation of private providers.3. He simultaneously called for protection of the rights of women and children and advanced a socially conservative agenda, which, while rejecting superstitions and abusive family practices, called for a revival of traditional values.4. Museveni argued for an all-out campaign to educate the public. <p><i>James Putzel., 2003. Institutionalizing an emergency response: HIV/AIDS and governance in Uganda and Senegal</i></p>

In analyzing Uganda's success factors, Swidler writes that "Uganda's democracy not only 'empowered' local communities. It created just the right environment for NGOs to flourish, constraining forces that elsewhere compromise NGO effectiveness".

Putzel (2004) describes three major speeches in which Museveni raised the central themes that shaped his subsequent interventions to fight the epidemic (Box 2).

Uganda's widely acknowledged success in responding to the HIV/AIDS pandemic is also analyzed by Putzel. In addition to Museveni's personal attributes, Putzel identifies "four factors that help to explain the origins of Uganda's successful central leadership in the fight against HIV/AIDS":

1. Museveni shunned the mythologies associated with HIV/AIDS and listened to expert medical advice.
2. The incentive structure that the government faced meant that overall it had little to lose and everything to gain by taking early action on HIV/AIDS.
3. The impact of the high-level political commitment to fight against HIV/AIDS and the all-out educational campaign, both clinched by December 1988, created a situation where the epidemic was put beyond partisan politics.
4. A firm coalition backed the President's HIV/AIDS campaign. By the time Museveni brought the NRM out forcefully behind a full-blown campaign at the end of 1988, there were few families in the country, including the families of most major political actors, who were not affected by HIV/AIDS.

5. Zambia

Kenneth Kaunda, Zambia's president from 1964 to 1991, has been one of the most vocal and committed AIDS activists in his country. During one Economic Commission for Africa conference in 2000, he referred to AIDS as:

"A disease that affects us silently, persistently and destroys us ruthlessly sucking away the life and vitality of our families."

In 2000, Dr. Kaunda warned that no one is too young and no one is too old for HIV/AIDS. Addressing Heads of State at a two-day Southern African Development Community (SADC) conference in Windhoek, Namibia, Dr. Kaunda described his personal experience with HIV/AIDS after he lost his son to the disease in 1988. At that time, not much was known about HIV/AIDS, but the community supported him.

Convinced that the fight against HIV/AIDS must be a communal one, he urged SADC leaders to join hands and fight the HIV/AIDS problem together, saying:

"Let us save the children. Let us save SADC. Let us save Africa."

Speaking in Lusaka, Zambia, in 2007, Dr. Kaunda called on leaders worldwide to help African countries fight HIV/AIDS. He argued that poverty, underdevelopment, illiteracy, ignorance, the status of orphans, and diseases like malaria, TB, and HIV/AIDS have undermined economic growth on the continent. Reminding listeners that AIDS has spread across the African continent at an alarming rate, he called for action from all quarters, noting that the pandemic requires collaboration among all stakeholders. African countries are facing a disaster, he said, but no clear strategies for fighting the disease have been developed. He added that the millions of people who have died from AIDS-related illnesses should be cause for global concern, noting that these numbers represent real people who are missed by their families. "Today our graveyards are expanding at a much faster rate than before," he said. "This is a disaster. If we do not act now, posterity will judge us harshly for the world has the capacity and resources to reverse this pandemic"²⁵.

As a member of the Africa Forum, Dr. Kaunda has also been an outspoken advocate for actions to reverse the continent's AIDS crisis. Speaking at the World Bank headquarters in Washington in 2000, he described "a deafening wall of silence on AIDS" that must be "broken." He added that an "unnecessary stigma prevents testing, and discussing AIDS openly in Africa is not acceptable in many places—in fact, it's taboo." Dr. Kaunda warned that, "If we don't break this dangerous wall, it will destroy Africa."

III.. The Role of Faith-Based Leadership

Certain faith-based organizations have been active on HIV issues. In many African countries, the church represents a strong community structure for decision making and problem solving. Nearly everyone is associated with a church or has been to a church at least once in their lifetime. In September 1999, at a church leaders' consultation in Gaborone, Botswana, facilitated by Cafod, Norwegian Church Aid and the Salvation Army, African church leaders admitted there was much more the church could do to help prevent HIV/AIDS and care for those living with the virus. Many church leaders at the consultation acknowledged that they had been too reserved in their response and had treated HIV/AIDS primarily as a health issue. They only became involved during funerals, at which HIV/AIDS was not even mentioned. They agreed that the way church meetings were being conducted did not reflect the impact of the pandemic, nor did youth meetings and women's meetings. Most church responses to HIV/AIDS have come from church hospitals and other social institutions, with little or no response from local congregations made up of ordinary men and women.

In 2000, in a communiqué signed by the Zambia Episcopal Conference (ZEC), the Evangelical Fellowship of Zambia (EFZ), and the Christian Council of Zambia (CCZ), pastors proposed that aspiring candidates for elections should be tested for HIV/AIDS to reduce deaths, unnecessary by-elections, and costs incurred during the polls. This was met with mixed reaction. The deputy minister for religious affairs, Reverend Peter Chintala, supported the call. However, he differed with the pastors about restricting the tests to politicians, which could be discriminatory since they are entitled to privacy

²⁵ Xinhua/CRIEnglish.com, <http://english.cri.cn/2947/2007/12/09/176@302896.htm>, 12 December 2007.

despite holding public office. Rev. Chintala felt that the test should be extended to the clergy, since they too are leaders, and to all parents to reduce the number of HIV/AIDS cases.

IV. Opportunities That Exist, But Are Not Well Known, for African Engagement with Global Initiatives and Forums

1. *New Partnership for African Development (NEPAD)*: NEPAD is designed to address the current challenges facing the African continent. Issues such as the escalating poverty levels, underdevelopment, and the continued marginalization of Africa needed a radical new intervention, spearheaded by African leaders, to develop a new vision that would guarantee Africa's renewal. However, the prevention and control of HIV/AIDS is not one of its key objectives. In 2002, the chief Advisor to the UN secretary general Mr. Stephen Lewis criticized NEPAD for only talking about trade, investment, governance, corruption, and financial architecture—with only a modest reference to the human side of the ledgers. Lewis argues that there can be no reference to sub-Saharan Africa without placing HIV/AIDS at the heart of the analysis. NEPAD aims to achieve an annual growth of 7% for 15 years, cut poverty in half by 2015, reduce infant mortality by two-thirds, reduce maternal mortality by 25%, have every eligible child enter school, and reinforce gender equality. These objectives cannot be achieved unless HIV/AIDS is brought under control. NEPAD therefore has an obligation to be involved in the control and prevention of the pandemic.

2. *African Growth and Opportunity Act (AGOA)*: This U.S. trade act significantly enhances access to U.S. markets for businesses in (currently) 39 countries in sub-Saharan Africa. Since it was signed into law in May 2000, AGOA has encouraged substantial new investments, trade, and job creation in Africa. It has helped to promote sub-Saharan Africa's integration into the multilateral trading system and a more active role in global trade negotiations. It has also contributed to economic and commercial reforms that make African countries more attractive commercial partners for U.S. companies. AGOA represents an important component of U.S. development policy toward Africa. The problem is how the HIV/AIDS epidemic affects African development prospects and the workings of AGOA. AGOA representatives met late in 2001, again in 2002, and for a third time in December 2003. They suggested a number of actions that AGOA member countries could consider to enhance the effectiveness of responses to HIV/AIDS. So far their initiative has worked in member countries.

3. *Swedish International Development Agency (SIDA)*: In 2003, SIDA unveiled a new structure to tackle HIV/AIDS based on a realization that the pandemic must be addressed by all sectors of development cooperation. The Swedish response is described in the strategy paper "Investing for Future Generations" (Article number SIDA1683en). SIDA has established a resource group composed of the HIV/AIDS Secretariat in Stockholm, the Africa Team in Lusaka, Zambia, and the Regional Advisor on HIV/AIDS in South Asia. It has also helped establish the Swedish/Norwegian Regional HIV/AIDS Team for Africa, which works as a resource base for the embassies. SIDA also supports regional organizations and initiatives responding to the epidemic.

4. *Japan International Cooperation Agency (JICA)*: JICA aims to advance international cooperation through the sharing of knowledge and experience and works to build a more peaceful and prosperous world. In 2005, in order to strengthen its assistance in tackling health issues in developing countries, Japan launched a Health and Development Initiative, contributing US\$5 billion worldwide over five years. In Africa,

it has developed an action plan on the basis of Africa ownership. JICA funding in Africa has increased over the years, but the agency does not provide financial aid to all African countries.

5. Korea International Cooperation Agency (KOICA): KOICA promotes international cooperation by contributing to the economic and social development of developing countries through grants, aid, and technical cooperation. Since 1995, it has supported the overseas development activities of Korean NGOs that aim to help impoverished and marginalized people. Development cooperation with NGOs can be very efficient, especially in regions where government assistance cannot be delivered directly. The rate of infant and maternal mortality remains high in developing countries, where people often lack access to basic medical facilities and health care services. This hinders efforts to eradicate diseases such as tuberculosis and HIV/AIDS. KOICA is implementing various health-related activities so that local people, at all levels, can receive medical services on a continuous basis. Such efforts include building, improving, and enlarging medical facilities; establishing health care policies and systems; and dispatching or training skilled health care workers.

6. AU Annual Summits: African leaders have a role to play in soliciting support from the industrialized countries to help curb HIV/AIDS in their countries. In the past several years, they have used the occasion of the annual summits of heads of state and government to reaffirm their commitment to combating the HIV/AIDS epidemic. However, African leaders may not have sufficiently stated their case for international support in the fight against HIV/AIDS, as compared to other pressing issues. A collective effort needs to be deployed on behalf of HIV/AIDS, as was done for African debt forgiveness, for example, at the G-8 2000 Summit. There is need for Africa-led advocacy efforts that could focus on:

- Access to ART and other expensive treatment regimes;
- More significant involvement of African scientific institutions in vaccine and pharmaceutical research; and
- Additional financial resources to carry out prevention, care, and support.

The AU secretariat, ECA, and other regional and subregional development bodies should play a key role in preparing African leaders for this global advocacy effort.

The targets for HIV prevention established by governments in 2001 at the Abuja Summit and the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS have laid the foundations for intensifying and accelerating bold actions to stem the tide of AIDS on the African continent.

The Africa Union, the United Nations Economic Commission for Africa, the subregional economic communities, and the New Partnership for Africa's Development provide opportunities for considering the broader determinants of health. The Millennium Development Goals, especially goal number six (combating HIV/AIDS malaria and other diseases), the World Health Assembly, the regional committee and African Union resolutions, and the NEPAD Health Strategy also provide opportunities for mobilizing political, technical, and financial resources to improve health in Africa.

Following a resolution by the WHO/AFRO Regional Committee in 2005, a Strategy for Renewal and Acceleration of HIV Prevention has been proposed for 2006–2010. This strategy and the ongoing regional and country consultations for the implementation of

the universal-access framework present major opportunities for responding to HIV/AIDS in Africa.

Forging links with other programs and services is important, for example through workplace programs, trade unions, faith-based organizations, community groups, women's and young people's organizations, and networks of people living with HIV.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria, established in January 2002, is an international public-private partnership that includes donors, recipients, affected people, and other stakeholders. The Global Fund was created to dramatically increase available resources and complement existing efforts to fight three of the world's most devastating diseases. It intends to rapidly direct those resources to effective prevention, care, and treatment programs in developing countries. It approves proposals submitted by country partnerships based on technical recommendations of a panel of international experts in public health and development, and it disburses money over time based on progress in achieving agreed-upon targets. The United States is its largest single-country donor. This Global Fund remains a major opportunity for African countries to fight HIV/AIDS.

V. Lessons and Good Practice

The following are lessons and good practices reported from selected countries:

1. Rwanda and Uganda: In these two countries, educating the public about the existence of HIV/AIDS and ways to avoid it has been shown to play a crucial role in reducing HIV prevalence rates. The education sectors, however, need help from outside their own staff to prepare and implement HIV/AIDS activities for their staff, families, and clients. The processes of social assessment and program preparation, contracting out program implementation, enlisting specialized consultants, and holding consultation workshops have all been shown to increase funding for the education sector's HIV/AIDS coverage and should be expanded quickly, including thorough use of specialized trust funds. The World Bank should expand its coverage to the education sector.

2. Zambia—'Debt for Development' and HIV/AIDS Response Fund: The HIV/AIDS pandemic seriously threatens Zambia's prospects for sustainable economic development as it depletes the country's most educated, energetic, and productive population. For this reason, the Zambian government in 2000 made a proposal to the Paris Club to exchange international debt service payments (i.e., interest on debts/loans) for funds to support the national HIV/AIDS response. Instead of paying creditors, interest is channeled to an HIV/AIDS response fund to combat the scourge in the debtor country. This idea has stirred debate, since it has profound implications that would favor most, if not all, Third World countries. The implementation of this fund would shift resources toward supplementary domestic investment in the national HIV/AIDS response, and thus a multi-donor 'Debt for Development' Agreement was proposed.

According to the proposal, the bilateral and multilateral cooperating partners will have different options for channeling resources into the HIV-AIDS Response Fund. These include, but are not limited to:

- Debt Servicing Swap: Principal and interest due to creditor countries would be paid into the HIV/AIDS Response Fund rather than to creditor countries;

- **Moratorium of Debt Servicing:** Creditors have the option of issuing a moratorium on debt servicing, which would defer debt servicing obligations (principal and interest) into the HIV/AIDS Response Fund;
- **Debt for Development Mechanisms:** Creditors can transfer debt obligations into the HIV/AIDS Response Fund;
- **Direct Contributions:** Creditor countries and multilateral institutions could provide direct contributions to the HIV/AIDS Response Fund as part of their overall assistance to the GRZ.

If accepted by creditor countries, this idea would help many Third World countries effectively fight HIV/AIDS—especially those in sub-Saharan Africa, which are the most affected by the pandemic.

3. Zambia Business Coalition on HIV and AIDS (ZBCA): This coalition of public and private companies and NGOs in Zambia came together in 2000 to respond to HIV/AIDS and mitigate its impact. The coalition is currently made up of 71 member companies from various business sectors all over the country. The private sector plays an important role in the multisectoral response to the epidemic, as defined in the Zambia HIV and AIDS Strategic Framework 2006–10. ZBCA thus works closely with the government, the donor community, and other entities involved in the response to HIV/AIDS in Zambia.

Through its activities, ZBCA has increased member companies' awareness of HIV/AIDS and the rights and responsibility of employers under the ILO Code of Practice on HIV/AIDS. It has also increased private-sector availability of sub-granting facility from the Global Fund, willingness to finance HIV/AIDS workplace activities, and the number of businesses contributing company funds to finance HIV/AIDS workplace activities.

However, it still faces a number of challenges with regard to building its image, expanding its composition, overcoming administrative gaps, and increasing the number of company personnel involved in the response as peer educators, counselors, nutritionists, nurses, doctors, etc. This is an initiative that could be encouraged in other countries to help in the fight against HIV/AIDS.

Appendix 2: TERMS OF REFERENCE

Contract Name: Strengthening African Engagement with the Global HIV/AIDS Establishment

Background: TrustAfrica's initiative on HIV/AIDS seeks to increase the frequency and quality of African engagement with key international institutions, initiatives and funders that shape the global responses to the HIV/AIDS epidemic in Africa.

The scale, manifestations, and impact of HIV/AIDS in Africa are now fairly well known. A closer look at the figures, trends and multitude of local/national efforts, however, reveals a more nuanced HIV/AIDS landscape. Around the continent, an impressive amount of work is being done at the community and national levels. Virtually every African country has a national control program for HIV/AIDS, and community-based groups working on HIV/AIDS abound.

At the global level, no epidemic in human history has, arguably, elicited the massive scale and visibility accorded HIV/AIDS. Many developed countries have increased funding for HIV/AIDS control in Africa in recent years, particularly through the Global Fund to Fight AIDS, Tuberculosis, and Malaria (www.theglobalfund.org), which was established in 2001 to coordinate international funding and has since approved grants totaling US\$3.3 billion for HIV/AIDS in Africa. In 2003, the US Government also initiated the President's Emergency Plan for AIDS Relief (www.pepfar.gov), which allocated US\$1.1 billion in 2005 for HIV/AIDS control in selected African countries. Other major global programs that target Africa are: UNAIDS (www.unaids.org), which brings together the efforts and resources of ten UN institutions (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, and the World Bank), and the International HIV/AIDS Alliance (www.aidsalliance.org).

While these global and international efforts are critical for the fight against HIV/AIDS in Africa, it is increasingly evident that Africa's own initiatives, experiences, lessons, knowledge and perspectives are rarely taken into account. African participation in global forums, where experiences are shared and new initiatives are often born, is at best only minimal and at worst paltry. Within Africa itself, yawning gaps exist between local experiences and knowledge on one hand, and national and regional policy making on the other. Country successes and best practices are rarely shared and yet the epidemic does not stop at national borders. Still today, some African leaders are in denial of the epidemic or claim solutions that are frankly embarrassing. Many key institutions are also yet to fully mainstream HIV/AIDS in their policy-making processes.

Purpose and Objectives: The purpose of this research project is to document gaps identified in Africa's response to HIV/AIDS and to identify specific strategies for filling the existing gaps outlined above as well as those to be identified.

The specific objectives are to:

1. Document the levels of interaction and collaboration among key African HIV/AIDS organizations and experts across disciplines and sectors and in ways that help to synthesize experiences and knowledge for concerted advocacy at the global level.
2. Identify the knowledge, attitudes and practices of African leaders and key regional institutions vis-à-vis HIV/AIDS.
3. Document opportunities that could promote learning and exchange among the HIV/AIDS community across the Sub-Sahara Africa.

4. Identify the funding and technical assistance needs of experienced actors in the field so as to sharpen their communication and advocacy skills.
5. Identify opportunities to African leaders to gain access to and take centre-stage at HIV/AIDS global forums and institutions.
6. Identify ways to stimulate global institutions and forums to create adequate space for African perspectives, lessons, knowledge and initiatives to be presented and heard.

Scope and Tasks:

- All consultants

TrustAfrica is looking for four (4) consultants to conduct a comprehensive scan of leading organizations, initiatives and experts on HIV/AIDS across Africa, with a special focus on those with a track record and results and who would add value with a wider and international outreach. Specific subjects and issues to be researched include:

- (a) Knowledge, attitudes and practices of African leaders and key regional institutions vis-à-vis HIV/AIDS;
- (b) Factors that impede African actors global outreach and engagement;
- (c) Innovative ideas and perspectives that provide useful contextual insights which global initiatives ought to incorporate;
- (d) Case studies of strategies that have worked well in fostering and bringing African leadership to global decision making on HIV/AIDS;
- (e) Opportunities that exist but are not well known for African engagement with global initiatives and forums; and
- (f) Strategies and opportunities for seeking greater accountability by global initiatives to their African beneficiaries.

Lead consultant: one of the four consultants will be designated to lead the team and will be responsible for collating the other consultants' reports.

Methodology

- Desk Review

The survey team will conduct a desk review of developments and initiatives, followed by in-depth interviews of key organizations focusing on the objectives above as well as their technical assistance needs, strengths and challenges. Special attention will also be given to initiatives that predominantly target marginalized groups, such as women, youth and sexual minorities.

The consultants will agree on a division of tasks to ensure that all relevant documents are reviewed.

- Structured interviews with principal partners and stakeholders

The consultants will develop a program of interviews and consultations in selected countries in four regions i.e.: Northern Africa, West and central African Region, Eastern African Region, and Southern African Region.

- Field Visits to Countries

Each consultant should be prepared to travel to two or three countries for data collection (i.e.: meeting TrustAfrica staff, meeting key partner organizations, conducting interviews with targeted stakeholders).

Deliverables / outputs

1. A research report that should provide recommendations on adequate strategic approaches and activities aimed at achieving the purpose and objectives above.
2. An important product of the research will be a database containing information from the comprehensive scan which TrustAfrica will share with partner organizations and update on a regular basis.

Inputs: while this project will be housed and primarily managed by TrustAfrica staff, it will be heavily anchored in partnerships with organizations and institutions that have a track record in HIV/AIDS and regional/global advocacy.

A leading partner in this effort is the Association for the Promotion of Traditional Medicine (PROMETRA, www.prometra.org), whose pioneering work in HIV/AIDS straddles modern and traditional medicine across Africa. PROMETRA has an impressive track record in this field and is poised to serve as a pivot around which we will conduct a series of informed and evidence-based dialogues with global HIV/AIDS establishment. With PROMETRA, TrustAfrica will design and manage the convening.

Another partner is the Africa Forum (www.africaforum.org.za), which is a forum of African ex-presidents and leaders dedicated to advancing Africa solutions to the continent's challenges. TrustAfrica's partnership with the Africa Forum will focus largely on co-organizing convening and leveraging other donors for this line of work.

A third partner that TrustAfrica staff members have consulted for this project is the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) (www.icasadakar2008.org), which brings together African scientists, social leaders, political leaders and communities to share their experiences and current trends in the management of HIV/AIDS and STIs (sexually transmitted infections) from an African perspective.

Representatives of the three (3) partner organizations will be on the project steering committee.

Consultant selection criteria

- The consultant should possess at least a Masters degree in Social sciences, Public Health or International relations or related areas.
- The consultants for this assignment should have at least 5 years' experience working on HIV/AIDS issues: KAP analysis, strategy development, etc.
- Extensive experience in research, Policy planning and analysis or partnership development.
- An excellent report writing skill.
- The consultants should be bilingual with a good knowledge of English and French (read and understand).
- At least one of the consultants must be fluent in French with a good knowledge of English.

Time and scheduling: The research is expected to take three (3) months, from January to March 2008. A mid-term draft report is required (i.e., mid-February).

Budget: We estimated that the total required days for this assignment is 20 days each for four (4) consultants.

General: TSF-WCA will manage the consultants. However, TSF will regularly report to TrustAfrica on the assignment progress.

Appendix 3: RESEARCH INSTRUMENT

A. General Questions

1. It has been said that the “African Perspective” is nil or weak in the global response to HIV/AIDS in Africa. What is your reaction to this statement? To your mind, what is the “African perspective”?
2. To date how have leaders sought to influence the global HIV/AIDS agenda to reflect African perspectives? What specific strategies and approaches have been used?
3. For the African perspective to prevail and be strong, what needs to be in place or occurring at the national, Africa regional and global levels?
4. What decisions and actions have you been involved in or aware of that contributed to creating or strengthening effective African perspective or African influence in any global effort responding to HIV/AIDS in Africa?
5. To your mind, what is the gap between what ought to be in place for Africa to be effectively engaged and what actually is? Please give specific examples.
6. What has been your experience with sharing of information on the response to HIV/AIDS at the national, African regional and global levels? What channels are you aware of, and what are strengths and weaknesses of efforts to date?
7. What lessons can you share with respect to engaging the international community on issues related to the HIV/AIDS response in Africa? What do you regard as best practice?

Coordination, collaboration, networking, and partnership

Preparation

Participation (in conferences, development/design of initiatives, etc.)

8. To effectively influence the HIV/AIDS agenda for Africa, what needs to be put in place to support African leaders (individuals and organizations at national and regional levels)
9. In addition to technical knowledge and advocacy and communication skills, what are the organizational and management skills required to influence the response to HIV/AIDS in Africa?
10. To your mind, have global policies, initiatives and interventions been sensitive and accountable to African beneficiaries? If so, what lessons can be built on to strengthen accountability? If not how can accountability be strengthened?

B. Specific Questions

RESPONSE TO HIV/AIDS

- What has been your country’s key response to HIV/AIDS? What have individual countries done to strengthen the national response?
- What are some of the challenges you have experienced in undertaking these response
- What have been some of your strengths
- Are there any special Technical Assistant needs
- Which Key African HIV/AIDS organizations do you collaborate with
- What has been the nature if your collaboration
- Can you name some of the experts across disciplines and sectors that you deal with?
- How do you promote or advance advocacy across the global level

KAP ASSESSMENT

- What is your assessment of the KAP of leaders with regard to HIV/AIDS? What is the KAP among regional institutions with regards to HIV/AIDS?
- Can you identify some HIV/AIDS-related policies?
- What do you see as the main impacts of the HIV/AIDS epidemic?
- What is your attitude towards people infected with and affected by HIV/AIDS?
- What is your perception of HIV/AIDS-related risks?

ADVOCACY PROMOTION

- What are the levels and manifestations of interaction of various HIV/AIDS key players to generate and disseminate data for global level advocacy?
- What are the funding and technical assistance needs to develop advocacy and communication skills required and suitable for the various levels?

AFRICAN ENGAGEMENT WITH THE GLOBAL HIV/AIDS FORUM

- What are African opportunities for such engagements? Please mention any such forums you are aware of in the past five years
- What are the impediments or constraints in participating in such forums? What have you and/or your organization done to overcome the constraints?
- What are the ways to promote the require paradigm shifts to strengthen African engagement?
- How can your country support its leaders to take centre stage at HIV/AIDS global forums and institutions?
- Are there any case studies of strategies that have worked well in fostering and bringing African leadership to global decision making on HIV/AIDS?

STIMULTATING GLOBAL INSTITUTIONS

- How can your country stimulate global institutions and forums to create space for African perspectives?
- How can your country stimulate global institutions and forums to create space for African lessons and initiatives on HIV/AIDS to be shared?
- How can your country stimulate global institutions and forums to create space for African knowledge and initiatives on HIV/AIDS to be presented and heard?
- What are some of the factors that impede global outreach and engagement?
- What are some of the innovative ideas and perspectives that provide useful contextual insights which global initiatives ought to incorporate?

INFORMATION SHARING

- How do you assess sharing of information to date? What channels have been used? What are the opportunities for promoting and strengthening information sharing?
- Documentation of innovative ideas
- What are some innovative ideas that can be part of the global initiatives to be shared?
- What are some case studies of strategies that have proven to work?
- How does your country foster opportunities that promote learning and exchange among the HIV/AIDS communities across Africa?
- Please mention specific moves, interventions, conferences, networking initiatives, etc undertaken by your country in the above-mentioned regard

ACCOUNTABILITY TOWARDS BENEFICIARIES

- What are strategies and opportunities to make global initiatives more accountable to African beneficiaries?
- Is there positive political will and support for the HIV/AIDS program? What is the nature of this support?
- Are there negative, detrimental or derogatory statements by political leaders that affect the response? What specifically are some of these statements?
- In your view what are the effects of some of these statements on the HIV/AIDS program in your country? What have been the effects from regional and global perspectives?
- What are some of the specific strategies and opportunities for seeking accountability by global initiatives to their African beneficiaries?

FUNDING AND TECHNICAL SUPPORT NEEDS

- How has your country mobilized funds for its HIV/AIDS programs?
- What are some of your specific technical assistance needs?
- What specific advocacy and communication skills would you require?
- Are there any funding opportunities that exist but are not well known for African engagement with global initiatives and forums?

C. Guide for Desk Review

- Developments and Initiatives in specific countries
- Special attention to initiatives that target marginalized groups such as women, youth and sexual minorities

D. The Database

What should we capture in this? Suggestions:

- List of Institutional memories, researches and documentation on HIV/AIDS for each country
- List of organizations interviewed by country
- List of Individuals interviewed by country
- Comprehensive list of all HIV/AIDS affiliated organizations in country
- Comprehensive list of UNAIDS Organizations

E. Methodology

1. Preliminary consultations
2. Consultations with national ministries, departments, and agencies; private enterprises; private health facilities; media; development partners; politicians; NGOs; PLWHAs; professional groups; and CSOs
3. Key Informant interviews
4. Review of various KAP studies, research reports, etc.

Appendix 4: PERSONS INTERVIEWED

S/N	Interviewee	Position	Institution
The Gambia			
1.	Ms Kay Sey	Programme Manager (HIV/AIDS)	PO Box 2164 Serrekunda, Gambia Telephone: + (220) 4494473, 4495716 Mobile: + (220) 7795861 Fax: + (220) 4494474 Email: Ky-sey@yahoo.co.uk Kay.sey@concern.universal.org www.concern-universal.org
2.	Baboucar Camara	Youth Officer Department of State for Youth & Sports Commonwealth Youth Caucus Representative	Telephone: - 00220 – 9937222/7937222/6037222 Office No - 00220 – 4496385/6 4498167 Email: sbcamara1@hotmail.com sbcamara2@yahoo.com
3.	Mr. Samba Touray	Administrative Officer Youth Against AIDS Network – Gambia Bakau New Town Community Center	Telephone: - 00220 - 4498167 Mobile – 00220 – 9915107 6615107; 7786631 Email: yaangambia@gamtel.gm yangambia@hotmail.com sambatry@yahoo.com
4.	Ms Tamsir Ann	Co-coordinator National Assembly Network on Population and Development	Telephone 990847 7347377; 6566709; 2244337 Email: -
5.	Hon. Borrie Ls. B. Kolley	Member of Parliament Health and Education Committee NEPAD Chairman	Telephone 00220-9942765 7247670; 6520749 Email: - honblsbkolley@yahoo.com
6.	Abdou Jammeh	Programme Manager	National Aids Control Programme Dept. of State for Health & Social Welfare. Email: - abdaijammeh777@hotmail.com
7.	Dr Mariatou Jallow	Chief Medical Director	Department of State for Health & Social Welfare Independence Drive Banjul, Gambia Telephone (220) 4228598 Home (220) 4371445 Mobile (220) 9921305 Email: - jallowmariatou@yahoo.com
8.	Jammeh Alieu	Director, National AIDS Secretariat	Office of the Presidency
9.	Mr. Bai Cham	Deputy Director	National AIDS Secretariat (NAS). Office of the Presidency

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S/N	Interviewee	Position	Institution
10.	Nyakkasi	ACTIONAID, Gambia	
11.	Amamo NK Barrow	HIV/AIDS/Malaria Programme Manager	Action Aid Gambia M.D.I Road Kanifaig P.M.B 450 Seire Kade Fax: - 00220 4392425 Tel. – 00220 4392004 / 4392244 Cell: - 00220 9939312 / 6507337 Email: almame.barrow@actionaid.org , barrownk@yahoo.com
12.	Hassan Njai	Head	Public & Environmental Health Department School Of Medicine & Allied Health Sciences University of the Gambia Email: hassannjai@yahoo.com Tel.(220) 4222816 – Office (220) 7794029 – Mobile
13.	Saikou Trawally	Director of Population Affairs	Office of President, Near National Library – Population Secretariat Mobile: - #9996251 Office – 224143
14.	Mr. Ousman M.S. Yabo	Director	The Association of Non-Governmental Organizations Fajara “M” Section, Bakau P.M.B 392 Serekunda. Gambia Tele. (220) 4390525 / 1 Mobile (220) 9921974 Email. tango@qanet.gm
15.	Ceesay Nahu	Country Officer	UNAIDS, UN House 5, Kofi Annan Street, Cape Point Bakau, Gambia. +220 996,6233 +220 779 9991 +220 449 4760
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4.	Dr. Peter M. Tukei	Assistant Director	KEMRI
5.	Ms. Regina Ombam	Head, Strategy	National AIDS Control Council
6.	Prof. Aloys S.S. Orago	Director	National AIDS Control Council
7.	Prof. Elizabeth N. Ngugi	Director	Univ. of Nairobi, Centre for HIV Prevention and Research, College of Health Sciences, Kenyatta National Hospital
8.	Mr. Ragi	Executive Director	KANCO
9.	Prof Otieno		
10.	Nduku Kilonzo, PhD	Director	Liverpool VCT, Care and Treatment
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2.	Mr. Abdoua Kanta	HIV/AIDS Advisor of the president of Niger	Presidency of Niger
3.	Mr. Alhousseini Maiga	President of the Nigerian network of people living with HIV/AIDS	Civil society

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6.	Ali Chaibou	Secretary general	Ministry of Women's Promotion and Protection of Children
7.	Mrs. Djataou Ouassa	President	SWAA Niger
8.	Mrs. Fatouma Zara Lamine	State representative	National Assembly HIV/AIDS Commission
9.	Dr Balkissa Hama	HIV/AIDS program Coordinator	Niger's World Health organization HIV/AIDS
10.	Dr Abdou Aboubacar	HIV/AIDS Program Coordinator	UNFPA Niger HIV/AIDS
11.	Dr Marie-Claire	HIV/AIDS Program Coordinator	UNICEF Niger HIV/AIDS
12.	Dr. Francois	HIV/AIDS Program Coordinator	UNDP Niger
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Appendix 5: REFERENCES

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