

responding to HIV/AIDS in africa

A comparative analysis of responses to the Abuja
Declaration in Kenya, Malawi, Nigeria and Zimbabwe

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RESPONDING TO HIV/AIDS IN AFRICA, JUNE 2004

Who we are

ActionAid International's vision is a world without poverty in which every person can exercise their right to a life of dignity. We currently work with nine million people in 40 countries across Africa, Asia, Latin America and the Caribbean to obtain this goal.

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Executive summary

The devastating impact of HIV/AIDS has been felt most severely in Africa. HIV/AIDS is the leading cause of death in Sub-Saharan Africa and the paramount threat to the region's development. More than 20 million Africans have now died, and 12 million have been orphaned by AIDS. Those living with the virus number 29.4 million, the vast majority in the prime of their lives as workers and parents.¹

The challenge of tackling HIV/AIDS was taken up by African Heads of State at their summit in Abuja in 2001. This led to the Abuja Declaration, the primary goal of which is to reverse the accelerating rate of HIV infection, TB and other related infectious diseases.

As part of its international campaign on HIV/AIDS, ActionAid International commissioned a series of studies in 2003 and 2004² to discover the extent to which the Abuja commitments were being realised in African countries.³

Alongside its direct programme activities, ActionAid International (AAI) is campaigning for the right and access to HIV/AIDS care for poor and marginalised communities, especially women and children.

This report is based on the research carried out in **Kenya, Malawi, Nigeria and Zimbabwe** and provides a comparative analysis of the achievements and challenges faced by these four African countries in relation to the Declaration.

Two and a half years after the Abuja Declaration there has been some progress in all four countries in implementing the agreed strategies. But much remains to be done. Political commitment is increasing and some progress has been made in the area of mobilising the formal and informal education sectors. Progress on the protection of human rights has been limited and everywhere stigma and discrimination remain a problem. All four countries have attempted to address the need for care, support and treatment, but there are major gaps in delivery, particularly with regard to antiretroviral (ARV)

treatment programmes. With the advent of the World Health Organisation's initiative to treat three million people by 2005, care and treatment should improve but this will require a large investment in health service infrastructure, not least the development of human resources.⁴ The lack of sufficient and sustainable resources is a critical issue that continues to pose challenges for all four countries, aggravated by weak infrastructure, poor legislation and policies, and lack of effective coordination of HIV/AIDS-related activities.

As countries continue to work towards meeting the commitments made in Abuja, it would be helpful to revise the framework for action and express the commitments in more specific terms. This, combined with greater transparency regarding budgets, increased participation from civil society, especially women, people living with HIV/AIDS (PLWHA) and community based organisations, will allow all sections of society as well as government and the international community to monitor progress more effectively.

¹ <http://www.worldbank.org/afr/aids/>

² ActionAid International Nigeria (2003): Matching words with action: monitoring the HIV and AIDS Commitments in Nigeria, Nigeria. October; ActionAid Kenya, (2004): Report of the study on the implementation of the Abuja Declaration 2001 on HIV/AIDS in Kenya, March 2004, Nairobi, Kenya; ActionAid International, Malawi, (2004): Monitoring HIV/AIDS commitments of the Abuja Declaration: Malawi CSO Report 2004, Lilongwe, Malawi; ActionAid Zimbabwe (2003), Monitoring the Abuja Commitments: Harare, Zimbabwe. 2003

³ ActionAid International is grateful to the John Lloyd Foundation for its generous support which allowed these studies to be conducted.

⁴ For further discussion of financing for HIV/AIDS programmes and the 3 by 5 initiative, see ActionAid International, Commitment to Care? The Role of Donor Countries and Multilateral Institutions in Financing HIV/AIDS Programmes, June 2004; and 3 by 5: ensuring HIV/AIDS care for all?, June 2004.

Introduction

HIV/AIDS kills at least 8,000 people a day⁶ and threatens tens of millions more. The number of infected people keeps growing. In Africa alone over 29 million people have been infected and over 20 million have died since 1984.⁶ Africa accounts for about 70% of the world's HIV-positive population.⁷ HIV/AIDS along with tuberculosis and other related infectious diseases have become catastrophes with far reaching implications for national and global development.

In Africa the need for urgent action to address the HIV/AIDS pandemic was taken up by African Heads of State at their 2001 Summit in Abuja. The Abuja summit acknowledged that HIV/AIDS, TB and other related infectious diseases (ORID) posed immense challenges to health, poverty alleviation and development efforts, not least because HIV/AIDS afflicts the most productive group in society, the 15–49 age group, thereby undermining productive capacity. It also transforms demographic and social structures, and has left millions of children orphaned. It is for these reasons that African leaders resolved to treat HIV/AIDS, TB and ORID as an emergency that needed concerted action at all levels.

Summary of Abuja Declaration Plan of Action

The challenge of tackling HIV/AIDS, TB and ORID is exacerbated by weak and inadequate health systems and infrastructure, inadequate policies, strategies, structures and processes to prevent, control and mitigate the effects of these diseases. It has been noted that these diseases are no longer public health issues but rather wider development and poverty related issues that pose serious implications for all groups, particularly women, children and other vulnerable people.⁸ At the Abuja summit, attended by heads of government from all African countries, a commitment was reached that countries individually and collectively will work to arrest and reverse the accelerating rate of HIV infection, TB and ORID. Countries committed to the following objectives:⁹

- To advocate for optimal translation of earlier commitments of African leaders into social and resource mobilisation for sustainable programming of primary health care.
- To develop policies and strategies aimed at preventing HIV, tuberculosis and other related infections, and at controlling the impact of the epidemic on socio-economic development in Africa.
- To establish sustainable mechanisms for national and external resource mobilisation for prevention, and treatment of people living with HIV/AIDS.
- To ensure that the needs of vulnerable groups such as children, youths, women, people with disabilities, workers and mobile populations are adequately addressed.

Recognising the need for the above list to be broken down into more specific, action-oriented priority areas, African leaders committed themselves and their countries to a framework of action to work as a monitoring and evaluation tool (see box). This framework sought to underscore the importance of tackling these diseases with concerted efforts across different sectors, countries, regions and continents.

Some key issues arising from the Abuja Declaration include:

- Consideration of AIDS as a state of emergency.
- Political leadership's commitment to personal responsibility in the fight against HIV/AIDS and promoting advocacy at the national, regional and international levels.

- Commitment to ensuring coordination of all sectors with a gender perspective and respect for human rights, particularly to ensure equal rights for people living with HIV/AIDS.
- Need for government to lead by example e.g. through effective workplace interventions.
- Making available drugs at affordable prices and technologies for treatment, care and prevention of HIV/AIDS.
- Need to establish a sustainable source of resources to fund HIV/AIDS and making resources available from all sources; at least allocating 15% of annual budget to the improvement of the health sector.
- Need to deal with issues of stigma and discrimination.
- Commitment to reducing and/or removing economic barriers to accessing funding for AIDS-related activities.
- HIV/AIDS as a priority in national development plans and the establishment of national AIDS commissions/councils.
- Need for mobilisation of all civil society groups in the fight against AIDS.
- Need to scale up the role of education and information in the fight against AIDS.
- Advocate for the establishment of the Global AIDS Fund financed by the donor community to the tune of US \$5 - 10 billion accessible to all affected countries.
- Developing the potential of traditional medicine and traditional health practitioners in the prevention, care and management of HIV/AIDS.
- Documenting and sharing successful and positive experiences.
- Securing the total cancellation of Africa's external debt in favour of increased investment in the social sector.

In 2003, ActionAid International began a review of national progress on the commitments made in Abuja to discover the extent to which these had been implemented, which areas required further action, and how civil society groups could promote continued progress. In this paper, the findings from four studies, in Kenya, Malawi, Nigeria and Zimbabwe, are reviewed.

⁶ UNAIDS (2004): "Three Ones" key principles: "Coordinating of National Reports to HIV/AIDS." Guiding principles for national authorities and their partners. Conference Paper 1. Washington Consultation 25.04.2004

⁷ <http://www.worldbank.org/afr/aids/>

⁸ UNAIDS AIDS Epidemic Update, December 2003, Geneva

⁸ Abuja Declaration (<http://www.uneca.org/adf2000/Abuja%20Declaration.htm>)

⁹ <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.htm>

The Abuja framework for action

Priority areas	Strategies
I. Leadership at national, regional and continental levels to mobilize society as a whole to fight HIV/AIDS, TB and ORID	Provision of an enabling environment at all levels of leadership in society
II. Improvement of information, education and communication	<ul style="list-style-type: none"> • Mobilize the formal and informal education sectors • Develop appropriate information system for the population
III. Protection of human rights	<ul style="list-style-type: none"> • Develop a multi-sectoral national programme for awareness of and sensitivity to the negative impact of the pandemic to people especially vulnerable groups • Enact relevant legislation to protect the rights of people infected and affected by HIV/AIDS and TB <p>Strengthen existing legislation to address Human Rights violations and gender inequities; and</p> <ul style="list-style-type: none"> • respect and protect the rights of infected and affected people; • Harmonize approaches to Human Rights between nations for the whole continent • Assist women in taking appropriate decisions to protect themselves against HIV/AIDS
IV. Access to treatment, care and support	<ul style="list-style-type: none"> • Integration of HIV/AIDS and TB Programmes in primary health care services • Promote and strengthen the continuum of care in a decentralized manner • Ensure development of community-based networks • Expand Directly Observed Treatment for Tuberculosis
V. Access to affordable drugs and technologies	<ul style="list-style-type: none"> • Enact and utilize appropriate legislation and international trade regulations to ensure the availability of drugs at affordable prices and technologies for the treatment, care and prevention of HIV/AIDS, TB and Other Related Infectious Diseases
VI. Strengthening health systems	<ul style="list-style-type: none"> • Development and strengthening of infrastructure • Capacity-building • Human Resource Development
VII. Resources Mobilization: <ul style="list-style-type: none"> • National • International 	<ul style="list-style-type: none"> • Collaboration with all national partners in order to mobilize additional financial resources to fight against the pandemic • Create and increase of HIV/AIDS, TB and ORID national budget line to facilitate access to diagnosis, care and drugs as well as to reagents for diagnosing other infectious diseases • Integrate International Partnership against HIV/AIDS, TB and ORID at all levels of society in Member States

Priority areas	Strategies
	<ul style="list-style-type: none"> • Integrate Regional policies and partnership programmes for migrants and refugees • Support the creation of the Global Fund to fight HIV/AIDS in Africa • Support the creation of the Global TB Fund* • Advocate for increased grants not loans • Advocate for debt cancellation
VIII. Research and development on HIV/AIDS, TB and other related infectious diseases including vaccines, traditional medicines and indigenous knowledge	<ul style="list-style-type: none"> • Promote and support research and development for vaccines and drugs for HIV/AIDS • Promote research and development of herbal medicines • Promote research and development on nutrition • Discourage the promotion of unproven medicines and remedies for HIV infections
IX. Poverty, health and development	<ul style="list-style-type: none"> • Develop/promote income generating capacity of families particularly those affected by the epidemic • Promote concessionary credit facilities to families especially women in rural areas • Promote good nutritional practices
X. Monitoring and evaluation	<ul style="list-style-type: none"> • Strengthen Health Information System • Establish a surveillance system for HIV infections • Organize regular meetings on access to treatment
XI. Partnership	<ul style="list-style-type: none"> • Strengthening national and regional network • Establishing developmental Coordinating Units • Development of networks of Experts and Institutions • Promote South-South cooperation • Promote public - private partnership
XII. Prevention of the spread of HIV/AIDS, TB and other related infectious diseases	<ul style="list-style-type: none"> • Ensure access to quality voluntary confidential counselling and testing • Ensure blood safety • Promote appropriate management of STIs and TB • Improve access to programmes for prevention of mother-to-child transmission • Ensure access to barrier methods • Ensure prevention of occupational hazards to health workers and others from exposure to HIV/AIDS and TB • Improve Information, Education and Communication at community level

Country comparative analysis

The primary goal of the Abuja commitments is to reverse the accelerating rate of HIV infection, TB and other ORID.¹⁰ Countries represented in Abuja are expected to have made some progress towards the achievement of this goal. The Abuja framework for action summarises the priority areas (and the strategies identified to address them) of the Abuja Declaration. Despite the broad nature of the priorities listed and the lack of targets and indicators expressed in measurable terms, this framework is the most comprehensive for assessing progress on the Abuja Declaration, and is the one used

in this report to analyse the progress made in the four countries in relation to the twelve priority areas listed. It is important to highlight the fact that one of the challenges of tracking progress on the Abuja Declaration is that the issues and priorities raised in the Declaration and the Framework of Action are described in very general terms. The lack of specificity in targets and indicators in the Framework, mean that assessment is often more qualitative than quantitative.

The table below summarises some vital HIV/AIDS statistics for the four countries.

Table 1. Country Summary Statistics

Country	Kenya	Malawi	Nigeria	Zimbabwe
AIDS deaths by 2003	1,500,000	80,000+*	170,000+*	180,000
HIV prevalence 2003	14%	14.4%	5.0%	24.9%
Total HIV+ population	2,500,000	900,000	3,500,000	1,820,000

*2001 estimates

Sources: UNAIDS, Report on the Global HIV/AIDS Epidemic, 2002, CIA World Fact Book, 2003, US Doctors for Africa fact sheets

Framework priority I

Provision of an enabling environment at all levels of leadership

Assessment of political commitment levels usually includes the level of emphasis placed on HIV/AIDS awareness, prevention and care by heads of government, politicians and other role models. This commitment can include verbal advocacy and campaigns, as well as development of policies and implementation of interventions aimed at reducing infection rates and mitigating the impact of HIV/AIDS.

Since the Abuja Declaration, political commitment has increased in all four countries. In Nigeria, President Olusegun Obasanjo is reported to have demonstrated good leadership and commitment to the fight against AIDS; however his efforts have yet to catalyse a similar level of commitment from his cabinet, party or other national political elites.¹¹ Kenya's political commitment to HIV/AIDS has grown over the last few years, with the President and his wife playing key roles. In addition, Kenya and Nigeria are involved in regional and international advocacy and are involved in efforts to fight AIDS at a regional level. Kenya is the only country that explicitly reports the efforts to mobilise all stakeholders in the national response to HIV/AIDS.¹² However, this work is being undermined by official denial, illustrated by the fact that, no AIDS deaths amongst political leaders have been publicly attributed to the disease.

Political commitment in Malawi is growing and HIV/AIDS was an issue in the 2004 elections. The government's commitment is demonstrated by the development of National AIDS Policy, National AIDS Strategic Plan, the establishment of a National AIDS Commission and the development of multi-sectoral HIV/AIDS policies and strategies following the Abuja Declaration.

Zimbabwe's political commitment seems low despite the fact that, amongst the four countries, it has the highest HIV/AIDS prevalence rate. The President is the patron of the National AIDS Committee and HIV/AIDS issues are dealt with at the parliamentary portfolio on health. Zimbabwe's commitment to the fight against HIV/AIDS is also highlighted in their legal and policy framework contained in the national AIDS policy, which also encompasses orphan care, home-based care, and prevention of mother to child transmission (PMTCT) policies.¹³

In all four countries, presidential level commitment is strong but this is not always echoed by lower level leaders and civil servants. Furthermore, while there is a clear link between governments' AIDS strategies and actions and a high level of awareness of the Abuja Declaration among government officials, awareness among civil organisations is weak. Addressing HIV/AIDS issues at a parliamentary portfolio committee is a good thing in order to ensure that people's representatives are involved, but it is not enough because authority is mostly derived from the executive arm of government.

Although the Abuja declaration was aimed at HIV/AIDS, TB and related infectious diseases, and there are clear synergies in tackling these diseases collectively, the primary focus of national bodies set up to spearhead programmes seems to be HIV/AIDS.

¹⁰ <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.htm>

¹¹ ActionAid International Nigeria (2003): Matching words with action: monitoring the HIV and AIDS Commitments in Nigeria, Nigeria. October

¹² Action Aid Kenya, (2004): Report of the study on the implementation of the Abuja Declaration 2001 on HIV/AIDS in Kenya, March 2004, Nairobi, Kenya.

¹³ ActionAid Zimbabwe (2003), Monitoring the Abuja Commitments: Harare, Zimbabwe. 2003

Framework priority II

Improvement of information, education and communication

This priority area was aimed at mobilising the formal and informal education sectors and developing appropriate information systems for the population. All four countries have programmes to this effect.

Kenya has implemented massive awareness campaigns, and currently 95% of the population is aware of HIV/AIDS. There is widespread information dissemination at hospitals, public places and in the media. However, most of the information available is not tailored to traditional values and the experiences of local communities. In Zimbabwe, the national family planning council and Population Service International have implemented television and radio programmes on HIV/AIDS awareness. A donor-funded adolescents' reproductive and sexual health programme is run in 16 out of the 52 districts in the country. However, these efforts have been curtailed by the government's ban on some of the youth programmes run by Population Service International and by privatisation of the national broadcaster.

There has been increased awareness about HIV/AIDS in Nigeria with 83% and 98% levels of awareness among rural and urban dwellers respectively. A national behaviour change framework has been instituted to coordinate the various organisations involved in promoting behaviour change. DFID and USAID have committed US\$100 million to a multi-channel approach to behaviour change. Youth-friendly centres offering reproductive health education have been established, but the impact of sex education in schools and through the media is still limited due to cultural and religious restrictions. The National Action Committee on AIDS (NACA) has an AIDS advertisement featuring prominent traditional rulers and some line ministries have produced commercials funded by the World Bank.

In Malawi, the government, through the National AIDS Council and reproductive health unit, came up with a national behaviour change intervention strategy for HIV/AIDS and sexual reproductive health in July 2003, but implementation is still underway. Approximately 100% of teachers have been trained to give life-skills education and 1,700 peer educators have been trained in 12 districts. The number of centres giving youth reproductive health services has increased since 2001.

Information, education and communication (IEC) are vital in the fight against the disease. Evidence shows that effective IEC interventions are those that go beyond awareness campaigns to address risk perception social self efficacy of individuals affected, and mobilise social support from wider society in order to elicit positive behaviour change. The four countries reviewed here are all involved in awareness campaigns and some efforts to change behaviour. These efforts need to be strengthened by involving government, civil society, cultural leaders, religious institutions and donors in order to ensure consistency and harness support from various groups. This is particularly critical for Nigeria. Government involvement in behaviour change initiatives is limited for Zimbabwe and needs to be stepped up. There is wide support from international NGOs and bilateral agencies in funding and running IEC programmes. What is lacking in these countries, apart from Nigeria, is a comprehensive framework within which all IEC work takes place.

Framework priority III

Protection of human rights

Strategies to achieve this priority include the development of a multi-sectoral national programme for awareness of the negative impact of the pandemic, as well as the enactment of legislation and the strengthening of existing legislation to protect the rights of people infected and affected by HIV/AIDS.

Malawi has made progress on this, mainly through the drafting of a workplace HIV/AIDS policy that caters for both public and private sectors. The country has in place a national policy on orphaned and vulnerable children, and they are currently trying to include policy on PMTCT in the National AIDS Committee (NAC) integrated work plan. But there are still gaps on issues such as stigma.

A task force was established in Kenya and its proposed bill on HIV and AIDS prevention and control bill awaits Parliament's consideration. But challenges remain because there is no legislation to prevent discrimination against PLWHAs and stigma is relatively high in Kenya. In

Nigeria, the government is currently reviewing existing legislation in order to inform the enactment of new and appropriate laws relating to various human rights issues, such as HIV/AIDS legislation in the workplace; legal rights and property ownership, and improving access to legal services for people infected and affected by HIV/AIDS.

Apart from some efforts to empower women, the commitment to care for orphaned children and the involvement of PLWHAs in NAC activities, Zimbabwe does not report any specific efforts aimed at enacting legislation to protect the rights of the infected.

All the countries are struggling with the issue of protecting of human rights. Stigma, especially for women, is still a problem in all four countries and no one country seems to have a specific plan of action to tackle it.

Zimbabwe: a humanitarian crisis

Zimbabwe has one of the highest HIV/AIDS rates in the world, estimated at 24.6% in adults aged 15-49. The total number of people living with HIV/AIDS at the end of 2003 was estimated at 1.82 million. The estimated number of AIDS deaths during 2003 was 171,000, while the number of children orphaned is estimated at 761,000.

Zimbabwe is also experiencing its worst political and economic crisis since independence, triggered by its controversial land reform programme and issues of governance and democracy. The result has been an almost total collapse of the agriculture sector, on which industry is also heavily reliant. This, and poor economic management, has resulted in the current economic meltdown, with GDP per capita shrinking by a cumulative 30% over the past three years.

After years of denial in the late 1990s, the Zimbabwean government has finally acknowledged the seriousness of the epidemic and now gives political support at the highest level to issues of HIV/AIDS. The late Vice President Joshua Nkomo was the first high-level political figure to admit that his son had died of HIV/AIDS.

The government's major contribution to HIV/AIDS prevention programmes for young people has been the life-skills programmes run by all primary and secondary schools. Life-skills education was made compulsory in 1999, although it is not examinable (except in Form VI where it is part of the general paper). Primary schools are expected to devote at least 30 minutes per week to it, while in secondary schools it should be taught for at least 40 minutes per week and one hour for Form V and VI. However, a major problem with the life-skills programme has been the shortage of trained teachers. In 2002, just 34,000 out of a total of 104,000 teachers had been trained, a mere 32%. This presents a major limitation to the effectiveness of the programme.

Although many civil servants admit that a workplace policy is necessary, no government ministry in Zimbabwe has an internal HIV/AIDS policy. There is a proposal that at induction, new recruits should go through an AIDS awareness programme. And the public service commission is planning a public service HIV/AIDS policy for the whole civil service in conjunction with UNAIDS and UNDP. Without this, it has been left to each ministry to come up with a work plan for tackling HIV/AIDS issues by itself, an unsatisfactory situation when so many civil servants are themselves infected or affected by HIV/AIDS.

Framework priority IV

Access to treatment, care and support

The integration of HIV/AIDS and TB programmes in primary health care (PHC) services, the establishment of community-based networks and the expansion of directly observed treatment for TB are the key strategies identified to ensure that proper systems are in place to achieve this target.

In Kenya there are still no national strategies and policies for comprehensive care and support of PLWHA and their families. HIV-related drugs are not available in public hospitals, and those in private pharmacies are too expensive. Accessibility to antiretroviral therapy (ART) and treatment of opportunistic infections (OIs) is limited by poor infrastructure and insufficient financial, technical and human resources. Kenya has developed national ART policy guidelines and has set a target to provide ARVs to 50% of those in need of 2005 and to increase this to 60% by 2008. The country has already received Kenya Shillings 14 billion from the Global Fund to fight HIV/AIDS, TB and Malaria

“Although the past two years have witnessed increased momentum towards ensuring greater access to treatment through the provision of affordable drug therapies, access to HIV-related drugs is still highly inaccessible for the majority of the poor. It is also important to stress that, although attention has focused on expanding access to antiretroviral treatment, other elements of comprehensive care are often not accessible to people living with HIV/AIDS. All the respondents felt that quality of services and care at public health facilities is poor. Patients share beds and are forced to purchase drugs from outside the facilities.”¹⁴

In Malawi, only 1% of those in need of ART are currently getting it, with the support of Médecins sans Frontières and a government fee paying scheme. There are plans to reach 80,000 patients by 2005 with support from the Global Fund. In Malawi, 90% of public health facilities have no capacity for the delivery of the essential health package for HIV/AIDS

“The Malawi government is still working on addressing inefficiencies in the supply chain for drugs. There has never been a year, in the past three years, when the central hospital has had 100% of the essential drugs available. Weaknesses in government drug procurement systems and unpredictable and poor financing are major

challenges and a key cause of drug unavailability. A new procurement act was passed in 2003 to help reverse the situation, but it has not yet been implemented. Currently, DFID is supporting plans to improve the management systems of central medical stores. UNICEF is procuring the drugs funded by the Global Fund for the first year of implementation because of weaknesses in government systems.”¹⁵

“Theft of drugs is another increasing problem hampering the availability of drugs. Low working morale, poor working standards and low pay for health workers are among other things aggravating this problem.”¹⁶

Nigeria and Zimbabwe have set aside funds from their national budgets for the purchase of ARVs. Zimbabwe has set aside Z\$2.5 billion for the purchase of ARVs, but lack of foreign currency has made it difficult to secure these drugs. The Nigerian government in 2003 allocated N400 million (US\$2.5 million) for the purchase of ARVs. The Nigerian national ARV therapy programme has over 10,000 adults and 2,000 children on antiretroviral therapy (ART). The government subsidises ARVs, with patients paying N12,000 (US\$100) per annum but these subsidies reach only 10,000 of the 3.3 million people who need them. Furthermore, the drugs themselves are only a small part of the costs of the total package needed but patients, which includes laboratory tests that are four times as expensive as the drugs.

Only Malawi, which has one of the most widely acclaimed directly observed treatment TB programmes in Africa, mentions strategies directly related to TB. The NAC intends to utilise the national TB programme infrastructure to scale up VCT and ART delivery.

While all four countries have plans to deliver to treatment, care and support this area is still requires much more action but capacity to roll out plans is insufficient and sometimes uncoordinated. Sustainability issues regarding antiretroviral therapy plans do not seem to be given the priority they deserve. As already mentioned, countries seem not to have plans to avail treatment and care for TB and other related infectious diseases outside the normal public health system. Although countries report efforts to secure funding for improved access to ARVs and care, much will depend on the actions of international donors.

¹⁴ Action Aid Kenya, Report of the study on the implementation of the Abuja Declaration 2001 on HIV/AIDS in Kenya, March 2004, Nairobi, Kenya.

¹⁵ ActionAid International, Malawi, Monitoring HIV/AIDS commitments of the Abuja Declaration: Malawi CSO Report 2004, Lilongwe, Malawi

¹⁶ ActionAid International, Malawi, 2004, ibid

Framework priority V

Access to affordable drugs and health technologies

To support this initiative, tariffs on drugs on the essential drug list have been removed in Nigeria, Malawi and Zimbabwe. Zimbabwe allocated foreign currency to a local company to manufacture generic ARVs, and is currently running trials on AZT at two of its largest hospitals. However, Zimbabwe's lack of foreign currency has made it difficult to secure drugs. In Kenya and Malawi public hospitals have no drugs for treatment of HIV/AIDS-related infections. All country reports focus on efforts related to making ARVs accessible and available, but no mention is made of any efforts relating to making laboratory tests more affordable. As seen for Nigeria above, in many countries laboratory tests are still very expensive.¹⁷

HIV/AIDS in Malawi

Malawi, with a population of some 11.5 million, is one of the poorest countries in the world. According to UNDP 2003 ranking Malawi is 11th from the bottom of the Human Development Index. It is acknowledged in Malawi's Poverty Reduction Strategy that poverty reduction cannot be achieved without addressing issues of HIV/AIDS and vice-versa.

Prevalence is considerably higher in urban areas than rural ones, but the gap is closing. Of the estimated 900,000 infected, 58% are women, highlighting their exceptionally high vulnerability. The overall levels of infection in the adult population of Malawi have remained constant for the last seven years. One third of the children infected live in urban areas and two thirds live in rural areas. Poor infection prevention and generally poor access to maternal health services in rural settings may be the cause of this disparity. Recent reports indicate that levels of infection among young women (15-24 years) attending antenatal clinics in Lilongwe have dropped from 26% in 1996 to 16% in 2003.

The impact on social services, particularly health, is devastating. The quality of health service delivery has drastically dropped due to lack of personnel, medical equipment and supplies, lack of funding, poor infrastructure and weak management systems. Primary health care facilities have no doctors but rely on the skills of clinical officers.

The impact of HIV/AIDS on the skilled workforce has a devastating effect on government capacity to formulate and manage national programmes. Total public sector mortality rates increased from 3% in 1990 to 16% in 2000. Support and treatment of public sector staff, HIV/AIDS-related absenteeism, morbidity and mortality, funeral expenses and death benefits continue to be a huge burden with serious financial implications on the already cash-strapped civil service. There is a serious shortage of health staff across the sector. Currently 90% of public health facilities do not have the capacity to

deliver a minimum package of health care for all. The World Health Organisation (WHO) estimates that Malawi has one doctor and 23.6 nurses for every 100,000 people. This makes care and support interventions for HIV/AIDS infected people a huge challenge. However, progress has been made in securing resources and scaling up prevention programmes.

The current HIV/AIDS trends for Malawi are as presented in table 1 below.

Table 1: Key National HIV/AIDS Statistics, 2003 (Malawi)

Indicator	Value
National adult prevalence (15-49)	14.4%
Number of infected adults	760,000
Number of infected adult women	440,000
Urban adult prevalence	23.0%
Number of infected urban adults	240,000
Rural adult prevalence	12.4%
Number of infected rural adults	530,000
Number of infected children (0-14)	80,000
Number infected over age 50	60,000
Total HIV+ population	900,000

Source: National AIDS Committee Malawi, AIDS in Malawi. 2003 estimates and implication

¹⁷ The research reports did not address the private sector sales of ARVs or the question of whether both generics and patented medicines are available for purchase. It would be useful to carry out further work on this issue.

Framework priority VI

Strengthening health systems

The Abuja strategies for achieving this priority included the development and strengthening of infrastructure, capacity building and human resource development. This is an important target because it has a direct impact on health service delivery, and hence on other key targets such as access to care and support, as well as access to affordable ARVs.

Not much has been achieved in this area in any of the countries reviewed. Malawi reports that they have been able to train 10 AIDS coordinating units from various ministries to take a leading role in initialising workplace HIV/AIDS interventions. Further, about 1,346 people have been trained in HIV/AIDS-related skills. However, Malawi still has weak and inequitable health systems. Not surprisingly, with its current economic and political crises, Zimbabwe does not report any progress or efforts aimed at strengthening health systems. In Kenya, although the government has proposed collaborative strategies to strengthen health systems, and has started setting up a few comprehensive care centres to support PLWHAs, there is no clear national strategy for comprehensive care. Nigeria recently embarked on health sector reforms, such as the introduction of Health Insurance (as a form of health financing), which could potentially impact on the health systems in general, and on the provision of and access to HIV/AIDS care in particular.

All countries face problems caused by understaffing and deaths in the civil/public service, particularly in the health sector.

“...the Malawi government is still faced with the usual challenges. These include a wide range of public sector reforms dictated by multilateral and bilateral donors including the IMF and World Bank. The high staff attrition in the civil service has not received the attention it deserves as most donors continue to decline supporting public sector human resource capacity development particularly in the training and recruitment of the critically needed health staff. Line ministries continue to grapple with these capacity challenges, as they have to prioritise available human resources for their ‘core business’.”¹⁸

For Zimbabwe, “Although each ministry has appointed a focal point person in charge of HIV/AIDS issues, including co-ordinating awareness and prevention programmes, their duties and responsibilities are not clearly defined and the person is expected to carry out this function over and above their normal duties. The result is that not much really gets done.”¹⁹

The biggest challenges in this area include the lack of adequate financial resources to strengthen very weak, fragmented and inequitable health system infrastructure and to develop human resources. The problem of high staff attrition rates, due to HIV/AIDS deaths and to personnel leaving for greener pastures, cuts across all countries and remains a challenge for them all. Although there are no frameworks to assess total funding into the health sector, including HIV/AIDS programmes, it is clear that there is a still a gap between available funds and the needs of these countries. Two issues require further research: how much money would be needed to strengthen health services; and whether the resources mobilised to date are being used effectively for the benefit of those that need them most.

¹⁸ ActionAid International, Malawi, 2004, *ibid*

¹⁹ ActionAid Zimbabwe, Monitoring the Abuja Commitments: Harare, Zimbabwe. 2003

Framework priority VII

Resource mobilisation

Several strategies for mobilising financial resources were identified, including increasing national budgets for HIV/AIDS, lobbying for increased grants and loans and advocating debt cancellation. Table 2 below presents a summary of each country's efforts at mobilising resources, both at national and international levels. Clearly, effort has gone into resource mobilisation but levels of financing are still inadequate.²⁰

Some countries have been more successful than others in this area, but the current situation in Zimbabwe is unique and should be noted. Zimbabwe has had more challenges with mobilising resources at an international level, where international donors have reduced or refused funds because of their disapproval of the government/political situation.

“...the incorporation of HIV/AIDS into national development plans does not always translate into action. A Ministry of Health and Child Welfare review report on the implementation of the National Economic Revival Plan cites fuel and vehicle shortages as major constraints in disseminating information, education and communication materials for behaviour change. It also points to inadequate funding for the project. On PMTCT there is inadequate funding to cover 50% of all district hospitals and human resource constraints in all centres. On the prevention of STDs, the report cites shortage of drugs due to foreign currency problems and fuel shortages in all districts. On the provision of drugs for opportunistic infections, the report says drugs are inadequate at all levels. The report also says the acceptability of the female condom in communities still lags behind; foreign currency to import the female condom is inadequate and there are transport problems to distribute condoms to rural health centres.”²¹

Table 2: Summary of resource mobilisation efforts at national and international levels

Resource mobilisation (national)

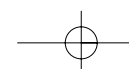
Kenya	Malawi	Nigeria	Zimbabwe
Government has allocated KShs 34 million to AIDS control units and KShs 142 million to NACC. NACC has disbursed KShs 200 million to line ministries and KShs 615 million to community initiatives aimed at the control and prevention of HIV/AIDS.	2% of line ministry budgets are earmarked for HIV/AIDS. US\$ 2.5 million set aside for ARVs in 2002.	Expenditure on HIV/AIDS in the health budget increased from 5.9% in 1999 to 22.5% in 2002 Government has allocated US\$2.5 million for the purchase of ARVs.	Percentage of health budgets increased from 29% in 1999 to 40-59% to date. The government has imposed a 3% levy on income and corporate taxes, through which US\$ 20 million is raised annually for HIV/AIDS. Government has set aside Z\$ 2.5 billion for the purchase of ARVs.

Resource mobilisation (international)

Kenya	Malawi	Nigeria	Zimbabwe
Kenya has been promised US\$129 million from the Global Fund, and US\$ 50 million from International Development Assistance through the World Bank Money is also expected from UNDP, USAID and the UK.	Malawi was awarded US\$ 196 million from the Global Fund and so far received US\$ 7.6 million for HIV/AIDS programmes. The NAC has received Kroner 7.5 million from Norway; Canadian \$1.5 million from Canada; and US\$134,000 from Centre for Disease Control. US\$ 32 million is expected from the World Bank and GBP 500,000 is expected from the UK.	Bilateral commitments to Nigeria are estimated at US\$180 million. Nigeria has been granted US\$28 million from the Global Fund (over a 2-year period) of which US\$9 million has already been received. US\$90 million is expected from the World Bank.	Government has set up a national AIDS trust fund for the financing of AIDS interventions, financed through the Global Fund. Global Fund has committed US\$ 10.5 million to fight HIV/AIDS and US\$ 5 million for malaria.

²⁰ It is difficult to assess whether levels of funding are adequate for countries that report only percentage increases in funding, because high percentage increases might not necessarily mean substantive amounts of funding

²¹ ActionAid Zimbabwe, 2003, *ibid*



Framework priority VIII

Research and development (R&D)

Kenya and Nigeria are the only countries that mention R&D work on HIV/AIDS. Kenya is involved in HIV vaccine research through the Kenya AIDS vaccine initiative and the Kenyan Medical Research Institute has been involved in research on HIV/AIDS drugs including traditional herbal therapy. Both these initiatives are entirely dependant on donor funds. The Nigerian government has been involved in research into local remedies through the National Institute of Pharmaceutical Research. In the other countries no attempts to collaborate on R&D are reported. Apart from Kenya, all countries need to consider additional research into both traditional and modern medicines and the possibilities of manufacturing generic ARVs.

Framework priority IX

Poverty, health and development

All four country reports cite the relationship between HIV/AIDS and poverty. Poverty has been blamed for the continued spread of HIV in Nigeria but there have been efforts to integrate HIV/AIDS into development strategies, for example, in work with the New Economic Partnership for African Development (NEPAD) and other international bodies. In Kenya, the National AIDS Control Council is leading a multi-sectoral programme integration strategy to implement poverty reduction strategies from an HIV/AIDS perspective. In Zimbabwe there is some evidence that the government is attempting to integrate HIV/AIDS into general development plans. Malawi's Poverty Reduction Strategy Paper discusses HIV/AIDS but the strategy it sets out needs to be strengthened by the inclusion of strategic indicators and targets. In addition, the importance of a multisectoral approach and the involvement of civil groups needs to be highlighted.

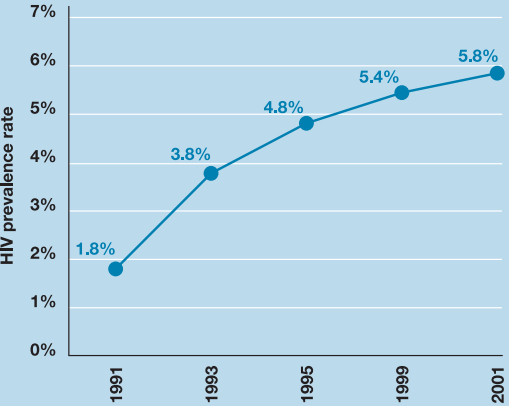
HIV/AIDS in Nigeria

Nigeria, the most populous nation in Africa, is estimated to have 3.47 million people living with HIV/AIDS, of which about 1.2 million are estimated to have developed clinical AIDS. Nigeria has already entered the generalised phase of the epidemic, where HIV infections advance well beyond high-risk groups and into the general population. Sentinel surveys show that prevalence rate has increased from 1.8% in 1991 to 5.8% in 2001 (see figure 1) and that approximately 3.5 million Nigerians are now infected with HIV/AIDS.

HIV/AIDS is affecting all areas of the country, with slightly higher rates (6.2%) in rural areas than in urban areas (5.8%). Poverty, lack of access to health information and services, cultural practices and disempowering traditional social structures are some of the factors encouraging the spread of the disease, especially in rural areas.

Nigeria already has over 1.3 million children below the age of fifteen orphaned by AIDS. The number of orphans is expected to continue to rise for at least the next 10 years. Mother-to-child transmission has also been on the increase and the number of infected children is increasing.

Young people are the worst hit, with those in the 15-19 and 20-24 age groups having infection rates of 6% and 5.9% respectively. This has disturbing implications for the future and seriously threatens Nigeria's economic and social development.



Year	Prevalence Rate (%)
1991	1.8%
1993	3.8%
1995	4.8%
1999	5.4%
2001	5.8%

Figure 1: HIV prevalence rate from 1991-2001

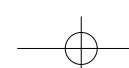
HIV/AIDS in Kenya

HIV/AIDS is now the biggest challenge to all sectors of the economy, with three million Kenyans estimated to be living with HIV/AIDS. Over 1.5 million people have died of the disease since the first case was diagnosed in 1984 and the cumulative number of deaths due to HIV/AIDS may rise to 2.6 million by the end of 2005. There are over 200,000 new cases every year and close to 700 people die every day due to the pandemic. Most deaths occur between the ages of 25 and 35 for men and 20 and 30 for women, and more than 1.5 million children have been orphaned. Life expectancy has dropped from 60 in 1993 to about 47 due to HIV/AIDS.

HIV/AIDS has had serious impact on the health system. Despite the fact that most people living with HIV/AIDS say they are unable to get access to health care, patients with HIV/AIDS-related illnesses occupy 60% of hospital beds.

There is a growing shortage of trained health staff – about 800 health workers died from AIDS between 1996 and 2002. The economic loss is estimated at a staggering US\$3 million (or Kenya shillings 240 million) a day. It is estimated that HIV/AIDS may reduce Kenya's GDP by 14.5% in the next ten years. Because HIV infection and AIDS deaths are concentrated amongst the most economically productive segments of the population the epidemic have serious consequences in terms of a decrease in production and increase in poverty.

Kenya is also experiencing an explosion in the number of orphaned and vulnerable children due to HIV/AIDS. The traditional extended family structure that provides social support is stretched to breaking point, as a decreasing number of economically active adults seek to support an increasing number of dependents.



Framework priority X

Monitoring and evaluation (M&E)

In order to achieve this priority, it was suggested that countries strengthen health information systems, establish a surveillance system for HIV infections and organise regular meetings on access to treatment.

All four countries have some reasonably good HIV/AIDS surveillance systems in place. Kenya reports substantive progress on improved surveillance systems for HIV infections through various demographic surveys. Assessing whether good general health information systems are in place is more difficult. Malawi and Kenya note that some efforts have put in place some M&E systems to evaluate and monitor the activities and resource use relating to HIV/AIDS. Malawi reports that their NAC established a grants facility to manage and coordinate resources for the national response. As a result the national HIV/AIDS monitoring and evaluation plan was developed in 2003, to cater for all programmes and projects on HIV/AIDS nationwide.

In Nigeria, the National Action Committee on AIDS has worked with stakeholders to develop the Nigeria National Response Information Management Systems to monitor HIV/AIDS prevention and control activities in the country and evaluate their impact. In designing the system the UNAIDS Country Response Information System was taken into account, and data generated from the process will fit into the Global Response Information Database to facilitate information sharing within and between partners locally and internationally. Further, there is a draft national M&E framework in Nigeria, and some reasonable amount of training has been done both locally and internationally on this.

Zimbabwe does not report much progress apart from mentioning that there exists an M&E unit functioning within the national response.²²

Despite some reasonable disease surveillance systems in the countries, there is a need for monitoring and evaluation systems to be strengthened across the board.

²² See page 14 of the Zimbabwe report

Framework priority XI

Partnerships

The achievement of the Abuja targets requires that countries strengthen national and regional networks, establish development coordination units, develop a network of experts and institutions and promote public-private partnerships. Nearly all countries in sub-Saharan Africa rely to some extent on donor funding, particularly with regard to HIV/AIDS. However, there has been little progress in the area of enhanced national, regional and international networks.

In Kenya, several networks and partnerships have been established, including the Private Sector HIV/AIDS Business Council, Kenya AIDS NGO consortium, and National Empowerment of People Living with HIV/AIDS in Kenya. Also, Kenya is the only country involved in regional and international activities and networks relating to joint efforts at fighting HIV/AIDS. Malawi reports the creation and training of HIV/AIDS coordinating units in various ministries, while in Nigeria there are some local and international partnerships like the business coalition, interfaith coalition and the transport corridor regional project. Nigeria also reports some institutional arrangements and networks, including the Civil Society Consultative Group on HIV/AIDS in Nigeria, the Network of People living with HIV/AIDS in Nigeria, and State Action Committee on AIDS. Zimbabwe does not make any explicit mention of progress in this area.

Though in-country partnerships exist in all the countries, they are not robust and have not been institutionalised. In addition, little attention has been paid to developing regional and international joint efforts and partnerships and countries seem to be more focused on their individual efforts. Kenya is the only country that seems to have established some regional networks.

Framework priority XII

Prevention of the spread of HIV/AIDS, TB and ORID

Research in the four countries focused on HIV/AIDS and all report declining adult HIV seroprevalence rates, except Nigeria with an increase from 1.8% in 1991 to 5% in 2003. All four countries have instituted PMTCT programmes. But prevention programmes are still faced with financial, human resources and infrastructural constraints.

Kenya has instituted comprehensive national preventative policies targeting youths, women and girls. They have invested in the necessary prevention, care and support facilities and infrastructure. Currently, there are 60 PMTCT facilities (from none in 2001), 250 Voluntary Counselling and Testing Centres (from 60 in 2001) and 30 CD4 testing machines (from none in 2001). However, the coverage of prevention programmes remains weak. Blood safety protocols mean that 96% of blood is safe but 5% of new infections are thought to result from the use of unsafe injection practices.

“Noting that knowledge of serostatus is an important entry point to care and prevention, only one in nine people seeking to know their HIV serostatus have access to voluntary counselling and testing services which are mostly located in urban centres. In rural areas where HIV infection rates have risen beyond levels previously thought possible, access to essential prevention services is especially limited, with fewer than one in three people at risk having access to contraceptive promotion programmes and only 14 per cent having access to services to prevent and treat sexually transmitted infections.”²³

In Zimbabwe, a PMTCT unit has been established by the ministry of health. By December 2002, 54% of hospitals had registered PMTCT sites, and 70% of HIV-positive mothers had received a course on ARV prophylaxis to reduce the risk of mother to child transmission.

PMTCT sites are only available at selected pilot sites in Malawi and are yet to be at the forefront of national programmes. PMTCT programmes have expanded in

Nigeria and a national team is in place to coordinate its various activities with the ministry of health, UNICEF and the Centre for Disease Control. Despite this, most PMTCT sites are at tertiary hospitals and uptake is still low. In Nigeria, there are six or eight pilot sites, all in teaching hospitals. Many of these teaching hospitals operate mandatory (sometimes consensual) HIV testing at antenatal clinics so issue of uptake should not arise.

All the countries reported an increase in condom use as a result of raised awareness, but this is still low in Nigeria with only 23% of males and 8% of females reporting condom use, compared to Malawi where 87% of males and 77% of females cited condom use, with increasing condom use among young people. Zimbabwe still has problems of lack of funds to import female condoms and the distribution of male condoms to rural health centres is hindered by fuel shortages.

“Working with young people remains challenging in Nigeria as strong cultural and religious restrictions continue to deny young people information. The Advertising Practitioner’s Council of Nigeria and National Broadcasting Commission have restrictive regulation on advertising of condoms and AIDS messages. Adolescent friendly health and information services are very few in the country and the impact of sex education in public schools still limited in scope, content and impact.”²⁴

Only Malawi mentions the existence of a good TB control programme but cites barriers to universal access for the poor. Kenya, Nigeria and Zimbabwe don’t mention TB in their prevention programmes.

Prevention of the spread of HIV/AIDS is a crucial tool in tackling the HIV/AIDS pandemic, sadly, as PMTCT and the use of ARVs gain prominence, other prevention efforts are apparently being given less priority. Where prevention programmes exist, roll out is more effective in urban than in rural areas.

²³ ActionAid International Kenya, 2004, *ibid*

²⁴ ActionAid International Nigeria, 2003, *ibid*

Conclusions and recommendations

In the four countries that are the subject of this paper, the Abuja Declaration and Framework for Action have proved to be useful catalysts in moving forward government responses to HIV/AIDS. Governments are struggling with capacity constraints, both human and financial, but much more could be achieved through the development of clear and well coordinated strategies and partnerships with civil groups and international and regional partners and donors.

ActionAid International calls on African governments to:

- Establish an institutional framework to coordinate partnerships, networks and multi-sectoral approaches to HIV/AIDS. Existing institutions including the National AIDS Committees and Country Coordinating Mechanisms could be further strengthened for this purpose.
- Increase the level of political leadership in the fight against HIV/AIDS. This must extend beyond heads of state to include parliamentarians and the civil administration. The impact of such leadership would be enhanced by a frank approach to the impact of the pandemic on government personnel.
- Develop coordinated strategies within a coherent national framework to ensure not only that HIV/AIDS awareness levels are high but that this awareness translates into positive behaviour changes. These strategies must take into account the sensitivities of different faith and cultural communities and produce materials that are appropriate for people with low levels of literacy. In addition, all communications should confront the issue of stigma as an inappropriate and unacceptable response to the disease.
- Introduce policies and legislation to protect the human rights of people infected with HIV/AIDS and ensure that they are not discriminated against in the work place or in relation to care services.
- Strengthen health systems and invest in human resource capacity building to ensure that robust treatment and care services are available to all sections of society, especially poor and marginalised communities, women and children. A proper assessment should be carried out in all countries to enable governments to specify the assistance needed to build capacity. Governments should encourage the participation of civil groups in this exercise and collaborate with international partners where appropriate.
- Focus on holistic approaches to HIV/AIDS care that are poverty-focused, gender sensitive, integrate responses to TB and other related infectious diseases and recognise the importance of good nutrition in combating the disease. For ActionAid International, a full care programme should include a wide range of interventions including prevention and PMTCT, prophylaxis, psycho-social support and palliative care, must be affordable to the poorest and delivered close to users. As treatment issues gain prominence, it is crucial that commitments to wider prevention and care strategies are maintained to sustain existing achievements.
- Involve affected communities, PLWHAs and women’s groups in the design and implementation of care plans in order to generate successful and sustainable strategies. ActionAid believes that PLWHA’s participation in the design and implementation of treatment programmes should be emphasised given their practical experience of dealing with the disease.

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- Develop sustainable plans for delivering affordable ARVs and other essential medicines to treat HIV/AIDS, TB and other related infectious diseases. Governments need to develop strategies that will ensure dedicated, long term funding for the medicines required. Creating international or regional partnerships with donors could be one way forward. Specific analyses to estimate the total cost of providing medicines to all and the affordability of drugs relative to income levels could form the basis for decision-making on this issue.
- Consider joint procurement of ARVs at regional level in order to attract better discounts and boost their negotiating power with pharmaceutical suppliers. At the same time, they should review legal and policy issues affecting patent protection for drugs so as to avoid enacting legislation that could impact negatively on access to medicines. Patent issues should be addressed by all national HIV/AIDS bodies and ministries rather than being left to trade ministries alone.
- Strengthen their advocacy with donors to secure increased resources for the fight against HIV/AIDS. Greater transparency and accountability in government budgeting and programming would encourage donors to provide additional support, while allowing civil groups to monitor the effectiveness of programme implementation. In addition, governments should seek to mobilise funds from employers and the private sector.
- Carry out research on local remedies and the cost of establishing national production of ARVs and other essential medicines.
- Ensure that all HIV/AIDS programmes take into account the link between HIV/AIDS and poverty and are integrated into wider poverty reduction strategies.
- Revise the Abuja Framework of Action against which progress is to be monitored and specify exact targets, deliverables and time-bound indicators. Such a framework would form the basis for future reviews of progress in these countries.
- Strengthen existing health, management and information systems to ensure that they can generate specific and consistent information across all areas of programmatic initiatives to enable proper evaluation and monitoring. Governments should consider seeking assistance from the international community, including WHO, UNAIDS and the Global Fund, in the design and/or strengthening of national monitoring and evaluation frameworks. These should be sufficiently comprehensive to allow for international comparisons, but also flexible enough to enable each country to collect information necessary for their own use.

Abbreviations

GDP – Gross Domestic Product	PACC – Provincial AIDS Control Committee
GFATM – Global Fund to fight Tuberculosis, AIDS and Malaria	PLWHA – People Living with HIV/AIDS
GNP – Gross National Product	PMTCT – Prevention of Mother to Child Transmission
GOK – Government of Kenya	PRSP – Poverty Reduction Strategy Paper
GoM – Government of Malawi	STI – Sexually Transmitted Infection
HIV – Human Immunodeficiency Virus	TB – Tuberculosis
IDA – International Development Association	UN – United Nations
IEC – Information, Education and Communication	UNAIDS – joint United Nations Programme on HIV/AIDS
ILO – International Labour Organization	UNDP – United Nations Development Programme
KANCO – Kenya AIDS NGO Consortium	UNGASS – United Nations General Assembly Special Session
KIRAC – Kenya Inter-Religious AIDS Consortium	UNICEF – United Nations Children's Education Fund
MCH – Maternal and Child Health	USAID – United States Agency for International Development
MDG – Millennium Development Goal	VCT – Voluntary Counselling and Testing
MDHS – Malawi Demographic Health Survey	WHO – World Health Organization
MOH – Ministry of Health	
MPRSP – Malawi Poverty Reduction Strategy Paper	
MTEF – Medium Term Expenditure Framework	
NAC – National Aids Commission	
NACC – National AIDS Control Council	
NASCOP – National AIDS Control Programme	
NEPHAK – National Empowerment of People Living with HIV/AIDS in Kenya	
NGO – Non Governmental Organisation	
NHIF – National Hospital Insurance Fund	
NSF – National Strategic Framework	
OAU – Organisation of African Unity	
ODA – Official Development Assistance	
OECD – Organisation of Economic Cooperation and Development	
ORID – Other Related Infectious Diseases	
OVC – Orphans and Vulnerable Children	

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