


The African Development Forum 2000

Leadership

at all levels to overcome

HIV/AIDS



Country	Prevalence (%)
Botswana	35.8
Swaziland	25.25
Zimbabwe	25.06
Lesotho	23.57
Zambia	19.95
South Africa	19.94
Namibia	19.54
Malawi	15.96
Kenya	13.95
Central Afr. Republic	13.84
Zambique	11.75
Cote d'Ivoire	11.32



Economic
Commission
for Africa

The African Development Forum 2000

Leadership at all levels to overcome HIV/AIDS

adf 2000

Country	Prevalence (%)
Botswana	35.8
Swaziland	25.25
Zimbabwe	25.06
Lesotho	23.57
Zambia	19.95
South Africa	19.94
Namibia	15.54
Malawi	13.95
Kenya	13.84
Central Afr. Republic	13.84
Zambia	11.75
Burkina Faso	11.32



Economic
Commission
for Africa

For this and other publications, please visit the ECA web site at the following address:

<http://www.uneca.org>

or Contact

Publications

Economic Commission for Africa

P. O. Box 3001

Addis Ababa, Ethiopia

Tel.: 251-1-44 31 68

Fax: 251-1-51 03 65

E-mail: ecainfo@uneca.org

Produced, edited and designed by Nii K Bentsi-Enchill, Lorna Davidson, and Seifu Dagnachew.

Foreword	i
I. The Event	1
1. Situating the Theme: “AIDS - The Greatest Leadership Challenge”	1
1.1 Highlights of national workshop presentations	2
2. Africa’s decisive moment	6
3. Leadership challenges	9
4. Resource and funding issues	14
5. Leadership responses	17
6. The task at hand: Fighting HIV/AIDS, sector-by sector	19
6.1 People living with HIV/AIDS	20
6.2 Youth	20
6.3 Gender	23
6.4 Labour organizations	22
7. Views from interest groups	25
7.1 Supporting young people working in development	25
7.2 Getting business and labour organizations involved	27
7.3 Sectoral impact and response	28
7.4 Leadership role of governments in social mobilization	37
7.5 Leadership roles and responses for migrants, refugees and other mobile populations	37
7.6 Access to care	38
7.7 Scaling up of targeted and general interventions	40
7.8 Economic impact of HIV/AIDS	41
7.9 Breaking the silence	42
8. Perspectives from the Highest Level of Leadership: The Heads of State Forum	45
II. Forum Outcomes and Follow-up	49
1. The Addis Ababa Consensus	49
2. Implementing the consensus	57
3. Milestones	58

TABLE OF CONTENTS

3.1 The Abuja Summit	58
3.2 Link to Special Events on HIV/AIDS	58
3.3 The international partnership against AIDS in Africa (IPAA)	59
3.4 Next steps for IPAA	59
III. Annexes	63
List of Annexes	
Annex I: The consensus annexes	63
A. Youth Statements to the African Development Forum	63
B. Declaration by African civil society organizations	67
C. Position statements on gender, HIV/AIDS and leadership	73
D. ILO pre-forum tripartite contribution to the African Development Forum 2000	76
E. The African Diaspora Focus Group Consensus statement	78
F. Statement from the religious leaders	82
Annex II: Fact: Economic impact of HIV/AIDS	84
Annex III: ADF 2000 media coverage	93
Annex IV: ADF 2000 exhibition	96
Annex V: ADF 2000 documentation	98
Annex VI: Relevant web sites	99
Annex VII: ADF 2000 partners	100
Annex VIII: ADF 2000 co-organizers	101
List of Boxes	
Box 1: Why HIV/AIDS for ADF 2000	2
Box 2: HIV/AIDS devastates families	7
Box 3: A litany on leadership	10
Box 4: Past commitments made by African leaders on HIV/AIDS	12
Box 5: Snapshot of international funding for the fight against HIV/AIDS, 1996 - 1997	15
Box 6: The unfinished agenda	18
Box 7: Why voluntary counseling and HIV testing	38
Box 8: Tackling mother-to-child transmission	39
Box 9: Malawi's multi-sectoral approach	45
Box 10: Botswana - a severely affected country	46
Box 11: Uganda - a relative success story	47
Box 12: Partnership roles	58

NO LONGER BUSINESS AS USUAL

The second African Development Forum may have ended, but the process of fighting HIV/AIDS in Africa goes full steam ahead. We can rightly say that in bringing together a representative group of Africans and their development partners to focus on HIV/AIDS as the Greatest Leadership Challenge, we took the fight against HIV/AIDS in Africa to a new level, building on previous conferences and gatherings, and adding significant value. For the first time there was a focus on leadership at all levels. And for the first time these different levels of leadership — from youth to traditional chiefs to women to policy makers to Heads of State — shared the same space, engaged in a substantive and constructive dialogue, and spoke with one voice. All agreed that the HIV/AIDS pandemic has forced us to change the way we do business in Africa. With the survival of the continent at stake, it can no longer be business as usual.



ADF 2000 ended with some concrete, practical and doable proposals. The Addis Ababa Consensus highlighted a number of commitments at personal, community, national, regional and international levels, while the Plan of Action spelled out the proposals in detail. Both the Consensus and the Plan are reproduced in this publication. Now we have the road map, the challenge is to ensure that the outcomes of the Forum are translated into concrete action that has a tangible and sustained impact in banishing HIV/AIDS from our continent.

As we publish this Report six months after the Forum, a lot of follow-up activity is already underway: at least 29 countries have organized post-Forum workshops to see how the consensus could be implemented at national level; with our substantive input, the Organization of African Unity organized a Summit on HIV/AIDS and Other Related Infectious Diseases in Abuja, Nigeria, from April 24 – 27, which endorsed the ADF 2000 Consensus and Plan of Action; and after discussing internally as well as with our partners, including UNAIDS, we have arrived at a clear sense of ECA's specific role in the follow-up and implementation process. In addition to mainstreaming HIV/AIDS in all of our socio-economic policy analysis, we plan to develop mechanisms to monitor the implementation of the Addis Ababa Consensus and Plan of Action. Drawing on our positioning as an African institution as well as a UN body, we also intend to strengthen partnerships, drawing on mechanisms such as the International Partnership Against HIV/AIDS (IPAA).

FOREWORD

Partnership in fighting HIV/AIDS is essential. Just as we joined hands for ADF 2000, we will need to continue to work hand in hand, in partnership with all stakeholder groups, including PLWHAs, civil society organizations, African policy makers, our partner agencies in the UN, and bilateral and multilateral funders. Each stakeholder group has a distinct and critical role to play, and ADF 2000 went a long way towards arriving at a division of labour in this regard. For example, we have always seen the ADF process as the sum of regional, sub-regional and country-level parts – with the real action in terms of implementation of strategies, plans and programmes at the country level. This makes country-level actors, including the UN Country Theme Group, key partners in any implementation strategy.

This report pulls together the substance of ADF 2000. It is written in a journalistic style to ensure accessibility, ease of understanding and easy dissemination of the key issues and outcomes of the Forum. It is intended as a more substantive companion to the ADF 2000 Popular Report, which was disseminated earlier, and will also be available electronically on the Web. I hope you find the contents useful.

On behalf of the Commission, let me say how much we look forward to working with you on the follow-up of ADF 2000, and assure you that ECA remains fully committed to play its role in eradicating HIV/AIDS from our beloved continent.

K.Y. Amoako
Executive Secretary
March 2001

1. SITUATING THE THEME: “AIDS - THE GREATEST LEADERSHIP CHALLENGE”

African countries must take extraordinary measures to overcome the continent’s HIV/AIDS crisis. There is absolutely no time to waste and in this struggle, every African is a leader who must demonstrate personal responsibility by playing a role, however small, in reversing the spread of the epidemic.

These were among the conclusions of a landmark conference organized by the United Nations Economic Commission for Africa (ECA) in Addis Ababa, Ethiopia, on 3-7 December 2000. The occasion was the second African Development Forum (ADF), attended by some 1,700 people from all over Africa and from the international community. There were local community activists and leading members of non-governmental organizations, government ministers and policy makers, academics, PLWA and researchers, senior staff of United Nations and other multilateral organizations. There were also traditional healers, religious leaders and Heads of State and Government, all contributing to a Forum that demanded concrete outcomes.

The major outcome of ADF 2000 was the Addis Ababa consensus (see II Forum outcomes and Follow-up). This comprehensive document outlines the tasks ahead – from local to continental level and in key sectors – in the prevention of HIV/AIDS and the treatment and care of infected people. Adopted on the last day of the Forum, the Addis Ababa Consensus was to be carried home by participants for discussion, modification according to local realities and implementation.

Describing the Forum as “a huge opportunity,” one of the keynote speakers, Ms. Graça Machel of Mozambique (and South Africa) hoped that Africans would in future look back and say that the ADF 2000 was a turning point in the struggle against AIDS in Africa.

Below: Masked agents of HIV/AIDS: Scene from skit by Ethiopia AIDS Orphans Group



Photo by Antonio Florence

I THE EVENT

Though she called it a “plea,” Ms. Machel issued a warning and a call for honest action to the audience of political leaders, religious leaders, civil society leaders, youth leaders, as well as officials of international financial institutions and creditor countries and organizations. She said: “NO MORE FICTIONS. Do not fool Africa any more. Let us move forward.”

Box 1: Why HIV/AIDS for ADF 2000?

Africa is home to about 70 per cent of the world’s adults and 80 per cent of the world’s children living with HIV/AIDS. Africa has buried

three-quarters of the over 20 million people worldwide who have died of AIDS since the epidemic began. And while HIV/AIDS is wiping out Africa’s hard-won gains in health, education and other key sectors, the continent has so far been the least able to mobilize an adequate response to the global epidemic.

In this context, ECA convened a forum of activists and leaders to sharpen perspectives on the HIV/AIDS crisis and chart a new course into the future. The vehicle was the African Development Forum (ADF), an innovative process that brings together each year governments, civil society, the private sector and external partners to focus on a selected development issue. Through intensive dialogue and debate, participants share experiences and discuss best practices, building cooperation and partnerships at all levels. The outcome is an African-driven response that aims for maximum impact at country level through appropriate strategies, policies and programmes.

Recognizing the society-wide and multi-sectoral impact of HIV/AIDS, ADF 2000 set out to define leadership amidst the HIV/AIDS crisis and analyse the array of challenges ahead. It also identified the actions required at all levels and in all spheres to organize people and galvanize institutions into making effective responses to the epidemic.

To attain these objectives, the Forum put specific emphasis on categories and issues seen as vital in generating the commitment, the leadership and the programmes to overcome the crisis. These included the role of Africa’s youth and of people living with HIV/AIDS, gender issues, the dramatic prevalence of HIV/AIDS in Africa’s armed forces, the critical need for action at community level, and the level of support needed from the international community.

Structured to encourage maximum participation and dialogue, ADF 2000 also featured daily “break-out sessions” and focus group meetings that enabled participants to discuss sectoral issues in detail and then to report back to plenary sessions. Poetry and brief dramatic scenes were also presented to show the different forms that campaigns can take to break the silence and spread positive messages and useful information in the fight against HIV/AIDS.

1.1 Highlights of National Workshop Presentations

Ghana, Uganda, Ethiopia, Mali, Namibia, and Burundi made presentations at ADF2000, highlighting aspects of their respective national HIV/AIDS programmes, strategies and plans as well as the National Workshops they held just prior to the Forum.

Ghana

Ghana is regarded as a low prevalence country. The HIV/AIDS incidence was 2.6 per cent in 1994, rising to 4.6 per cent in 1999, said Dr. Kwaku Yeboah, Director of the country’s National AIDS Control Programme. The country’s first AIDS case was reported in 1986. By September 2000, 90 per cent of all reported cases was located in the 15 – 49 years age group.

In presenting details of Ghana’s HIV/AIDS programmes and strategies and the administrative and coordination structure of the National AIDS Programme, Dr. Yeboah noted that the country had an overall Strategic Framework that was approved by the Cabinet.

The main conclusions were:

- Because of the current low prevalence in Ghana, the worst impact of HIV/AIDS was yet to be felt;
- Responses at all levels were being put in place to stem possible catastrophe;
- “Best practices” had been documented;
- Clarification of leadership roles and the establishment of partnerships at all levels were paramount in the national response; and
- Socio-economic impacts were not yet adequately documented due to the relatively low prevalence.

Uganda

Uganda’s pre-ADF2000 National Workshop stressed the role of leadership at all levels, took the opportunity to intensify and expand on what was already being done at all levels and emphasized the need for full involvement of stakeholders such as sex workers and the private sector, said Professor John Rwomushana, Director for AIDS Research and Policy Development of Uganda AIDS Commission.

A critical factor in the country’s successful reversal of the rising trend of HIV/AIDS was the involvement of leadership at all levels, from the President down. This leadership, accompanied by openness and transparency also helped reduce the social stigma of HIV/AIDS.

Uganda’s HIV/AIDS programmes and strategies had adopted the multi-sectoral approach and this process was enhanced by the social cohesion of Uganda’s ethnic groups. However, there were obstacles and challenges to report. According to Prof. Rwomushana, these included inadequate lower level commitment, competing funding priorities, poverty-level incomes, unemployment and the national debt burden. Other key elements included stigma and cultural impediments, as well as the lack of access to affordable drugs to treat people living with HIV/AIDS.

Ethiopia

Ethiopia’s pre- ADF2000 National Workshops made a number of recommendations, reported Dr. Dagnachew Haile Mariam, head of the National HIV/AIDS Council Secretariat. The key proposals stated that Africa should unite to fight the HIV/AIDS holocaust by pressing for more comprehensive debt relief, and that the Ethiopian Government, the international lending agencies, the pharmaceutical companies and the private sector should allocate resources for HIV/AIDS prevention and control.

He said Ethiopia had set up a National AIDS Council, headed by President Negasso Gidada. The Council had an Advisory Board made up of major stakeholders and a multi-sectoral strategic framework that was being implemented. Also in place were laws, rules and guidelines with special emphasis on discrimination, stigmatization and the protection of human rights. He also reported that economic assistance, care and social support were being given to people living with HIV/AIDS, AIDS orphans, care-givers and all those affected by the epidemic.

Dr. Dagnachew emphasized the need to mobilize the national and international media, and also to strengthen international partnerships in the fight against HIV/AIDS. A major objective of such partnerships, he said, was to make available and affordable the appropriate medicines for opportunistic infections and anti-retroviral drugs.

Mali

Strengthening leadership roles and sharing experiences and best practices were among the strongest features of the pre-ADF2000 Forum Workshop in Mali, said Dr. Josephine Keita Traore, Technical Counsellor in the Ministry for the Promotion of Women, Children and the Family.

Other highlights of the Workshop included its emphasis on a multi-sectoral approach, the decentralization of anti-HIV/AIDS activities, the strengthening of local responses to HIV/AIDS, and the involvement of civil society organizations (CSOs) at all levels of leadership. The workshop also discussed the introduction of new responses in the fight against the disease.

On leadership roles at different levels, the National Workshop examined the activities of such categories as parliamentarians, CSOs and people living with HIV/AIDS, and noted the positive role of President Osmar Alpha Konaré in social mobilization against the epidemic.

Namibia

HIV/AIDS had become the primary cause of death in Namibia, said Dr. Nestor Shivute, chairman of the National HIV/AIDS Executive Committee and about 20 per cent of all sexually active adult Namibians had the virus.

He said Namibia's anti-HIV/AIDS plan was multi-sectoral and its implementation would be decentralized. He also presented details of the structures put in place to implement the Plan.

The country's pre-ADF2000 National Workshop attracted 160 participants, including Cabinet members, parliamentarians and people living with HIV/AIDS. Some of the resolutions adopted included the need to translate political commitment into practical action, expanding access to treatment of sexually transmitted diseases and opportunistic infections and to anti-retroviral drugs for people with HIV/AIDS. Other decisions were to accelerate the nation-wide response to HIV/AIDS; promote and strengthen scientific and social research interventions; and review school curricula for their appropriateness with regard to HIV/AIDS, sexuality, and reproductive health.

Burundi

HIV prevalence in Burundi was about 20 per cent in urban areas and about 3 per cent in rural areas where the majority of people reside, said the Minister of Health Hon. Stanislas Ntahobari. Infection rates were higher among adult women than adult men, the education and agriculture sectors were hard hit by the epidemic and continuing civil conflict was compounding the problem.

Nevertheless, Burundi's pre-ADF2000 National Workshop was a two-day event that attracted 175 participants, including people living with HIV/AIDS. The use of condoms, mother-to-child transmission and access to drugs were among the themes of the workshop.

The Minister noted that high-level political commitment in Burundi had been translated into establishing national HIV/AIDS policies and programmes. A National Solidarity Fund had also been set up to finance treatment and care for people living with HIV/AIDS. There were also national networks to control HIV/AIDS in the workplace and in communities, as well as those set up by people living with HIV/AIDS and by traditional healers.

Recommendations of the pre-ADF2000 National Workshop included the strengthening of the National Solidarity Fund, the protection of positive social values, the need to promote the use of condoms, the need to adopt a decentralized and multi-sectorial approach, the need to provide help for AIDS orphans, regulation of prostitution, legal protection for people living with HIV/AIDS and more intensive mobilization of local resources. The workshop called for resolution of the civil conflict, and also for relief on the country's external debt in order to free resources to fight the HIV/AIDS pandemic.

These presentations were followed by contributions from the floor. One speaker noted that in Ghana, strong and effective messages – “If it is not on, it is not in” is one of the current slogans – had increased the use of condoms. Another contributor from Gabon called for more transparency in issuing data as such information could be subject to political manipulation. “We also need to know what is going on beyond geographic borders. We need more clarity about the HIV problem in Africa, given that there are areas where HIV is not spreading,” this speaker added. A delegate from Sudan called for more experience sharing and suggested that countries with similar religions should be twinned.

On a different note, a speaker from Benin said there was “an epidemic” of National HIV/AIDS Councils in Africa instead of National HIV/AIDS Control Programmes. “We need to review the situation, and to determine if this is just convenient for our partners. We need indicators to measure political commitment, and to determine internal and external inputs,” this speaker concluded. In response, a delegate from Algeria said “Africa must blame itself if it has worked with imposed programmes that are hardly relevant to its needs. Do we really know the true rates of HIV? This is important, if we are to stop new infections, and for early management.”

A speaker from Kenya said Ethiopia, Kenya and Uganda were among the countries that have representation of people living with HIV/AIDS at high-level policy making positions, but this could not be said of many other countries. “We need a statement of intent to have this happen in every country.” Another speaker, from Zimbabwe, suggested that traditional leaders had not been adequately addressed in the Forum and that traditional medicines could be important alternatives but not a replacement for Western medicine.

2. AFRICA'S DECISIVE MOMENT

Keynote speakers in the plenary sessions addressed the central themes of ADF 2000 and went into detail on several aspects. The main points of major presentations are summarized below.

“This is our decisive moment” when Africa must define its own response to the HIV/AIDS pandemic, declared ECA Executive Secretary K.Y. Amoako. And this response must match the scale of a challenge he described as “a battle for our continent’s survival.”

Ethiopian President, Negasso Gidada said that Africa’s culture of communal life provided a natural basis for taking care of people living with HIV/AIDS. However, that same culture must confront the widespread problem of exclusion and stigmatization of people living with HIV/AIDS. President Negasso then opened up the central themes of the Forum by emphasizing Africa’s collective responsibility.

He said religious leaders and civil society “can make a big difference by changing the way people think and act in relation to people living with HIV/AIDS.” He pointed out that citizens, community leaders, trade unions, businesses, “in fact, every part of our societies” must join “a grand African coalition against HIV/AIDS.” Furthermore, youth, women and people living with HIV/AIDS should be at the forefront of this coalition, he added, describing the challenge of HIV/AIDS as “a multi-faceted struggle: a struggle for human rights, the empowerment of women, for the restoration of basic health and education services, for equitable development – in fact, it is a struggle for the future of the African continent.”

Organization of African Unity (OAU) Secretary-General Salim Ahmed Salim filled in the immediate context. Until recently in most African countries, the level of preparation to fight this pandemic was very low. Most communities felt leaderless as to how to deal with the pandemic and develop coping mechanisms, Mr. Salim pointed out. With clear information and open discussion about HIV/AIDS yet to reach most Africans, many communities attached stigma and discrimination to the disease, which encourages concealment and silence.

At the same time, Mr. Salim continued, the institutional infrastructure for prevention, treatment and care remained inadequate. Many countries had only recently formulated clear national policies on the pandemic and there were still others who did not have policies. Budgetary allocation to fight it was minimal or did not exist at all in some countries.

Campaign activities also tended to be externally driven.

The situation was now improving but the pace of change needed to be faster, with a commitment and zeal to match the omnipresent and multi-dimensional threat of HIV/AIDS, Mr. Salim said.

Among the speakers bringing a message of hope and determination to ADF 2000 were

United Nations
Secretary-General,
Kofi Annan



Photo by Antonio Florentino

United Nations Secretary-General Kofi Annan and Ms. Graça Machel. Mr. Annan reminded participants that “we are far from powerless. We can halt the spread of HIV/AIDS. We can even reverse it.” Not even HIV/AIDS “can defeat this great continent of ours,” Ms. Machel added. “Among the assets in this struggle is the fact that we know how HIV/AIDS can be prevented. The other great assets are the people and communities of Africa, complete with our strength, determination and proven ability to survive.”

Mr. Annan acknowledged that “far too many graves accumulated in Africa” while national and multilateral institutions were responding painfully slowly to the continent’s HIV/AIDS crisis. “But finally, finally, we are galvanized.” He hoped people would in future look back at ADF2000 and say, “This is where the breakthrough occurred.”

He said the world had begun to hear and heed the call for billions rather than millions to be spent on HIV/AIDS in Africa. Africa now had to set up reliable mechanisms for spending the money where it was most needed and could do the most good. It would be particularly important to decentralize those resources, the Secretary-General pointed out.

Women’s empowerment was a key element in overall strategy, but men could also make a real difference, Mr. Annan said. In talking about men and AIDS, the usual and limited view was of men refusing to use condoms, men having sexual relations outside marriage and practising other misguided concepts of masculinity.

However, he argued, the focus should also be on men in political life who “still tend to predominate at the highest political levels and, therefore, control both policy making and the purse-strings.” The Secretary-General said that such men must spend political capital to make the fight against HIV/AIDS their top priority and they must allocate more resources for treatment and prevention.

AIDS requires us all to speak up and speak out, to open our eyes to suffering, to open our minds to new ways of thinking, and our arms to people living with HIV/AIDS, who need help and support.

UN Secretary-General Kofi Annan

Box 2 : HIV/AIDS devastates families

African families. Through song and dance, the children portrayed the agony of a family as, first the father, the mother and then one child, are claimed by masked agents of the virus. As the children cry for their parents, they also make a strong call for people to take responsibility for their actions and avoid immoral behaviour. The performance ended with a positive message of hope as the agents of the virus are unmasked and the virus is overcome.

The opening session of ADF 2000 concluded with a moving portrayal by the Ethiopian AIDS Orphans Group of the devastation caused by HIV/AIDS in

Mr. Annan reported that in December 1999, he convened five partners – African governments, donors, NGOs, the private sector and the United Nations – and asked them “to develop an unprecedented response to an unprecedented crisis.” The result was an International Partnership Against AIDS in Africa (IPAA) that “has made an excellent start.” Mr. Annan said the IPAA has helped strengthen national planning, create momentum for advocacy, mobilize new resources and improve access to the full range of HIV care, support and treatment.

The pervading message in speeches to plenary sessions was that all participants must leave Addis Ababa with a new and higher level of commitment, caring and social responsibility. Most important was the imperative of breaking the silence about HIV/AIDS. In order to do this, participants would have to find practical ways – in their homes, in their communities and in all places of work, leisure and worship – of waging an urgent campaign on two simultaneous fronts. The first of the two fronts was the prevention of any further spread of HIV/AIDS. The second front was to improve the treatment, care and support of people already living with HIV/AIDS.

As Ms. Graça Machel observed, “each one of the statistics that we have heard has a name, has a family, is someone’s daughter, son, sister, brother.” In turn, President Negasso put Africa’s HIV/AIDS crisis in a professional context. He observed that people living with the disease and those who have died “are some of our doctors, engineers, scientists, teachers, farmers, managers and journalists whom we have trained for so long, using much of (our) meagre resources.”

3. LEADERSHIP CHALLENGES

Speakers discussed the nature of leadership that Africa needs to overcome the HIV/AIDS crisis, the levels at which this leadership must operate and the responsibilities that leaders must assume.

African governments must show genuine leadership by abandoning rhetoric and taking action to energize people and mobilize the necessary resources to conduct the campaign against HIV/AIDS, said Ms. Machel. She argued that the lack of resources “is not a sufficient excuse. When governments lead their countries to war they can spend as much as 45 per cent of the of resources on that war. What percentages of national budgets are currently being spent to vanquish HIV/AIDS? Our governments must show the leadership to allocate greater proportions of our admittedly limited budgets to ridding our continent of the threat of HIV/AIDS. If you can mobilize resources for war, why can’t you mobilize resources for life?”

In a similar vein, President Festus Mogae of Botswana asked of his fellow Heads of State: “Can all of us honestly say that we have assigned, instructed and mobilized our best professionals to move with speed and sustained determination to deal with this the greatest development emergency of our time – HIV/AIDS?” He said they should all divert resources from military expenditure to fighting the HIV epidemic.

Ms. Machel also took a very personal approach, speaking as a mother to an audience that included other parents as well as political, civil society and other types of leaders. “How would you react if you were told that of your five children, two would die prematurely, but that you still had a chance to stop their deaths? Which parent wouldn’t mobilize all of their financial, emotional and human resources and act immediately?”

Mr. Amoako in turn stressed: “No one is going to save us from this crisis but ourselves.” He said ADF 2000 participants must “shake the remaining complacency and ignorance about HIV/AIDS.” He challenged participants to use the Forum as an opportunity to learn how to be better leader in the fight to stop the spread of HIV/AIDS and to help ensure a decent and a caring life for those burdened with HIV/AIDS and their families. Mr. Amoako urged participants to think hard about how to scale up the best strategies, policies and programmes. “This must not be theory, but real action.”

Finally, ADF 2000 would produce the Addis Ababa Consensus. This document would be tabled at the April 2001 Heads of State Summit being organized by President Olusegun Obasanjo of Nigeria in Abuja, with the full backing and collaboration of OAU Secretary-General Salim Ahmed Salim. “But, do not wait for us. Think about holding your own consultations when you return home. Invite media, civil society, business, labour, youth groups, women’s groups. In fact, look around at the kind of people you see at this Forum, and remember the people at home who will help you replicate a Forum to take your own actions to the next levels of effectiveness and impact.”



**ECA Executive Secretary,
K.Y. Amoako**

Box 3: A litany on leadership

This excerpt from a speech by ECA Executive Secretary K.Y. Amoako at ADF 2000 summarized the leadership challenges facing Africa in the fight against HIV/AIDS.

Leadership is our topic. Leadership at all levels: within the family, the community, the towns, the provinces, civil society, the churches and mosques, the elders' meeting places, business, labour and, uppermost, at the national political level; leadership that is the boldest, most persistent, most insightful, compassionate, forceful, cooperative and imaginative we have ever had.

Leadership to move into the open, to be in solidarity with those who carry HIV/AIDS, who face the most dramatic possible challenges.

Leadership to do not just what is right in education, in health care, in economic support, but to do what is right on the proper scale.

Leadership to shun, fight and jail those who beat up and rape girls and women,

Leadership to insist that schools and teachers and communities teach sex education to all children before the actual age of sexual activity;

Leadership and courage to be human and compassionate;

Leadership to do the very best we can to improve health systems, especially for mothers and children;

Leadership to ensure that those with HIV/AIDS can work as long as they are able;

Leadership to make absolutely sure that AIDS orphans will not be lost to this world, but will be given decent and fully supportive chances.

Now: think of all these. Each and every one of the leadership acts necessary to prevent HIV/AIDS and to help those burdened with HIV/AIDS, each of these leadership acts, without exception, are things we want anyway for a stronger, better developed Africa.

Do we want to ensure that African women are empowered to control their own lives and destinies only because we know this will help reduce HIV/AIDS, or because it is right, just, moral and part of the foundation of a society that can advance?

Do we want to start working with the millions of dedicated youth on this continent? Millions seeking to be part of the answers to our poverty... only because this will help control the HIV/AIDS pandemic, or because we have so much lost time to make up in partnering with our youth for a better common future?

Leadership on HIV/AIDS calls for so many of the fundamental things we should have been doing anyway. An Africa where all our leaders, at every level, where each of us here today works for the policies, practices and programmes to reduce HIV/AIDS is, in fact, the Africa we should all be working for anyway.

But we must go beyond even this, for we are in a war for survival, where we need to ratchet up all our work to battle HIV/AIDS.

Leadership is on test now, leadership of a special kind. There are those who honestly manage the day-to-day tasks of their institutions and governments. These are adequate leaders.

Other leaders do more. They spend time inspiring people to be better than they otherwise would, and to act not only for their own selfish ends but also for the benefit of all. These are good leaders.

Then there are leaders who rise to face unusual threats to their people. They search for answers and successes, and when they find them, they scale up the response to the maximum. They surpass even themselves, mustering the energies of the whole people. They crusade for change and reform. And they lead by personal example as well as by exhortation. They are selfless. They are dedicated. And they do everything they can to bring success to their people. They are the great leaders. They are the leaders who will be remembered.

Reminding participants of Africa's emergency situation, Vice-President Justin Malewezi of Malawi said that every day, 5,500 Africans died of AIDS while 11,000 new infections occurred. By 2010, the projected life expectancy in heavily affected countries would decline to less than

30 years. A secondary pandemic of orphans caused by HIV/AIDS was exploding throughout the region. “Unless we scale up our response, more people will die of AIDS in Africa than in all the wars of the 20th century combined. Recall the suffering caused by a single death, the grief of a child at its mother’s graveside. Multiply that sorrow by tens of millions. We face grief beyond words and sorrow beyond tears. “

Many speakers emphasized that commitment at the highest political level was essential for an effective national response to HIV/AIDS. They said the approach must be multi-sectoral and reach the community level. Others agreed that the first role of a leader was to protect the most vulnerable members of society: the children and women.

Indeed, the full power and authority of the State must be brought to bear on the crisis, added the UN Development Programme Administrator Mark Malloch Brown. “This is not business as usual. We are not dealing with a health crisis but a national crisis,” he declared. National AIDS plans, coordinated at the highest level of government and involving all relevant actors and institutions, were proving particularly effective, he said, citing Uganda, Malawi, Ethiopia, Botswana and Tanzania as countries that had set up a coordinating body that reported directly to the Prime Minister or President’s office to drive this process. According to Mr. Brown, the early results were very encouraging, helping kick-start the process of integrating AIDS issues into overall development plans.

The first and perhaps most important step that leaders must take is to break the silence on HIV/AIDS once and for all, said Mr. Brown as he touched on another of the central themes of ADF 2000. The aim was “to alter permanently the norms, values, and traditions that are fuelling the epidemic, especially those that perpetuate gender inequalities and discrimination against those living with HIV/AIDS.”

Speakers agreed on the need to “bring down the barriers of shame and silence” at all levels. “When local leaders speak out,” said Mr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), “they create the space for people with HIV/AIDS to speak out fearlessly, (so that) communities are empowered to act against AIDS. And when national leaders speak out, their example resonates throughout the nation.” Africa needed “leadership that promotes openness and helps turn people living with HIV into leaders,” Mr. Piot added.

Mr. Brown observed that some individuals “have embodied this challenge, risking personal injury, scorn and injustice to spread these messages. The same must now be done from classroom to clinic, from factory to football field until everybody, not just in Africa but in other parts of the world where AIDS is accelerating, has heard and understood that behaviour change is the best protection.” One such individual is Ms. Charlotte Mjele, a young South African living with HIV/AIDS whose speech at the opening session of the conference was one of the most powerful moments of the entire ADF 2000.

Providing another angle on leadership issues, Vice-President Malewezi argued that leaders must be prepared to work with everyone without polarizing institutions but by focusing on how best to collaborate to meet the needs of the people. Leadership was not about power, or the delegation of authority, Mr. Malewezi continued. It was about taking responsibility to address the most important issues facing our people.

“Unless we scale up our response, ...
we face grief beyond words and
sorrow beyond tears.”

**Vice-President Justin Malewezi of
Malawi**

In a powerful passage, Mr. Malewezi affirmed: “Leadership demands that we serve the people we represent so that we earn their respect and trust. We cannot influence people unless we earn their trust. Perhaps the most important aspect of leadership that we should bring to this struggle is that of credibility. As leaders we will be judged by our actions, not by our words. We must prioritize HIV/AIDS interventions in our development programmes. We must give the example of responsibility within our own marriages. We must protect vulnerable groups, respect women and show compassion to all those suffering from HIV/AIDS and care for orphans. As leaders we also need to combine intellect, tolerance, compassion and resolve to address the most important issue facing Africa.”

Box 4: Past commitments made by African leaders on HIV/AIDS

Organization of African Unity Secretary-General, Salim Ahmed Salim, told ADF 2000 that African leaders had long recognized the gravity of the HIV/AIDS pandemic and had repeatedly stated their determination to combat the disease. At the OAU Summits in Dakar (1992) and Tunisia (1994), they resolved to mobilize their populations to fight HIV/AIDS and they set the following targets: By the end of 1992, all African Heads of State would be publicly recognized as the leaders of the fight against HIV/AIDS in their respective countries;

- By mid-1993, all African Heads of State would have ensured that all adults, including young adults in their countries know how HIV was transmitted and how they could protect themselves and others from infection;
- By mid-1993, African Heads of State would have adopted a national AIDS care plan, including essential drugs for HIV-related illness and a national plan for family-based or community care and support of AIDS survivors, including orphans;
- By the end of 1993, all African Heads of State would have endorsed a National Plan of Action for the promotion and coordination of HIV/AIDS research in their countries including an operational ethical code for such research;
- By the end of 1993, all African Heads of State would have ensured that every sector had worked out a plan that took into account the sectoral implications and consequences of HIV/AIDS and allocated funds to it, and would have established an effective mechanism for multi-sectoral coordination of planned activities;
- By the end of 1994, a “national policy framework” would have been established to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues;

“Regrettably”, said Mr. Salim, “many of these commitments have not been translated into action.” It had taken some time for most African countries to give appropriate recognition to the HIV/AIDS menace and

Addressing these central issues, former President Kenneth Kaunda of Zambia challenged national political leaders to “eat, sleep and think the war” against HIV/AIDS by “energizing, visiting, committing resources, comforting, expressing a nation’s total commitment to controlling this dreaded disease.” He congratulated religious and cultural leaders “who have done so much in the struggle against AIDS,” and then challenged them to do more, “to speak to their people more openly, ceaselessly and fearlessly about the epidemic, about reducing stigma, about preventing transmission, about love and care for orphans and for people living with HIV/AIDS, and to mobilize their people to take action in all those areas.”

Mr. Kaunda then demanded action from a list of other leaders: civil service and private sector executives, civic leaders, media managers, heads of business and captains of industry, heads of institutions of learning, leaders of the military, of women, of special interest groups, the youth, NGOs and various partnerships. “All leaders must commit all the moral, human and financial resources at their disposal to prevent HIV transmission, to provide care and support to mitigate the impact, and to achieve lasting control over this hitherto uncontrollable disease,” Mr. Kaunda declared.

4. RESOURCE AND FUNDING ISSUES

Several speakers called for debt cancellation to free resources for the HIV/AIDS pandemic. Among them, Peter Piot of UNAIDS said that Africa's need for HIV/AIDS resources "constitutes the most compelling case for debt cancellation altogether."

President Kaunda went further, stating that Africa had the resources but was not being allowed to use them against HIV/AIDS and to save the lives of Africans. Citing UNAIDS, Mr. Kaunda said Africa needed \$US 3 billion each year for basic HIV/AIDS prevention and care. However, African countries spent \$15 billion each year in debt repayments. Then they had to go "cap in hand to the international community to beg for the resources to keep its people alive, to fight HIV/AIDS and other scourges."

“We need action now on the AIDS crisis. But we also need action now on the debilitating debt crisis that is preventing African countries from being in the driving seat for action against HIV/AIDS.”

**Former President of Zambia,
Kenneth Kaunda**

“Something is terribly wrong here,” said Mr. Kaunda. “The world is denying life to people so that debts can be repaid, financial institutions retain their creditworthiness and banks their profitability.”

“Over the past decades,” Ms. Graça Machel added, “we have heard many promises from the international community to provide billions of dollars to assist the development efforts of Africa. Only too often those promises have not been kept, or the assistance has been given in ways that undermine rather than

support us.” She insisted that any international support “can only be additional to our own efforts and it will be our own efforts that bring us rewards in this struggle.”

A number of speakers blamed World Bank and IMF structural adjustment policies for Africa's current levels of indebtedness. They also voiced their opposition – sometimes verging on outrage – to the fact that the World Bank was making loans and not grants for HIV/AIDS interventions.

HIV/AIDS viciously attacked the most fundamental right, the right to life, said Professor Michael Kelley of Zambia, a member of the ADF 2000 Technical Advisory Committee. All governments, international agencies and community organizations must acknowledge that right and their responsibility to come together in partnership. However, that partnership has still got to be built and it should not merely be those with resources listening sceptically to those without resources.

Former President
of Zambia,
Kenneth Kaunda



Photo by Antonio Firenze

Prof. Kelly said the World Bank's Multi-country AIDS Programme should move from loans to grants. "Loans may have been acceptable in a world without AIDS, but are unacceptable in a world with AIDS." He asked the World Bank to stand on its head and look at the epidemic from the proper perspective: if the Bank had the resources but could only give loans, then why not give a hard loan to the pharmaceutical companies and oblige them to supply drugs to Africa at much reduced and affordable prices? "Those companies can be squeezed just as Africa has been," said Prof. Kelly, adding that "because of AIDS, it cannot be business as usual."

World Bank officials such as Managing Director Mamphela Ramphele and HIV/AIDS Coordinator Debrework Zewdie came well prepared for criticism. They explained that the soft loans in question were a very good investment that would save African countries a lot of money down the road.

Box 5: Snapshot of international funding for the fight against HIV/AIDS, 1996-1997

- The official development aid (ODA) agencies of 10 creditor countries increased their funding for HIV/AIDS programmes in 1987-1996 but did not keep pace with the growth of the epidemic.
- Absolute amounts increased but funding per HIV-positive person more than halved between 1987 and 1997. At constant prices, ODA for HIV/ADS rose from \$60 to \$280 million, while the number of HIV-positive people rose from 4 million to over 30 million. For people living with HIV/AIDS, ODA funding fell from a 1988 peak of \$22 per person to under \$9 in 1997.
- Between 1992 and 1997, net ODA fell by 23 per cent in real terms.
- ODA funding for HIV/AIDS from 13 creditor countries* in 1996 was 0.6 per cent of their total ODA. This rose to 0.7 per cent in 1997 but was due to a 13 per cent reduction in total ODA; their HIV/AIDS funding stayed the same.
- Ethiopia, Kenya, Mozambique, Nigeria, Tanzania, Zimbabwe and India were seven of the eight countries in the world with over 1 million adults estimated to be living with HIV/AIDS. They accounted for nearly half of the global population living with HIV/AIDS, but for only 16 per cent of reported national spending and 25 per cent of international spending on HIV/AIDS.
- In a 64-country study, Latvia had the highest HIV funding per person — \$12,000 — and a 0.01 per cent prevalence rate in 1996. Figures were generally lowest in sub-Saharan Africa. Among countries with a prevalence rate of 1 per cent and above, only Mali, Senegal and Uganda had funding of \$40 or more per HIV-positive person.
- Nigeria had more than twice as many HIV-positive people as Uganda but a lower prevalence rate due to its big population. Nigeria reported spending less than \$2 million in 1996 on HIV/AIDS compared with the \$37 million reported by Uganda.

*Australia, Belgium, Canada, Denmark, Finland, Germany, Netherlands, Norway, Japan Sweden, Switzerland, UK, US.

Source: UNAIDS and Harvard School of Public Health, Level and flow of national and international resources for the response to HIV/AIDS, 1996-1997.

The initial \$500 million in soft loans to fund HIV/AIDS programmes came from the International Development Association (IDA) and had a built-in grant element of 65 per cent. This meant countries repaid only about one dollar for every three they received.

The initial \$500 million in soft loans to fund HIV/AIDS programmes came from the International Development Association (IDA) and had a built-in grant element of 65 per cent. This meant countries repaid only about one dollar for every three they received.

Continuing the arithmetical demonstration, Ms. Debrework Zewdie said that a cost-effective HIV/AIDS programme in Africa could prevent one HIV infection for an estimated average of about \$200. The medical costs of treating one AIDS case were, by most estimates, at least \$700 in sub-Saharan Africa without counting anti-retroviral drugs.

Therefore, if a country received \$200 from IDA “for a good HIV/AIDS programme,” it would have to repay only \$70 (or 35 per cent). It would save at least \$700 in medical costs and will also save on absenteeism, lost productivity, orphan care, and so on.

In other words, every IDA dollar an African country repaid would save at least \$10 down the road. If that country failed to invest in halting HIV/AIDS, it would pay larger and unsustainable costs in the future.

Ms. Zewdie said the HIPC debt relief initiative would ultimately provide billions of dollars in debt relief to countries, many of them among the hardest hit by HIV/AIDS. The Bank would help ensure that some of this relief went to increase funding for HIV/AIDS.

5. LEADERSHIP RESPONSES

Plenary speakers reviewed the forms that leadership must take and the actions required to ensure greatly expanded access to information on prevention along with treatment, care and support for people living with and affected by HIV/AIDS.

Participants agreed that the fight against HIV/AIDS could only be won at community level and that programmes could only be genuinely “national” when they were decentralized, when they reached into rural villages and hamlets and when local people were devising and running local programmes. Communities must be allowed to find out what worked against AIDS and how to make it a reality in their own context, added Peter Piot, insisting that “the community level is where multi-sectoralism gets its true meaning.”

As Graça Machel put it, national plans to vanquish HIV/AIDS must permeate every corner of a nation and must reflect national, district and local action. “Every village, every town, every district, every sector should have clear plans and identified people as focal points. The national plans must permeate to the places where people work, where they live, where our values are made and challenged – in our families, our religious gatherings, our councils of traditional leaders, our parliamentary gatherings, our mothers’ unions.”

Individuals, families and communities were the frontline troops in the war against HIV/AIDS added Mr. Kaunda (who has set up a foundation for AIDS orphans in Lusaka). They were the “real heart of the response” across Africa, they needed to be listened to, they needed support and they needed resources. Linking the credibility of leaders to practical actions, Mr. Kaunda listed the following steps towards these objectives:

- Political leaders must account for financial resources allocated to the HIV/AIDS fight;
- Medical supplies, including drugs for tuberculosis and other opportunistic infections must be always available at no cost;
- Provision must be made for home-based care, orphan support and prevention activities;
- Fees and other user-costs must not prevent the sick from getting medicines and attention;
- Orphans must get schooling;
- Young people must get life-affirming sexual education;
- Income-generating and micro-financing activities must enable women and men to support themselves and their families in dignity and safety.

If families and communities were the focal points for action on HIV/AIDS, Mr. Kaunda continued, then bureaucracies, procedures and accounting systems must be adjusted so that resources could flow to them quickly. “HIV/AIDS is imposing a new world on us” and systems



African Heads of State and Government at ADF 2000

“People must reach out to those living with HIV/AIDS, empowering them to contribute their unique insights to the struggle against the disease, overcoming all discrimination, stigma, silence, shame, secrecy and ostracism.”

**Former President of Zambia,
Kenneth Kaunda**

and procedures must change at every level “so that people do not die because bureaucrats do not feel easy dealing with thousands of small organizations and small-scale community responses.”

Mr. Kaunda also called for “unequivocal action” to prevent mother-to-child transmission along with therapies to prolong the lives of infected mothers so that their children would not become orphans. Besides a dramatic increase in

efforts to create jobs and reduce poverty and “unprecedented moves towards gender equity,” he said countries must use the “enormous potential for positive change that resides in our young people, recognizing that they are the future.” Finally, every leader at every level must become accountable for their role in fighting HIV/AIDS. They should publicly declare at regular intervals: “this is what I have done, this is what I have tried to do.”

Box 6: The unfinished agenda

Much has begun that remains to be taken much further in the fight against HIV/AIDS, said Peter Piot, Executive Director of the United Nations Joint Programme on HIV/AIDS.

This is the annotated “unfinished agenda” he presented to ADF 2000:

- **Prevention**, particularly for the most vulnerable, especially the youth. Even the basics cannot be guaranteed: male and female condoms run out, or are too expensive. The United Nations aims to cut HIV infection in young people by 25 per cent by the year 2010, but in too many countries, most sexually active teenagers do not know the basics of HIV transmission, and too many countries do not provide their youth with sex education. But communities know what to do. The Muslim and Christian leadership in Senegal have found ways to properly educate their followers about HIV, even if it required flexibility in their stance on condom promotion.
- **Caring for people living with HIV/AIDS, affected children and orphans.** This whole agenda item of affordable and comprehensive care is unfinished. Comprehensive care for people with HIV requires voluntary counselling and testing, psychosocial support, essential medicines, pain management, treatment for opportunistic infectious and anti-retroviral drugs. This package is out of reach for many in African countries but must not remain permanently so.

Over the course of 2000, it has become a moral given that there should be preferential pricing for brand-name drugs in the developing world. The Treaty on Intellectual Property Rights (TRIPS) agreement and the extent of patent application in many countries are also less restrictive than thought. Options are broadened – including the option of generic drug production as an additional lever to lower prices.

The world needs nothing less than a new deal between the pharmaceutical industries and society - a deal that elevates the principles of public interest and humanitarian need to universal values embraced on all sides, while at the same time continuing to provide incentives for industrial innovation.

- **Multi-sectoral action.** Various high-level AIDS commissions provide a strong institutional framework. If they can link up with district response, when leadership above meets that from below, then we will have an unbeatable synergy.

6. THE TASK AT HAND: FIGHTING HIV/AIDS, SECTOR-BY-SECTOR

Participants at ADF 2000 reviewed the array of challenges ahead at local, national and subregional level and in relevant categories and concerns. Some of the key issues and categories are summarized below.

Turning to a more detailed review of the tasks at hand, speakers went through the different sectors and actions they identified as essential for Africa to match its efforts to the scale of the HIV/AIDS crisis.

Peter Piot set the scene, reminding participants to remain positive. “We have achieved results - fewer people are infected (in 2000 compared with 1999) and those who are have a better quality of life. Various lessons have been learned from past and current interventions, but we have nowhere applied them on the right scale, the scale of the epidemic itself”. Urging participants to refer to the UNAIDS publication on effective initiatives and best practices, Mr. Piot declared: “We have the solutions! But unless they are applied at scale, they are unable to show results.”

Agreeing that Africa must learn lessons from the past decade, Mr. René Bonnel of the World Bank singled out “the clear differences that leadership, empowerment and community-based actions can make. Countries that (took early action) were deriving long-term benefits from a reduction in the number of new infections and savings in medical expenditures. He said the modest decrease in the total number of new infections in Africa — from 4 million in 1999 to 3.8 million in 2000 – was a hopeful indication of what can be done. “Our challenge is to build on these gains by scaling interventions to a nation-wide level.”

HIV/AIDS had registered a dramatic impact on various sectors and on overall social welfare, Mr. Bonnel continued. In some communities, children were heading households. Many ended up in the streets where they were prone to abuse. Multiply that impact tens of thousand of times, and the social fabric began to unravel. “We may now see a whole generation of children that could be left to grow without the support and guidance of adults.”

HIV/AIDS tended to increase the number of people living in poverty because poor households were most vulnerable to such long-lasting diseases. When a breadwinner fell sick, people in a poor household had little or no savings for maintaining household consumption, let alone to pay for treatment and care. They often had to take their children out of school, which in turn compromised the chances of higher income these children might have. The consequence was a transmission of poverty and disease to the next generation.



Photo by Antonio Forense

Focusing in a break-out session

For these reasons, Mr. Bonnel said, investing in HIV/AIDS prevention and care programmes was not just one among many policy choices. In the worst-hit countries, otherwise sound investments were already proving uneconomic and unsustainable because of the epidemic. An adequate investment in HIV/AIDS programme was now a precondition to virtually any other investment a developing country had to make, he concluded.

6.1 People living with HIV/AIDS

Compassion should not be the only attitude towards PLWHA. They are and remain citizens who can generate ideas for the national and continental fight against HIV/AIDS.

A key message of ADF 2000 was that people living with HIV/AIDS must have more say in policy making and execution. PLWHA speakers themselves demanded inclusion and proper representation in planning and implementation processes. They also called for more resources to strengthen support groups and empower PLWHA networks to enhance their capacity to contribute.

Participants stressed that PLWHA can define their own needs and help devise appropriate policies that preserve their dignity and enable them to contribute to national and local programmes. They said that PLWHA can give informed guidance to education programmes and advise on how best to target support for people living with HIV/AIDS.

Compassion should not be the only attitude towards PLWHAs, speakers declared. They are and remain citizens who can generate ideas for the national and continental fight against HIV/AIDS. As one participant said, the response of the society should consist in “giving hope to the patients through a comprehensive treatment of the disease by the entire community.” Another speaker simply said: “We are all people living with HIV/AIDS. If it is not in your bloodstream, it is in your family or your community.”

Other key points made in the discussion included the statement that national strategies on HIV/AIDS prevention must be extended to incorporate clear policies on care and treatment. The best formulation came from Peter Piot: “Prevention and care are inseparable.”

Among the specific recommendations addressed to policy makers was the call for government officials living with HIV/AIDS to be transparent about their status. By acting as role models, prominent policy makers would help break down the social stigma and encourage ordinary citizens to declare their own HIV status.

Policy makers were urged to press pharmaceutical companies in order for PLWHA to get anti-retroviral drugs at reduced rates. Some participants also called for a tax on luxury items such as cigarettes and alcohol that could be used to fund research.

6.2 Youth

Many speakers stated that Africa’s youth were central to the HIV/AIDS crisis. Indeed, ADF 2000 organizers had taken this fact into account by giving young people from several African countries a role of some prominence in the proceedings.

When the youth spoke, they were forthright. One of their representatives said the youth involved in ADF 2000 were starting to believe that the time when others spoke on their behalf was coming to an end. They insisted that Africa’s youth understood that with rights, there were also responsibilities, and young people were ready to take responsibility. Because young

people counted – constituting around 60 per cent of the continent’s total population and 60 per cent of new cases of HIV/AIDS – they made a number of demands.

The youth called for the aggressive development of an African plan for political and social mobilization to fight HIV/AIDS as well as serious plans to care for people living with the virus. They said each country’s Council of Ministers must create a national body that would work with civil society. Also, each government should set up a fund not financed by the World Bank or the IMF but from domestic taxes on imports (such as alcohol and other luxuries) to support action against HIV/AIDS.

Furthermore, all programme and policy development and implementation should include youth who would help in monitoring resource allocation to avoid waste and corruption and to ensure maximum impact. The youth insisted on comprehensive action to ensure that every aspect of HIV/AIDS was discussed and addressed. For example, the youth said health ministers must work hand-in-hand with traditional healers in order to get the best out of traditional medicine in the treatment of HIV/AIDS.

They pointed out that young people needed employment and education as basic conditions for reducing risk, since they were the group most at risk. “How can a young person who has gone without breakfast go out to buy a condom or take the future into his hands,” one youth representative argued.

Keenly conscious of Africa’s future, Graça Machel said: “So many of the people living with HIV/AIDS are young, with skills and knowledge to offer and the fundamental right to live as well as they can for as long as they can. How can we condemn them to earlier deaths than need be?” She said the actions of all participants “must be fuelled by a deep respect for the rights of all of our people.”

Africa’s leadership must recognize its obligation to ensure that people living with HIV/AIDS, as well as children and young people, had their voices heard and were fully involved in all elements of the planning and implementation of development work. In order to defeat HIV/AIDS, Ms. Machel observed, Africa’s communities needed to use all available human resources and this meant recognizing the importance of women and young people as engines of change.

She noted that life expectancy in most African countries was currently worse than at any point in the past 40 years and that the youth were in the category contracting HIV/AIDS at the greatest rates. “Young people are the key to prevention and often shoulder the greatest burden of care. They are the group that inherits this catastrophe. Yet we continue to marginalize them, not recognizing their strengths and not building on their potential.”

Ms. Machel urged adults to have the common sense and the courage to open spaces for young people, to listen to them and to work with them. Youth leaders should in turn work with political leaders, religious leaders and civil society and community leaders.

She noted that culture had never been static and that young people must necessarily “challenge and change” some traditions in this era of HIV/AIDS. Parents should learn to talk openly about sex and sexuality with their children, empowering them with the information they need to protect themselves. Young people must also learn to talk to each other openly about sexual issues, to negotiate and in doing so, to live.

The traditional inheritance of wives in parts of Africa had become a dangerous practice, she pointed out, particularly in communities with high HIV/AIDS prevalence or in cases where it was known that the husband died of AIDS. Another tradition in some communities was that of perpetuating young men's notions of normal manhood that include multiple sexual partners and having as many children as possible. However, this era of HIV/AIDS indicated different priorities and different values. Having multiple partners not only endangered the young men themselves and their partners, it also endangered the lives of any children they might have. "Instead of carrying on the family name, we are helping them to destroy it."

Pursuing the focus on youth, Vice-President Malewezi said, "Keeping young people HIV negative is probably the greatest challenge to us as African leaders. It will also be the most rewarding." With Infection rates currently very high among young people, who account for half the population of the continent, it was clear that the success of national programmes for HIV prevention would depend on keeping the youth HIV negative.

Young people were very vulnerable to HIV infection due to peer pressure, certain cultural practices, family instability, poverty and limited access to information about sexual and reproductive health. Parents, community leaders and teachers should have a key role in promoting responsible sexual behaviour, Mr. Malewezi said. Their role would be to provide the youth with accurate information about HIV/AIDS, sexually transmitted infections and methods of prevention.

Mr. Malewezi cited international experience of young people being highly responsive to HIV-prevention messages. They were also highly effective disseminators of prevention information. He turned to Malawi's experience of using young people as advocates for responsible sexual behaviour both within schools and in broader education programmes and said that "where HIV prevention has been most successful, young people have been in the forefront of the change."

On a more sombre note, Mr. Malewezi pointed out that the sexual abuse of children was a major factor in the transmission of HIV/AIDS throughout the region and was an appalling human rights abuse. "Girls as young as 10 years old can become infected with HIV when sex is forced on them. We cannot and must not tolerate sexual abuse of children. We must strengthen advocacy and education on this issue. We must show zero tolerance for the sexual abuse of children."

Participants agreed that increasing access to education was a basic component of the fight against HIV/AIDS. According to one speaker, education could generate hope because it worked at the three levels where AIDS-related interventions were most needed. With regard to HIV-negative youth, expanding access to education gave them more control over their own lives and a greater range of opportunity. Education was the sector for providing the knowledge that informed self-protection and fostered a positive value system. Education could also enhance young peoples' capacity to help others to protect themselves against high-risk sexual behaviour.

Second, when a youth or a family member contracted HIV, education strengthened young peoples' ability to cope. Education could also help people adopt a caring approach to those infected. Education helped young people stand up for the human and civil rights of people living with HIV/AIDS and helped reduce stigma, silence and discrimination.

Third, when AIDS brought death, education helped young people to cope with grief and loss, to adjust to death and to assert their rights. Some speakers also mentioned the long-term role of education in raising incomes, in empowering young women, thereby reducing their dependence on men and their vulnerability to HIV infection.

6.3 Gender

Many speakers recognized the particular vulnerability of African women (including married women) in the HIV/AIDS crisis and emphasized the interaction between gender, sexuality and vulnerability. They pointed out that throughout Africa, the majority of people living with HIV/AIDS were women. While more vulnerable to infection on a biological level, women lacked equal access to health services. Women had more vulnerable employment status and job security, lower incomes and the least entitlement to ownership of assets and savings. Empowering women would therefore be key to reducing the spread of the HIV epidemic, many speakers agreed.

To achieve this empowerment, African societies would have to respond positively to the new challenges being imposed on them by HIV/AIDS. “The key challenge is the position of women,” said Mary Chinery-Hesse, former Deputy Director-General of the ILO.

Gender-based violence (such as the rape of virgin girls and domestic violence) must be confronted, she said, adding that child marriage was another practice that must be discouraged. “Our traditions allow men to have multiple sexual partners, and to engage in other risky behaviour. This is not in their interest or that of women, and should be confronted.”

Poverty and illiteracy were also seen as holding women back from playing a greater leadership role in the fight against HIV/AIDS, Chinery-Hesse observed. With the proper support, women and young people could spur a faster pace of positive change in the HIV/AIDS crisis facing African countries.

Speakers filled in the other part of the gender equation, emphasizing that promoting change in the sexual behaviour of men was an essential part of preventing HIV transmission. One immediate and practical step was to reduce the number of unprotected sexual encounters. Another was to make information about HIV/AIDS prevention freely available in the workplace, to broaden access to sexual and reproductive health services by men and to include men in advocacy about changing sexual behaviour.

6.4 Labour organizations

Speakers emphasized the strategic importance of the workplace – where most adults spent most of their days – for information programmes about HIV prevention and care. HIV/AIDS was already having a major impact on the workforce, with illness increasing absenteeism, medical and funeral expenses raising overall business costs and the investment made in training being lost.

Participants agreed that workplace programmes could be very effective in reducing HIV transmission. It was also more cost-effective for businesses to prevent transmission rather than to finance the cost of health care when workers became sick. Planning and monitoring activities worked best if they involved workers, management and health service personnel as well as the wider community. It was especially important to improve access to voluntary testing and counselling in the workforce.

Looking at realities in many countries, some speakers pointed out the importance of strengthening the ability of ministries of labour, employers' federations, trade unions and other partners to launch and sustain workplace programmes against HIV/AIDS. This would require better collaboration between businesses, unions, governments and other stakeholders in disseminating HIV/AIDS education. Some participants expressed concern that very few workplaces had formal programmes to educate and motivate workers to prevent HIV/AIDS, with the situation being worse in the informal sector.

According to Vice-President Malewezi, Malawi's Ministry of Labour and Vocational Training was tackling HIV/AIDS in the workplace in collaboration with partners such as the Employers' Consultative Association of Malawi and the Malawi Congress of Trades Union. "We are confident that this unique collaboration between employers, workers and government will form a foundation for replication throughout Malawi and the region," said Vice-President Malewezi.

Organized labour was also taking action, noted Mr. Hassan Sunmonu, Secretary-General of the Organization of African Trade Union Unity (OATUU). Besides raising general awareness among union leaders and workers about HIV/AIDS, OATUU had also been organizing education and training for shop stewards and education officers of affiliated unions. One of the key topics was the protection of the trade union rights of people living with HIV/AIDS at the work place with regard to salaries, promotion, social security benefits and assistance to the families of PLWHA.

OATUU'S programme on HIV/AIDS was being expanded, Mr. Sunmonu added. Affiliated unions at country level were being urged to develop or strengthen their policies on HIV/AIDS and include HIV/AIDS issues in collective agreements. There would be training of PLWHA in entrepreneurship so that if retrenched, they could set up their own businesses. Trade unions were also setting up solidarity funds for affected members, Mr. Sunmonu said.

Participants felt that the proposed international code of good practice would help protect workers living with HIV/AIDS. Some employers were already moving towards codes of good conduct and such initiatives should be encouraged.

Speakers also noted that migrant workers were another vulnerable group that required specific attention in terms of HIV/AIDS prevention, treatment and care. The far-flung nature of the migrant labour system called for greater collaboration across borders to meet the needs of migrant workers as well as of their families at home.

7. VIEWS FROM INTEREST GROUPS

At the heart of ADF 2000 were several break-out sessions held each day after the morning plenary. These sessions allowed more participants in smaller groups to exchange their ideas, their experiences and their vision of the leadership challenges and the actions required for Africa to overcome the HIV/AIDS crisis. Brief reports from some of these sessions are presented below:

7.1 Supporting young people working in development

The session discussed the challenges of HIV/AIDS to the youth and the availability of adequate and appropriate structures to carry out youth-specific projects. The consensus was that national structures neither reflected nor properly addressed the problems of the youth because:

- Youth activities were not considered a national priority;
- Most of the time, youth were not listened to and adults speak on their behalf;
- Youth are organized by governments and were often used for political purposes that did not necessarily address problems of the youth;
- Youth representatives became accomplices and acted as bureaucrats without giving due attention to the problems of their peers;
- Youth organizations lacked support; and
- Conflict between different structures directly or indirectly in charge of matters relating to the youth.

Participants gave country-specific examples. One said that Swaziland had a National Youth Council but youth activities were not considered a priority and the focus was more on soccer. It was reported that youth in Botswana were not involved in HIV/AIDS issues. Adults had been the ones discussing youth issues and the youth should be allowed to speak for themselves, said another. In Malawi, a National Youth Council did exist in addition to youth organizations dealing with HIV/AIDS, but they lacked support and capacity-building programmes. The same lack of support was cited by Lesotho where the youth had been involved, in conferences, meetings and church groups, but their contribution was not taken seriously.

Turning to Côte d'Ivoire, one speaker said the Ministry of Youth dealt with youth matters while HIV/AIDS was the responsibility of the Ministry of Health. This had led to a conflict over which one should handle HIV/AIDS. There was also the *Réseau ivoirien de lutte contre le SIDA*, financed by the UN Fund for Population Activities (UNFPA) but both ministries claimed to be in charge of the project. The speaker called for youth-specific structures independent of the government and able to obtain direct funding from donors.

Ethiopia's past and current governments had set up a number of structures to organize the youth but they were not really representative of the youth. The appropriate strategy for dealing



Channel "O"
youth leaders,
MbusoT, Mimi K
and Lebo
Mokwena

with the problems of youth had yet to be defined. Another speaker said Mali had a *Commissariat de la promotion des jeunes*, for which representatives were initially selected at grassroots levels. However, they gradually began behaving like civil servants and became bureaucrats.

The discussion turned to the definition of youth and participants acknowledged that any African aged between 16 and 35 years old was counted as a youth. Participants in this session agreed to define youth as people in the 16 -24 year-old bracket.

They felt that young people tended to become bureaucrats once they got into leadership positions. Some speakers stated that countries with a one-party system had total control of youth associations. The youth installed as leaders were handpicked and provided with all material facilities. Such youth, they argued, became corrupted by “the system;” they were being used, had no autonomy and ended up behaving like civil servants.

Going further, speakers said such leadership positions had little or no significance, unless for rubber-stamping government decisions. There was no peer review mechanism and no real links to youth organizations. In this context, participants agreed the youth could not push for changes in their situation. Effective participation by young people was seen as impossible so long as youth leaders were not selected from genuine youth structures. Real participation by the youth required strong and independent structures of their own in which they could be organized from grass roots to national levels.

Participants observed that political leaders could not be expected to empower the youth. They emphasized that Africa’s youth should take advantage of the democratization process by creating effective organizations and networks of their own that select and elect their own leadership and their own policies. Only such organizations could become important and influential, with their decisions and resolutions passing directly into governmental structures for implementation.

Some speakers cited Rwanda and Uganda as examples in this regard, explaining that youth representatives sat in the parliament of both countries. Guinea’s experience called “Caravanne” was also mentioned as a youth-specific project.

Participants said Africa’s youth should devise an effective mechanism to work in tandem with state structures. They urged governments to trust youth organizations and to work with them to improve conditions for the continent’s youth. Since donors had proven reluctant to directly finance the activities of youth organizations, they proposed a tripartite structure involving the donor community, the government and youth organizations. This body could design, develop and implement youth-specific projects. Macro- and micro-economic policies should also be responsive to the needs and aspirations of the youth.

Another proposal was for an annual forum in which Africa’s youth could meet to exchange views and experiences, debate ideas and design strategies. Participants learned that a conference for African youth would be held in Rwanda in 2001 and there would also be an OAU conference on development that same year. After floating the idea of pressing for both conferences to be combined, participants decided to consult their parents and the community at large.

With regard to the mass media and youth, representatives of the South Africa-based television Channel “O” told the meeting that their network was ready to work with independent youth organizations. This would provide African youth with a platform on which to air their views and transmit messages to youth around the continent. Participants called for greater effort from the media to promote African youth role models, and to support youth activities, particularly HIV/AIDS campaigns.

Speakers emphasized the important role that journalists could play in promoting youth issues. One participant said that since 1997, journalists in Benin had been getting some training in dealing with HIV/AIDS issues. There were also community and rural radio programmes on HIV/AIDS transmitted in local languages, and the best programmes on HIV/AIDS were awarded a prize. This encouraged journalists in Benin to come up with good programmes.

Participants agreed that radio was the best medium of communication, particularly in rural areas, citing the continent's low levels of literacy and of infrastructure development. They also pointed out that while the majority of Africa's youth live in rural areas, only two out of the 80-90 participants in the conference room discussion were from the countryside.

Speakers criticized African governments for not doing enough to reach the rural youth that are mostly unfamiliar with HIV/AIDS issues. They said that rural youth tended to have little or no income, no primary services available to them and the Internet and Channel "O" mean nothing to them. With all this in mind, participants called on youth organizations to ensure that half their members are in the rural areas and to work with them in developing specific strategies for rural youth.

7.2 Getting business and labour organizations involved

Panelists highlighted the need for business and labour to take initiatives in the workplace to help tackle the spread of HIV/AIDS. With Africa losing some of its prime labour force to the pandemic, workers' and employers' organizations were seen as having a pivotal role to play in the fight against HIV/AIDS, as they offered an effective channel for awareness raising, prevention, care and support initiatives.

Illustrating the gravity of the situation, a study by the ILO estimated that the size of the labour force in some African countries would be between 5 and 35 per cent smaller by the year 2020 than it would have been without HIV/AIDS. The loss of skilled and highly experienced workers would lower the quality of the labour force and there would be new costs associated with replacing sick workers. Trade union leaders and business managers were urged – as social partners – to tackle the human, social and economic consequences of HIV/AIDS.

Participants said business and labour could make specific contributions to the effective implementation of national action plans to combat HIV/AIDS. Areas of involvement included the legal and policy framework, data collection and information dissemination, advocacy, linking with the international community and cooperation with partners in the multilateral system. They also noted that business and labour organizations had extensive networks of influence and communications that could be mobilized to strengthen action across sectors, and broaden the base for national policy and programmes on HIV/AIDS.

The workplace provided the framework for mobilizing business and labour networks to support and facilitate different levels of action. These included adopting and making use of ILO legal instruments and technical cooperation programmes for HIV/AIDS prevention and control programmes; protection of rights of HIV-positive people; promoting codes of conduct and good practices and linking workplace initiatives with household and community-based activities for prevention, care and support.

Panelists suggested workplace initiatives such as peer education and training for workers and management to change attitudes and behaviour (discrimination, stigmatization, safe sex, etc.), data collection and information sharing (e.g. role of shop stewards and personnel managers). Consultation between employers and workers could lead to guidelines for codes of conduct in the workplace. Other activities could include advocacy on public policy issues in the areas of health care and social services, legislation (social security, occupational health and safety, etc.), collaboration with international and local partners in planning and implementing workplace initiatives, and the joint organization by management and workers of community-based HIV/AIDS prevention, care and support activities for workers and their families and others in the vicinity of enterprises.

One panelist observed that the workplace was unique in bringing together under one roof and on a daily basis people between the ages of 20 and 49. Thus, it could be said that HIV/AIDS prevention campaigns targeting this group were reaching the community as a whole. However, a lot of capacity building and training was needed to sustain special programmes for road transport workers, seafarers, miners and plantation workers, who were all in the high-risk category.

From the management side, one speaker noted that the participation of business managers in the fight against HIV/AIDS was like making human resource investments. Greater management training would result in enlightened practices such as providing recreational facilities for employees and paying for counseling for workers. The tea industry had taken the initiative to set up burial funds, and was providing for schooling for AIDS orphans.

HIV/AIDS had increased the cost of doing business, and had also resulted in discrimination, another speaker observed. Not only would prevention and education programmes facilitate workplace acceptance of HIV-positive co-workers, it would also make for fairer employment practices. HIV-related health care programmes could be linked with private health care programmes. While business coalitions were playing key roles in combating HIV/AIDS in Botswana and South Africa, trade unions generally needed to lobby firms to invest in their staff without discrimination.

As one speaker pointed out, if a person was productive for 15 years and then contracted HIV, they still deserved employer support and should not be dismissed on account of low performance. Another aspect of discrimination noted was that if a prospective bank employee was HIV-positive, a job offer was unlikely. The same was true for certain scholarships. So, HIV status was rarely disclosed, which did not help the overall prevention campaign. Participants agreed that all employers and workers should educate themselves about HIV/AIDS issues and address the implications for job security and productivity.

7.3 Sectoral Impact and response

(a) Health care services

The HIV/AIDS pandemic was putting a growing burden on national health systems and increasing demand for health services in African countries. However, current levels of response by health systems and leaders of all types and levels had failed to meet the challenge.

The key conclusions of the session were that:

- The HIV/AIDS pandemic was an emergency comparable to a war and the fight against Ebola virus;
- The challenges posed by this emergency required collective effort by all types of leaderships at all levels; and
- It was only with this collective effort that the overburdened health facilities and services as well as the overwhelmed health workers could be helped to cope with the increasing demands made on the sector by HIV/AIDS.

Participants in this breakout session called for new strategies and linkages among individuals, communities and health service providers. Political leaders should also be able to mobilize all parts of society through their personal commitment.

African scientists should take greater ownership of their own research, said one participant, pointing to the local contribution to the validation of traditional medicine (particularly with respect to sexually transmissible and other contagious diseases). Such research should conform to universal standards, depend less on external technical and financial resources, be conducted on regional and subregional bases of consultation and the findings should be more equitably shared.

New curricula should be developed for training social workers and health service staff in the new and specific tasks of HIV/AIDS information and counseling, participants said. It was also agreed that the HIV/AIDS challenge provided a number of opportunities including that of reforming current health delivery systems. Others included strengthening linkages within the sector using modern communication techniques for diagnoses and treatment in remote areas, and advancing the process of coordination and partnership at all levels and with other sectors in order to secure more reliable data.

Participants identified a number of strategic issues. Some felt that governments should declare a national emergency on HIV/AIDS, thereby placing health services on an emergency footing similar to that which was declared for the Ebola virus. Awareness campaigns should focus on a daily basis on high-risk places such as nightclubs, youth clubs and transportation associations.

Speakers emphasized the important role traditional leaders should play at community level in creating links between health structures and homes in the provision of health care and services. They called for bottom-up planning, from individual communities to national level, to ensure full local participation in programmes. They said the effectiveness of HIV/AIDS prevention campaigns and the provision of care, treatment, counseling depend on the extent to which they are decentralized and the level of local participation in running them. Campaign objectives could be reached only if resources were concentrated at local level. People living with HIV/AIDS must be part of decision-making processes and anti-retroviral drugs must be made affordable and accessible where they were most needed.

Participants observed that voluntary counseling and testing services had been effective as small projects but needed to be extended to cover entire communities. The suggested methods were to build on the foundations of the primary health care system laid by the Bamako Initiative

and to integrate HIV/AIDS concerns in all health services. The modern health care system should also see traditional healers as useful partners in the war against HIV/AIDS and should help them conduct research on their herbs to make them even more useful.

Speakers urged African governments to pool resources in order to support HIV/AIDS research by African scientists through national, subregional and regional networks. Such coordination and collaboration would make it easier to share research results and experience.

(b) Rural dimension

If you looked at the facts and figures, one presenter told this breakout session, HIV/AIDS was a predominantly rural issue in Africa and posed a far greater threat to communities in rural areas than to those in urban centres. Yet, responses to the pandemic had focused on urban areas in which the mass media concentrated, another speaker observed.

Yet, Africa's rural areas were home to the majority of the population as well as to the key economic activities of agriculture and mining. And it was precisely in rural areas, where infrastructure and all kinds of services (especially for health) are relatively scarce, that HIV/AIDS prevalence rates were rising sharply. Participants agreed that national HIV/AIDS campaigns would be effective only to the extent that they become increasingly decentralized and increase the number of people in rural areas with the skill to make the campaigns sustainable.

The session discussed the broad and deep impact of HIV/AIDS in rural areas. As people fell sick with HIV/AIDS symptoms and others spent time caring for the sick, fewer people could work the fields and in other income-generating capacities, or they could only work for shorter periods of time. The loss of peers in the family and in the community had tended to weaken the transfer of knowledge and expertise to the next generation. Households had also suffered when forced to sell income-generating resources, such as livestock, in order to care for the sick and pay for funerals.

The vulnerability of rural women to HIV/AIDS was worsened by such social factors as lack of access to land, credit and other economic inputs. In some cases, they were being forced into prostitution in order to survive.

Participants agreed that these grave effects of HIV/AIDS in the rural areas and the special needs of rural communities should have far-reaching implications for economic policy-making and resource allocation. An equally important dimension of appropriate responses to the pandemic included the promotion of cultural and behavioural changes that help to halt, rather than fuel, the spread of HIV/AIDS.

All HIV/AIDS campaigns should, therefore, involve traditional rulers and healers. This would help ensure that people were well informed and persuaded to adapt cultural and traditional practices to the requirements of halting the spread of HIV. Speakers said traditional leaders are respected and are also more credible than the health worker coming in from urban areas to "educate" rural people.

However, some speakers stressed that traditional leaders and healers also needed to have the right information about HIV/AIDS. It was suggested that the reason orphans were not being abandoned in some rural areas might be that the traditional ruler had told the relatives that if they abandoned the children of the deceased, the spirit of the dead would haunt them. Another

type of problem identified was the need to ask traditional healers to use one razor blade per person when, in some areas, the local shop might not get any new razor blades for months on end.

The session learned that a Traditional medical centre had been set up in Zimbabwe by traditional healers. The healers worked closely with Zimbabwe's Ministry of Health but used their own traditional medicinal products, drugs and equipment. The healers had declared that since malaria could be treated with traditional herbal preparations, it should be possible to find a treatment for AIDS. They had already been involved in educating rural people about AIDS prevention and had demonstrated their capacity to play a useful role in the struggle against the pandemic. Their work should be duly recognized, supported and harnessed as part of responses to AIDS in rural areas, one speaker said. Support needed included modern medical facilities, such as sterilization equipment, to enhance the hygienic environment of their practice.

(c) Education

This breakout session looked at the effect of the pandemic on schools and how schools could help reduce the incidence of HIV/AIDS. Participants noted the alarming mortality rate of teachers due to HIV/AIDS. With teacher-pupil ratios already low, unqualified teachers were coming in as replacements, worsening the quality of education. Alongside the lack of proper educational materials, existing cultural taboos and barriers left teachers in most African countries poorly equipped to provide the information and support that students need in the midst the HIV/AIDS crisis.

Nevertheless, schools needed to develop a curriculum that addressed HIV/AIDS. Relevant topics included sex education, peer counseling, and information about the rights of young people. Teachers would need training in these areas so that they would be comfortable discussing these topics with their students. Countries could benefit from the experience of other countries that had developed an appropriate curriculum, participants observed.

(d) Orphans

The global HIV/AIDS epidemic has left 13.2 million orphans, of which 95 per cent are in Africa. The fact that the local community has to look after these is having a negative impact on social structures in some places, with serious consequences for future generations.

Participants recommended a number of strategies, such as increasing resource allocation to social sectors in affected countries, providing funding to local orphan projects, and promoting the respect of children's rights to education, care and family protection. The best approach was to ensure the integration of orphans into new families rather than into orphanages. Speakers agreed that it was preferable to work with existing programmes rather than create new ones, and that older people were available in the community and should be enlisted as care-givers.

(e) Gender issues

One of the major conclusions of this session was that appropriate responses to the HIV/AIDS pandemic must be gender sensitive. Simply because the disease affects both men and women, effective programmes must recognize the different implications of HIV/AIDS for men and women.

Participants noted the gender-specific division of labour and the subordinate status of women in most countries. To a large extent, these factors limited women's choices and actions. Sensitivity

to these types of factors should inform the nature of responses to the HIV/AIDS pandemic. A case in point was the need to understand the complex interaction between HIV/AIDS, gender and agricultural production and to use this understanding in designing HIV/AIDS programmes in rural communities.

Speakers emphasized that as long as poverty and economic needs predominated in African countries, programmes to address the different aspects of the HIV/AIDS crisis would have only marginal impact. Poverty was a major driving force of HIV/AIDS because it contributed to the incidence of multiple and casual sex and of women trading sex for material gratification. The gender-specific effects of poverty, therefore, had to be key considerations in HIV/AIDS programmes at community level.

Several people felt that interventions had so far paid insufficient attention to men's sexual behaviour and attitudes and how these drove the HIV/AIDS pandemic. In general, men had an upper hand in taking decisions on circumstance and forms of sexual contact and on whether or not to wear a condom. It was noted that men's masculinity had usually been characterized by their having multiple partners, older men having sexual relationships with younger women, and sometimes by a socially acceptable level of violence against women. All these factors were seen as contributing to the dynamics of HIV/AIDS transmission and reinforce the argument that men had a vitally important role to play in the fight against HIV/AIDS.

The session observed that appropriate legal instruments and frameworks were a necessary condition for combating the HIV/AIDS pandemic. Speakers felt that clear legislative and policy frameworks should be formulated to plug any gaps. Thus, ensuring natural justice for people living with HIV/AIDS required the review of constitutions and legislative instruments to make them gender sensitive.

In reviewing current legislation, participants said that there should be particular emphasis on issues of:

- Human rights, in order to incorporate non-discriminatory access to care and treatment;
- Voluntary testing for HIV, with informed consent;
- Enforcement of medical ethics, particularly to maintain confidentiality,
- Using humans in HIV/AIDS research; and
- Penal sanctions against people who deliberately infected others.

In discussing HIV/AIDS, gender and the youth, participants noted the need to revisit norms and cultural practices that favour boys. Speakers said it was the girl child who suffered the most: she was most frequently made to drop out of school (if she even went in the first place), or engage in commercial activities (including sex work), or forced into early marriage to support the household.

Sensitivity to these issues would help in the design of intervention programmes able to strike the right balance of gender diversity. Lessons learned from different countries and campaigns had revealed the tremendous amount of ignorance shared by men and women, and by religious and political leaders. Although the HIV/AIDS pandemic was regrettable. It also provided a perfect opportunity to go beyond stereotypes and develop an understanding of gender issues and the practical consequences.

The session concluded that for Africa to overcome the HIV/AIDS pandemic, leaders at all levels must seize every opportunity to address the gender implications of halting the spread of HIV/AIDS and of providing care and support for people living with the virus.

Participants decided to secure the support and involvement of community and cultural leaders who were strategically placed to influence attitudes, perceptions and behaviour positively. Their role as opinion leaders should be activated to increase knowledge about the links between gender and HIV/AIDS.

Another conclusion was about the need to educate men about their critical role in halting HIV transmission. Given prevalent notions of masculinity, men should be challenged to define appropriate strategies to promote the required changes in masculine sexual and social behaviour.

In examining various leadership roles, participants noted the special position of women – more vulnerable to infection but also having a unique educational role within the family. Turning to civil society organizations, participants said CSOs had so far led the way in tackling the HIV/AIDS pandemic. They should improve their relationships with cultural leaders by establishing networks and partnerships to promote gender equality and positive cultural practices as part of the fight against HIV/AIDS.

Participants insisted that interventions at community level must be the focal point of national responses. They called for innovative strategies to build capacity at local and national levels in advocacy, awareness creation and dissemination of experiences. It was agreed that much more sex education would be needed for children and communities, and elderly people should be enlisted in care and prevention programmes.

(f) HIV/AIDS and the military

This session identified the military as a very important factor in Africa's HIV/AIDS crisis. The incidence of HIV among soldiers was said to be about 2-5 times higher than among the civilian population during peacetime and higher still during wartime. According to one estimate, 30- 40 per cent of military personnel in sub-Saharan Africa were HIV positive.

Causal factors of the HIV/AIDS crisis among military personnel included the mobility of soldiers over wide geographical areas, spending long periods away from home, often posted to high-risk areas. Typically, these were conflict zones where there has been much displacement and social turmoil, leading to high incidence of HIV/AIDS among the host population.

Soldiers were seen as having an inherently risky career, with self-images based on 'virile' values. They tended to have high rates of sexual intercourse with multiple partners. Added to these high-risk factors was the fact that rape occurred frequently during armed conflict and was often used as another weapon of war.

Speakers outlined some problems on the road to halting the spread of HIV/AIDS in the military. Among them was that of denial. Speakers agreed that many armies were in a state of severe denial about the extent of the pandemic, even in some countries in which the military was formally involved in national HIV/AIDS programmes. Very few senior military officers had publicly admitted that they were HIV positive.

It was agreed that there was little or no coherence in military policies on testing and counseling. In some armed forces, testing was mandatory only for recruits or candidates for promotion or special training. Shocking cases were reported of forced testing and of failure to provide any counseling or support to soldiers (and their wives) found to be HIV positive. Many had been told there was nothing that could be done for them.

Despite relatively high spending on defence in some African countries, most military budgets allocated only modest sums for the health care of personnel. Although some armies had excellent policies to deal with sexually transmitted infections (STIs), many could not even provide basic treatment for STIs, let alone for HIV-positive soldiers.

The session stated that HIV-control efforts within the military should be integrated with national and local programmes for civilians. It was evident that there was little point in having a programme for soldiers without providing the same services for the civilians who might be living close to military garrisons and interacting with military personnel on a daily (and nightly) basis.

In working towards appropriate policies for the military, participants in this session emphasized that governments were responsible for the welfare of military personnel and their families, including those who might be HIV positive. They added that governments had the responsibility to create the conditions in which the military would cease being a major vector of HIV/AIDS.

It was clear to participants that peace was a precondition for an effective strategy to contain HIV/AIDS. Another precondition identified was a professional and disciplined military. As one speaker said, armies that routinely violated human rights and engaged in looting, rape and pillage were unlikely to implement HIV/AIDS prevention policies conscientiously.

The session recommended that rates of HIV prevalence among armies should become public knowledge and that military personnel who were HIV positive should publicly admit this fact. To make this feasible, military authorities should prevent bullying and stigmatization of soldiers who have declared they have HIV.

All this was seen as forming part of changing attitudes and behaviour within the armed forces. Requirements should include the prevention and punishment of rape, changing gender attitudes among soldiers and providing condoms. Participants agreed that as with civilian society, efforts to halt the spread of HIV/AIDS in the military should reach the lowest ranks and not just stay at senior officer level.

Turning to care and support, the session emphasized that HIV-positive soldiers should not simply be discharged and sent back into the community without counseling and treatment. Speakers called for moral and material assistance to support organizations for soldiers living with HIV/AIDS. These organizations could play a central role in changing the position of the military in the HIV/AIDS scenario. They could also make sure that demobilized soldiers get proper information as well as condoms, and become important agents of education and change among the civilian population.

Participants noted the differing and sometimes conflicting considerations involved in the status and assignments that should be given to soldiers who were HIV positive. They said that many of these considerations also applied to other uniformed services, especially the police, who

should be integrated into HIV/AIDS control programmes in similar ways. Since the police in particular were responsible for the personal security of citizens, meaningful interventions with them should also be considered a priority.

(g) Religious leaders and HIV/AIDS

Religious leaders were commended by the participants in this session as very effective in disseminating anti-HIV/AIDS messages. In certain ways, they could communicate with people and entire communities more than any other category of leaders and they were generally held in very high social esteem. Despite differences in religious doctrines, spiritual leaders could work together and link their efforts with those of other opinion leaders in the fight against HIV/AIDS.

Religious leadership in the context of HIV/AIDS was seen as best expressed by addressing issues of sexuality with greater frankness and by no longer considering people living with HIV/AIDS as immoral. While their message tended to be based on chastity and abstinence before marriage, and on mutual fidelity after marriage, religious leaders were now showing greater acceptance of complementary messages of the anti-HIV/AIDS campaigns aimed at halting the spread of the virus and extending the range of pastoral care.

The religious community, it was observed, had seen the need to join the forefront of national efforts to tackle the pandemic: It was pointed out that governments could not compel people to change their moral behaviour whereas spiritual counseling could induce such changes. Through pastoral care for people living with HIV/AIDS or affected by it, spiritual leaders had decided to fight against stigma and discrimination, mobilizing resources and most importantly inspiring hope. Participants observed that church leaders should be able to adapt their messages to the language of the youth in order to communicate more effectively. They also emphasized the increased role that the religious community could play in reducing poverty, upgrading community facilities such as health posts and schools and working with vulnerable youth and women.

However, it was felt that for religious leaders to achieve the range of positive activities outlined above, they would have to accept the reality of sex outside marriage and risky behaviour and propose practical solutions. They would also need to become fully informed and inform others about HIV/AIDS prevention, as well as becoming fully involved at all levels of the fight against HIV/AIDS. This would involve taking the lead in fighting taboos, cultural barriers and misconceptions in traditional as well as in religious practices.

Participants said religious leaders should also put pressure on political leaders who form part of their congregation and play a vigorous role in mobilizing national resources to fight the pandemic and provide care. Muslim leaders could use *Zakat* – one of the fundamental principles of Islam regarding alms giving – to mobilize resources and channel them to poor people living with or affected by HIV/AIDS.

The session concluded with several recommendations, including the call on governments and the United Nations system to see religious leaders as full partners at all levels of the struggle against HIV/AIDS. Participants said moral education should be given a substantial place in the school curriculum. Governments should work with religious leaders in the provision of social services that strengthen individuals and communities in the fight against HIV/AIDS.

Participants also said religious bodies should demonstrate their leadership, moral rectitude, responsibility and compassion with activities of prayer, advocacy, education and care. People living with HIV/AIDS and their families should be treated with acceptance, love and dignity by their congregations and communities. Religious organizations should also mobilize financial and material resources in order to help tackle the root causes of HIV/AIDS.

Besides setting up inter-faith councils at national level that specifically address HIV/AIDS, Africa's religious leaders should seek support from ECA, UNAIDS and other UN agencies to organize a conference of all African religions to address the role religious leaders could play in the fight against HIV/AIDS. This could be done in consultation with the African Council of Churches. They also asked UNAIDS and the World Health Organization to help build capacity within religious organizations to participate knowledgeably in the prevention, care and management of HIV/AIDS.

(h) The media and HIV/AIDS

The Media Focus Group concluded that all sectors of the media should be more involved in the fight against HIV/AIDS. This would involve more meaningful interaction with non-governmental and community-based organizations. It would also require some specialization on the part of journalists, strict observance of professional ethics and an improvement in the volume and quality of broadcasting in local languages for rural areas.

Participants urged media owners to learn more about the pandemic themselves, and also to allocate resources (such as personnel and airtime) for messages and programmes related to HIV/AIDS issues. Media organizations should also discuss and establish guidelines for reporting on HIV/AIDS in order to avoid sensationalism and stereotyping, elements that perpetuate the stigma associated with HIV/AIDS.

Speakers also called for more investment in capacity building and training of journalists and producers of programmes who tended to be inadequately informed about HIV/AIDS issues. A basic part of this investment should be in information technology.

(i) HIV/AIDS and human rights

The session noted that in spite of the 1996 guidelines developed by UNAIDS and the United Nations High Commissioner for Human Rights, there was still rampant discrimination and physical violence against people living with HIV/AIDS (PLWHA). The prevailing view was not in favour of specific legislation to protect PLWHA from stigma and discrimination, as this might be counterproductive. Effective advocacy would help to foster an environment that enabled PLWHA to come out into the open and join the fight against HIV/AIDS.

With regard to refugees and migrants in the context of HIV/AIDS and human rights, participants noted that they were usually marginalized and denied basic human rights, and were also particularly vulnerable to HIV/AIDS. Governments should make sure that national HIV/AIDS programmes and policies do not discriminate against such exposed groups, the participants concluded.

Among the recommendations made by the session, participants said leadership at all levels must ensure the observance and monitoring of existing legislation and covenants for the protection and promotion of human rights, a necessity made more acute than ever by HIV/AIDS. Also, PLWHA should be helped to increase their awareness of their rights as this would enhance their role in prevention and care programmes.

Heightened awareness and more effective advocacy would help governments and civil society leaders maintain as a top priority access to treatment, care and support for PLWHA and people affected by HIV/AIDS, with special attention given to the prevention of mother-to-child transmission.

Another pressing issue for the group was the exploitation of young girls due to conflicts and general socio-economic inequalities. It called for widespread dissemination and replication of practices that contributed to effective protection and promotion of human rights in the context of HIV/AIDS.

7.4 Leadership role of governments in social mobilization

Participants emphasized the critical and irreplaceable role of governments in the fight against HIV/AIDS. They identified a number of key actions that governments are best placed to take. These included the creation and implementation of national HIV/AIDS programmes, coordination of all activities, resource mobilization, dissemination of information and facilitation of access to treatment and care.

Speakers felt that overall, government efforts have yet to make the necessary progress. Among the reasons is the weak performance of national HIV/AIDS programmes, inadequate mobilization of financial and human resources and under-utilization of PLWHA. Urgent steps were needed to make medication easily accessible to PLWHA and information campaigns must be increased.

7.5 Leadership roles and responses for migrants, refugees and other mobile populations

Participants in this session called for specific and urgent attention to the health access needs of mobile populations such as migrants, internally displaced people, refugees, commercial sex workers, truck drivers and tourists.

They said action was needed at local, national and regional levels, with an emphasis on STIs and reproductive health services for these high-risk groups. Effective action would require multi-sectoral prevention programmes as well as treaties and agreements on repatriation, on the trafficking of women and on commercial sex workers. Such agreements would have to be coordinated with strengthened national laws as well as expanded national access to counseling services on drug and alcohol abuse, all with the participation of the affected populations themselves. International agencies would also have to sharpen their focus on these at-risk groups.

7.6 Access to care

Several speakers in plenary sessions emphasized the importance of linking campaigns for HIV/AIDS prevention with campaigns for expanding access to care and treatment for people already living with the disease. Nobody challenged the imperative for Africa of slowing the rate of new infections. However, over 25 million Africans were already HIV positive and as many as 90 per cent of them did not yet know it.

Speakers described this fact as a time bomb ticking underneath the continent's weak and already overburdened health systems. Participants went further, noting that due to the multi-sectoral impact of HIV/AIDS, sooner or later, everybody in every part of society was directly or indirectly affected by the epidemic.

Box 7: Why voluntary counseling and HIV testing?

Globally, perhaps nine out of 10 people who are HIV positive do not know it. This ignorance can also be

fatal to others. Voluntary testing is the solution and counseling must follow for those found HIV positive. Such knowledge and behaviour change is essential for halting the spread of HIV/AIDS.

However, voluntary counseling and testing (VCT) is a low priority in many places. Governments are already struggling to cope with "competing" diseases such as malaria and tuberculosis. Some question the importance of VCT as it involves neither vaccines nor medicines but requires infrastructure, personnel and time to be done properly.

Counseling before and after a test, delivered to small groups or one-on-one, cannot be rushed. There must also be follow-up sessions to increase the chances of behavioural change.

However, most people find it very hard to seek HIV testing and counseling. People see little point in getting tested for HIV if treatment is mostly inaccessible. The time it has often taken to get test results in some places (up to two weeks) has also discouraged people from returning for their results and attending counseling sessions. Newer and more rapid HIV tests are now helping to make VCT more attractive.

There was clear consensus that appropriate strategies to overcome the crisis must involve vastly expanded access to care and treatment. Speakers pointed out that such access was a basic human right and that people could not be encouraged to break the silence without offering them treatment and care in return.

While some countries were judged to be further ahead than others, the need for better care and treatment was clear across the continent. This meant improving health infrastructures and all aspects of community care, including training for health workers and care-givers. It also required a drastic reduction in the price of the full range of drugs that have been developed to combat opportunistic infections and sustain people living with AIDS. Participants agreed that lower prices and better delivery systems must be pursued simultaneously, and immediately.

It was agreed that governments currently have at their disposal some mechanisms to lower the prices of drugs for opportunistic infections as well as anti-retroviral drugs (ARVs).

They could determine the best prices on the world market for each essential drug by using the database managed by WHO, UNICEF, UNAIDS and Médecins sans frontières (MSF).

Governments could also establish the local patent status of essential drugs. Where drugs had not been patented, governments could contact generic manufacturers directly to secure the lowest-priced drugs. Where drugs were patented, governments could negotiate with the patent-holding company for significant discounts. Senegal was reported to have recently done this (with the help of UNAIDS) and gained significant price cuts.

If a patent-holding company should be unwilling to offer appropriate discounts, governments could request a voluntary license for the drug, which would allow them to license a state enterprise or a private firm to make the drug for them. If the license should be refused, countries could then use the provision in the World Trade Organization's trade-related intellectual property rules (TRIPS) which allows them to override patents in cases of national medical emergency.

Participants agreed that alongside non-governmental and other organizations involved in prevention, treatment and care campaigns, people living with HIV/AIDS need clear information on drug costs, treatment options and strategies to help their governments make use of available options to lower prices.

Governments should also review the local prices of drugs in light of the lowest international prices. To do so, they would need lists of reliable manufacturers, including (but not necessarily limited to) those indicated by WHO, UNICEF, UNAIDS and MSF. Participants urged WHO and other agencies to help governments find the lowest prices and, where necessary, negotiate the legal requirements to buy drugs at the least cost.

Some speakers insisted that international financial institutions and bilateral agencies should acknowledge their responsibility for pushing structural adjustment policies that have not helped, and in some cases hindered efforts to combat HIV/AIDS. They argued that donor agencies should compensate for any past mistakes and ensure that their current programmes are more responsive.

Box 8: Tackling Mother-to-child transmission

Of all the children in the world who contracted HIV in the womb, during birth or through breastfeeding in 1999, more

than 90 per cent of them were born in sub-Saharan Africa.

Several countries now have pilot projects to help reduce HIV infection among babies. These projects also address the need for care and support not just for the HIV-positive mother and child but also for family members. Moving from pilot to generalized services will mean planning ahead for the increased case load and ensuring better links between mother-and-child health centres to other health facilities.

The biggest challenge will be expanding coverage to reach all HIV-positive pregnant women and their families. Health systems will need to improve infrastructure, train, motivate and retain staff and improve the supply and distribution of HIV test kits, preventive drugs and infant formula.

Finding alternatives to breastfeeding is a central – and multi-sectoral – issue. The fact that the vast majority of rural Africans do not have access to clean drinking water points directly to the issues of resource allocation, infrastructure and poverty.

Despite the encouraging example of countries such as Senegal that had successfully negotiated with companies to lower prices of drugs, speakers pointed out that drug prices were often higher in Africa than everywhere else and certainly, prices of HIV/AIDS drugs were still too high for the vast majority of Africans.

One suggestion was that countries interested in getting lower prices for ARVs and other drugs should consider forming subregional groups to support one another, increase their negotiating and purchasing power and spread the benefits across the region.

Participants also insisted on the equitable distribution of treatments that were currently available or would become available so that the benefits are not restricted to only a few countries and to urban areas within some countries. They added that their concerns and suggestions should be forwarded to the Abuja Summit on HIV/AIDS and progress assessed there.

7.7 Scaling up of targeted and general interventions

One of the greatest leadership challenges raised was the need for countries to make a priority of increasing spending on prevention and care. They must also widen the scope of targeted and general interventions through more effective mobilization and use of resources that might amount to two to three times more than initial estimates.

Participants agreed that data from Africa were often unavailable. They learned that studies from Latin America showed that HIV/AIDS took approximately 10 per cent of all health funding. Contributions to HIV/AIDS costs were predominantly from households (93 per cent), from donors (6 per cent) and from governments (1 per cent). Most of the funding for HIV/AIDS was going to HIV-related treatment paid for by patients (79 per cent), for anti-retroviral AIDS treatment paid for by patients (14 per cent) and for preventive activities (7 per cent). Data from Ghana showed that household access to care was largely determined by ability to pay user fees, which raised equity concerns.

With health services already overstretched, government should set feasible targets, define the infrastructure and capacities required, calculate costs, design appropriate prevention campaigns, and apportion resources to prevention and care. Upgrading HIV/AIDS interventions to a desired scale required data on existing coverage, the cost-effectiveness of measures (including unit costs for specific interventions) and results from care studies to guide the decision-making process.

The basic decision should be on the scale of intervention as different targets could be set for prevention and care. For example, a 70 per cent prevention intervention could target sex workers, treatment for STIs, voluntary counseling and treatment, mother-to-child transmission and blood transfusion at a cost of \$284.7 million. National programmes had to design affordable and cost-effective interventions, meaning difficult choices for leaders with limited domestic resources and a difficult international environment.

Moving to a microeconomic perspective, participants observed that earlier prevention programmes used a lot of resources for awareness campaigns and condom distribution. However, the lack of understanding of local situations and of target groups had led to ineffective interventions. Other problems included the exclusion of relevant constituencies such as women groups and absence of gender analysis. HIV/AIDS was also seen more as a health rather than a multi-sectoral issue. It seemed clear that women in general must be empowered to negotiate for safer sex and their associations strengthened in order to make their vital contribution to the fight against HIV/AIDS.

Even though some scaling up of interventions was taking place at community, provincial and country levels, speakers called for thorough evaluation of current strategies before further scaling up, adding that women and youth must take part in the evaluation. They agreed that scaling up required a “bottom-up” approach that would help communities gain access to resources. Scaling up should also feature education (vital for empowering women and reducing gender inequity), closely link prevention and care and greatly expand voluntary care and testing, widely seen as a powerful tool for behaviour change.

7.8 Economic impact of HIV/AIDS

Participants at ADF 2000 left more informed about the profound economic impact of HIV/AIDS. Available statistics were willingly shared. It was agreed that the HIV/AIDS epidemic is reversing the socio-economic gains that African countries have made since independence. One important indicator - life expectancy - illustrated the gravity of the situation. Although Africa's mortality and morbidity rates were already among the highest in the world, life expectancy had been rising steadily until the onset of HIV/AIDS. Now, it has declined in nearly all the 25 countries where HIV prevalence among adults exceeds 5 per cent. On the basis of current trends in the countries most heavily affected by the epidemic, life expectancy is expected to fall to around 30 years by 2010, a level not seen since the beginning of the 20th century.

This deep impact of HIV/AIDS was seen as arising from its direct attack on the most productive age groups of the present and the immediate future — the 15-49 years bracket. This attack has resulted in the reduction of the quality and quantity of the continent's labour force and further erosion of already low savings rates. The World Bank presented estimates suggesting that if the continent's HIV prevalence rate had not reached 8.6 per cent in 1999, Africa's per capita income would have grown at 1.1 per cent a year, nearly three times the 0.4 per cent annual growth rate recorded in 1990-1997. See table 1 for adult prevalence rates in Africa.

Where HIV/AIDS prevalence rates remained below 5 per cent of the adult population, the epidemic tended to spread slowly, with the greatest impact felt at household level and within the health sector. But as prevalence rates rise, the impact has widened quickly until it has been felt across all sectors of the society and economy. Once prevalence reach 5 per cent, there tends to be an exponential increase, with prevalence increasing by 50 per cent a year in some cases. It was reported that already 16 African countries have more than 10 per cent of the adult population HIV positive. Table 2 shows the decline in output in AIDS- affected households in Zimbabwe.

The demographic impact was said to be catastrophic at current trends. Only two years from now, in 2003, Botswana, South Africa and Zimbabwe are expected to record a decline in total population, according to the US Bureau of Census. Population figures are likely to remain constant in several other countries, including Malawi, Swaziland, Namibia and Zambia, instead of growing by 1-2.3 per cent a year.

These figures stemmed from the erosion of hard-won gains in life expectancy. Those countries worst hit by HIV/AIDS — such as Botswana and Zimbabwe — were seeing projections of life expectancy at birth by 2010 nearly cut in half, from 70 to 39 years. In Malawi, Mozambique, Rwanda and Zambia, life expectancy by 2010 has been reduced by a decade.

However, participants felt that these outcomes were based on a continuation of current trends and were, therefore, not inevitable. Life expectancy in Uganda declined in 1990-1995 but had since shown signs of increase. Similarly, life expectancy in Zambia was expected to rise in the period to 2010 as a result of an expected fall in HIV rates among the youth. In Senegal, prompt and sustained campaigns have contained prevalence rates below 2 per cent.

7.9 Breaking the Silence: a young African woman living with HIV/AIDS

Extracts from the speech by Charlotte Mjele to the opening plenary session of ADF 2000. Ms. Mjele works for the Hope Worldwide Jabavu Clinic in Soweto, South Africa, and is a member of the South African branch of the Society for Women and AIDS in Africa.

“Two years ago I was confronted with absorbing the news of being HIV infected. Being only 20 years old, a fresh college graduate, and with an exciting job as a junior consultant with an employment agency, it was certainly a great personal blow. Since then, I have been faced with many challenges as a single young woman with no child and open about my HIV status...

From being devastated by the news of my HIV status, and overwhelmed by the thought of a future with no prospects, I went through a very rough time and traumatizing emotional pain that also resulted in a lot of physical pain.

However, death was not on my agenda. I was young, and knew deep down that I still wanted to live...

My main questions were: how was I really going to fight this battle and what were my family, relatives, friends, colleagues and friends going to say and think about me? The thought of being stigmatized hit me very hard, considering that in the eyes of my family and of those who've known me, I have been a good child and daughter and a young role model, looked up to by many...

When I started losing my hair because of stress, it didn't make me look good. I then stopped for a moment and thought - “I have been seeing others showing themselves on TV and declaring their HIV-positive status and some have been alive for years and they still are looking good and healthy. If they have learned to accept their status, and have coped, I CAN TOO! I looked up places of help for People Living With HIV/AIDS.” I joined the HOPE Worldwide support group for women and men living with HIV in Soweto, Johannesburg. I gave myself a mission to learn more about my newly found companion - HIV. For me, it made sense that if I could understand more about HIV, I would definitely know how to move on with a normal life...

As the days, weeks and months went by, my knowledge increased and my fear decreased. Were these months easy? Surely not. But I had to fight and move on. Learning about HIV enabled me take the next steps. I was now ready to reclaim my self-esteem and confidence. I knew this was a calling for me to make a difference not only in my life but in the lives of many other young women, men, girls, boys and children who are infected and affected by this epidemic.

The time had come for me to break the silence.

I knew it was not going to be easy to disclose my HIV status to my family, friends and the community. I asked myself many times - Charlotte do you really have to do this? HIV is so highly stigmatized in my society.

Charlotte Mjele,
PLWHA and
youth activist
from South Africa



Photo by Antonio Florentine

After having educated my family about HIV/AIDS for over a year to try and prepare them to receive the news I had for them, I then disclosed (my status) to them. They were shocked, angry and sad. My parents felt like life had been unfair to them. But, when they started to see that I was still a happy young woman, with goals and dreams for an

even better future, they also learned to accept my status and decided to follow my motto: With HIV infection one can either allow it to be an obstacle to a truthful life ahead, or use it as stepping stone to a determined and productive life.

When I started going public about my status, I already knew people would discriminate against me but that did not bother me because I knew that they were the very ones who needed to be educated. It was obvious to me that if you treat yourself as a shameful HIV VICTIM, others will be happy to treat you that way as well, but if you treat yourself as a positive ROLE MODEL, they'll accept and respect you. I let people see and know that I'm not an HIV statistic, but a dynamic young woman full of life, and with dignity, who happens to have HIV.

Today, I stand here, knowing for sure that not many young women and men or mature women and men have the courage to do what I'm doing. I made a conscious effort to be a leader in showing that an HIV diagnosis is not the end of one's life. Many in a similar situation would not even go out to learn and update themselves with information about this virus that is affecting us so much. Not many can stand the risk of being discriminated against. Many are still dying in fear and many are still in the VICTIM mindset. We need to help them make the transition from a victim to victor.

Our continent did not have to be devastated like this by HIV/AIDS. We should not have allowed it get to this stage and we therefore have a responsibility to reverse the situation.

I appeal today to the leaders of our communities, the leaders of our countries. Yes, something is being done about HIV/AIDS, but the problem far outstrips our current efforts and solutions. We need a lot more action where it matters most - to reach young people, children at the grassroots, and to deal with the poverty that is breeding HIV infection, fear, hopelessness and premature death.

The poor in our communities, girls, boys, the young and mature women and men need to be empowered with knowledge of how to deal with the burden of HIV/AIDS, and find the means to cope with poverty without putting themselves at risk of HIV infection. We need to ensure that those infected and affected by HIV/AIDS are offered meaningful alternatives so that they can cope, and not die without dignity as many of them are now doing. Poor people have dignity and value their lives like the rest of you. They should become empowered so that they can find solutions to the many problems affecting their lives, including HIV/AIDS.

Leadership needs to play a major role in reversing the stigma attached to HIV/AIDS because no matter what we do, as long as there are misconceptions, negative attitudes and beliefs about HIV/AIDS and about those infected and affected, stigma will continue to render our interventions ineffective.

It is time many leaders in our communities and countries start to break the silence too and disclose their HIV status. If leaders, in governments, the private sector, churches and so forth urge their people to test for HIV, these leaders need to take that giant step first. This is called leading by example. The more we have prominent men and women talk about their HIV status, the better the chances of reducing stigma. I sincerely admire and honour noble men like Judge Edwin Cameron of South Africa who did not let their high standing in society discourage them from disclosing their HIV-positive status.

The rights of people living with HIV/AIDS are violated without any sanctions. This offence needs to be taken seriously because if it is not dealt with, it will deter many positive people from making their contribution as frontline HIV/AIDS educators and counsellors.

A major role still needs to be played by the leadership to make available affordable treatment for HIV-infected pregnant women, and HIV-related illnesses. Anti-retroviral treatment has helped improve the health of many people. The life of an African with HIV should not be seen to be less valuable than that of his or her counterpart in other parts of the world.

The needs of young people, infected or affected should be given high priority. And, in this regard parents, school authorities, religious and community leaders and all stakeholders should ensure that young people have the information, skills, and resources to cope with the situation.”

8. PERSPECTIVES FROM THE HIGHEST LEVEL OF LEADERSHIP: THE HEADS OF STATE FORUM

Structured to promote frank dialogue, ADF2000 included a briefing for Heads of State and Government. The briefing was delivered one by one by representatives of the main focus groups of the forum: people living with HIV/AIDS, gender, youth, information and communication technology, religious groups, the military, the diaspora and civil society organizations.

Among those present were: Presidents Paul Kagame (Rwanda), Festus Mogae (Botswana), Yoweri Museveni (Uganda), Prime Ministers Moustapha Niasse (Senegal), Nagoum Yamassoum (Chad) and Meles Zenawi (Ethiopia).

Those present from the United Nations system included K.Y. Amoako (ECA), Carol Bellamy (UNICEF), Peter Piot (UNAIDS), Mampela Ramphela (World Bank) and Nafis Sadik (UNFPA). Some of the key points made are presented below.

Focus group representatives wasted no time reminding political leaders of their leadership responsibilities. Youth representative, Charlotte Mjele, was particularly direct. The youth were angry with African leaders for squandering on wars resources that properly belong to Africa's youth. Structural adjustment programmes had undermined health and education and this was a violation of the Universal Declaration of Human Rights. The World Bank's \$500 million facility for HIV/AIDS loans to Africa was an outrage that would leave African youth to inherit massive debt.

Box 9: Malawi's multi-sectoral approach

One of the key lessons in dealing with HIV/AIDS is the importance of a comprehensive approach.

Malawi has emphasized social mobilization, consensus building and the full involvement of institutions. The Ministry of Health and Population led an 18-month planning process that included detailed consultations with communities, religious and other civil society organizations and the private sector. A series of workshops enabled direct input from the community level and produced an inventory of existing community-based actions against HIV/AIDS

The resulting report made a broad analysis of existing strengths and the opportunities for an intensified response to HIV prevention and care in thematic areas. Malawi's Strategic Framework contains goals for each of the major components of the national response, guiding principles, general objectives for each component, detailed budget estimates and guidance on implementation.

In line with its multi-sectoral strategy, the Framework recognizes the critical role of education in keeping the youth HIV negative. It sees the health sector as vital for providing care for people living with HIV and in strengthening home-based care for AIDS patients. As agriculture is the major economic activity in many African countries, agricultural extension and research services are to factor in the challenges posed by HIV/AIDS. The private sector should in turn provide workplace programmes for HIV prevention and care. The same applies to military institutions.

Malawi's programme takes account of the fact that HIV/AIDS is weakening the skills base by killing professionals in every sector including teachers, medical personnel, skilled craftsmen, lawyers and economists. This indicates careful planning of human resource management and expanded investment in secondary, technical and tertiary training to train more professionals in all sectors.

Speaking for people living with HIV/AIDS, Frank Gunney said African leaders had to intervene personally to dispel the stigma and end the discrimination against PLWHA. Similarly, gender sensitivity at the highest levels is a big factor in successful programmes, said Ellen Bortei-

Doku Aryeetey for the gender group. Leaders should adopt legislation on violence against women and children and help break the silence over HIV/AIDS.

Both President Yoweri Museveni and Prime Minister Meles Zenawi insisted that discrimination was mandatory in certain jobs such as those of soldiers and surgeons. On the issue of loans, Prime Minister Meles Zenawi said the only resources available to Ethiopia when it began to fight HIV/AIDS were from a World Bank loan. That did not mean it was the best option; it was the only option until a better one came along, a point echoed by Prime Minister Nagoum Yamassoum of Chad. It was fine to say African leaders must refuse to take such loans but you needed dollars to import condoms, the Ethiopian Prime Minister added.

Box 10: Botswana – a severely affected country

Botswana is the most severely affected country, per capita, in the world with nearly 36 per cent of

adults living with HIV/AIDS by mid-2000, according to UNAIDS. The Government's approach is considered exemplary, given the scale of the national crisis.

President Festus Mogae himself chairs the National AIDS Council. Government Ministers, the National Assembly Select Committee on AIDS and the House of Chiefs together provide political leadership for the national response.

The Council has sectoral committees that develop and implement national programmes as prescribed by the Council and the National Action Plan. Apart from the traditional sectors, we have committees for men, women, youth and children and a decentralized strategy that focuses national efforts on reaching people at the grassroots levels of districts and villages. The multi-sectoral strategy is rigorously monitored and evaluated against targets coordinated by the National AIDS Council through the National AIDS Coordinating Agency (NACA). The private sector, NGOs and community organizations are represented on the National AIDS Council as well as PLWHA in order to ensure total community mobilization.

The Ministries of Health, Finance, Local Government, Education, Labour and Home Affairs lead the development and refinement of strategies for prevention, care and mitigation. These Ministries integrate HIV/AIDS into development planning, take programmes to the communities and facilitate local ownership. They also deal with the protection of children and women and the implementation of information, education and communication programmes targeted at workers, youth and other special groups.

Botswana's programmes include house-to-house counseling and home-based care, HIV/AIDS curricula in primary, secondary and tertiary institutions, along with voluntary testing and counselling services that aim to be accessible to all. There are also specific programmes for orphans, youth, workers and people living with HIV/AIDS.

There are a number of other concerns, notably that of preventive therapy where appropriate. This includes prevention of mother-to-child-transmission, protecting HIV-positive people from TB, post-exposure prophylaxis for rape survivors and health workers.

He described as valid Ms. Mjole's premise that African governments were squandering resources fighting meaningless wars. Ethiopia had spent hundreds of millions of dollars in the past two years, said Prime Minister Meles, promising to do everything in his power not to let his country remain in the same quagmire.

President Mogae said the World Bank and International Monetary Fund had made some mistakes and that so had African leaders. Perhaps it was inadvisable for some countries to incur additional debt for HIV/AIDS. He proposed converting old debts into new aid for fighting HIV/AIDS. Prime Minister Yamasoum felt that education and information that counter fear would dissipate stigma much better than legislation.

The representative of civil society organizations pointed out that HIV/AIDS was not like Ebola in that people could live with HIV/AIDS for more than 15 years. Africa could not afford to marginalize its few professionals. He called for true partnership with national leaders to fight HIV/AIDS, along with better resource mobilization and allocation.

Box 11: Uganda - A relative success story

Until recently, Uganda was synonymous with AIDS. By 1993, 1.5 million Ugandans, or 15 per cent of adults, were living with HIV/AIDS.

By 1998 there were 2 million people with AIDS, of which 800,000 had died. AIDS had also made orphans of 1 million children. "It is very little consolation that, since 1993, we have moved from number 1 to number 14," President Museveni told participants at ADF2000. Still, the decline in HIV prevalence in the last seven years in Uganda is clear indication that "given the will, we can, ultimately, overcome the HIV/AIDS pandemic."

CREATING AWARENESS

When the first cases of HIV/AIDS were positively identified in Uganda in 1983, people associated the disease with witchcraft and the religious regarded it as a punishment from God. Stigma, concealment, denial and resignation were prevalent when Mr. Museveni's National Resistance Movement took power in January 1986. The immediate task was to bring HIV/AIDS out in the open and give it a face.

In May 1986, Uganda's Minister of Health told delegates at the World Health Assembly in Geneva that the country had an AIDS problem and needed international help to deal with it. The fact that Uganda had owned up to a disease associated with homosexuality and drugs, a disease of stigma and shame, was shocking news to many and did not go down well with some Africans.

The Government opened up the AIDS problem to public debate and began to develop a broad consensus on how to tackle the problem. It set up an AIDS Control Programme in the Ministry of Health, the first of its kind in the world; held an international conference on AIDS in Kampala to mobilize financial and material support for prevention and care activities, and created the National AIDS Prevention and Control Committee, composed of government officials and members of civil society. This Committee was replaced in 1992 by a statutory body, the Uganda AIDS Commission based in the President's Office.

By 1993, AIDS Control Programmes had been set up in 12 Ministries besides the Ministry of Health. The Government encouraged the private sector to set up similar programmes in work places. The approach was multi-sectoral right from the beginning.

THE POLITICS OF HIV/AIDS

Once the leadership decided to take HIV/AIDS out of the closet, all opinion leaders, from the President to the village committees, mobilized to raise awareness. "We explained what it was and what it was not; how the infection spreads; and how it can be avoided."

The Government encouraged the electronic and print media to join the struggle against HIV/AIDS. They carried very important messages, from the fearsome ones such as "AIDS KILLS" to those that tackled stigma, such as "DO NOT POINT FINGERS AT PEOPLE WITH AIDS."

Most important, has been the empowerment of Ugandan women. "It is very difficult to confront the AIDS problem without empowering women," President Museveni said.

As a result of the awareness campaign, close to 100 per cent of Ugandans know what HIV/AIDS is, how it spreads and how it can be prevented. And there are signs of positive behaviour change. The prevalence rate fell from around 30 per cent in the early 1990s to about 8 per cent in the late 1990s. Between 1995 and 1998, the age of first sexual intercourse among girls rose from 14 to 16 years and from 14 to 17 among boys; and condom use increased from 57.6 per cent in 1995 to 76 per cent in 1998. The stigma attached to PLWHA has in turn become far less.

According to President Museveni, Uganda's relative success is due to "political commitment, thorough knowledge of our country and compassion for our people."

“We really have nothing to offer in Uganda – neither advanced science nor superior health facilities – but commitment. Political will exists and with it, we have brought about behaviour changes vital to the reduction of infection.”

President Yoweri Museveni

remove the stigma and strengthen their role in campaigns . One of them said: “We need to be respected, we need treatment, we need anti-retrovirals, we need all the love we can get.”

Broad partnerships were essential for extending the fight against HIV/AIDS to all parts of a country, said Dr. Peter Piot of UNAIDS. There must also be a focus on the youth as the basic challenge was to achieve a generation free from HIV/AIDS. He called for a new deal between pharmaceutical companies and the world’s people as the current system only benefited the rich.

Ethiopian youth had the last word, having marched through Addis Ababa for two of their delegates to enter the restricted conference room. They called for more direct support from national leaders to

1. THE ADDIS ABABA CONSENSUS

The formal outcome of the ADF 2000 is the *African Consensus and Plan of Action: Leadership to Overcome HIV/AIDS*. The document describes the specific commitments made at different levels of leadership: governments, international organizations, civil society organizations, community and individuals.

Preamble

Now is the decisive moment in Africa's struggle to overcome the continent-wide threat of HIV/AIDS. Success in overcoming the HIV/AIDS pandemic demands an exceptional personal, moral, political and social commitment on the part of every African. Leadership in the family, the community, the workplace, schools, civil society, government and at an international level is needed to halt the preventable spread of HIV/AIDS, and to provide a decent life for all citizens of Africa. Each and every one of the leadership acts necessary to prevent HIV/AIDS and to help those living with HIV/AIDS, without exception, are things we want anyway for a better, more developed Africa, and must be implemented in full and without delay.

Much has been achieved. Many African communities and several entire nations have shown that it is possible to contain and reduce the spread of HIV/AIDS. Success is a reality in many places and is possible across the continent. The Africa Development Forum 2000 is a breakthrough. It represents a watershed in national leaders' readiness to address intimate personal beliefs and behaviour in a public and political manner. It marks an unprecedented collective commitment to the struggle against HIV/AIDS. With the required resources and the right leadership at all levels, we will win. Too much time has been wasted. Too many lives have been lost. Now is the moment.

1. Personal leadership

- 1.1. Every individual must personally break the silence around the norms and practices that fuel the HIV/AIDS pandemic. As a citizen, leader, wife, husband, parent, child, youth, adult, worker, or employer, there are critical issues of information, attitudes and behaviour that must be learned and faced. Every person must be ready to speak openly about sexual relations and the unequal power relations within sexual relationships.
- 1.2. Families are the cornerstones of society. Parents have a special responsibility to educate their children from a very early age about the realities of HIV/AIDS and to socialize them into personal morality and social attitudes that will help contain the pandemic.

II

FORUM OUTCOMES AND FOLLOW-UP

- 1.3. Each person must regard himself or herself as affected by the HIV/AIDS pandemic, and must acknowledge the possibility that they themselves or a loved one may become infected.
- 1.4. Every person must confront the reality of denial, stigmatization and discrimination against people living with HIV/AIDS, and should embrace people living with HIV/AIDS as fellow members of their families, communities and nations.
- 1.5. People living with HIV/AIDS are human beings in full possession of their human rights. They must be valued as a resource in and of themselves, and as crucial allies in the common struggle to overcome HIV/AIDS. They should not be used or manipulated in the campaign against HIV/AIDS.
- 1.6. Each person must take responsibility for avoiding risky sexual behaviour, for protecting himself or herself, and for preventing the virus being transmitted to others. For many this will mean promoting and living lives of fidelity.
- 1.7. Youths have a personal responsibility to respond to the challenge of HIV/AIDS, in their personal lives and by setting examples to their peers.

2. Community Leadership

- 2.1. The struggle against HIV/AIDS will be won community by community, in every family, village, township, and settlement across Africa. Authority and resources to overcome the pandemic must be devolved to the local level.
- 2.2. At the community level, there should be a common struggle to overcome HIV/AIDS, with actions and strategies that combine all members and component parts of the community, resulting in a true local partnership.
- 2.3. People living with HIV/AIDS stand at the centre of any community efforts to overcome the pandemic, and to change attitudes to overcome denial, stigmatization and discrimination. Their rights must be respected in full and their leadership potential recognized.
- 2.4. Women and girls must be empowered in their homes, workplaces, schools and communities, and provided with the cultural, legal and material means of protection from sexual abuse. Traditional leaders need to be reliable allies in protecting women from abuse. Perpetrators of sexual and domestic violence against women and children must be prosecuted in the courts. Child- and woman-friendly family courts must be created at scale and supported.
- 2.5. Men's responsibilities towards women and girl children must be emphasized. Men must be a target for educational efforts with a view to their being important allies in the fight against HIV/AIDS.
- 2.6. Children orphaned by AIDS should be both a family and community responsibility, with the family receiving sufficient support to ensure their welfare, education and health.
- 2.7. Governments have a special responsibility to promote social responsibility among soldiers and other uniformed officers of the state. They must take the lead in preventing and punishing sexual crimes by these servants of the State.

- 2.8. All people, regardless of their sexual orientation, must have access to appropriate information about HIV prevention, access to appropriate treatment and care, and should be free of stigmatization, discrimination and fear.
- 2.9. The accessibility and low price of condoms must be ensured, and people must be taught about their importance and use. Access for youth and rural dwellers are especially important.
- 2.10. Youth comprise over half of Africa's population, and are leaders of today and tomorrow. Youth must be clearly recognized and encouraged both as key participants and as key targets in developing and implementing HIV/AIDS action plans at all levels. Youth organizations require support and resources. The youth representatives from throughout Africa played an important part in the Forum and the Youth Statement is appended as Annex I, as an integral part of this statement.
- 2.11. The many different stakeholders in communities each have particular roles and responsibilities, which often need to be developed more fully, to make them full allies in the common struggle against HIV/AIDS and the support of people living with HIV/AIDS. They include:
 - (a) People living with HIV/AIDS, whose involvement is essential.
 - (b) Spiritual leaders, who are among the most influential community members, provide moral guidance and awareness.
 - (c) Traditional healers have multiple roles including palliative care, and contribution to global research efforts in search of a cure.
 - (d) Health care providers in both their roles as health educators and caregivers, are crucial allies.
 - (e) Women's groups are an integral component of the community. Women's leaders are educators and role models for women and girls, and can play a key role in changing the attitudes of men.
 - (f) Teachers and educators, including traditional communicators, are pivotal intermediaries in influencing children and youth and are influential role models. They must be trained to teach forthrightly about sex and HIV/AIDS education.
 - (g) Employers and trade unions have key roles in workplace initiatives to combat HIV/AIDS, and overcome stigmatization and discrimination.
 - (h) Elected representatives and traditional leaders should represent and be accountable to all their constituents, including PLWAs, and can play an important role in advocating for their interests and mobilizing community-wide campaigns.
 - (i) Older people require education and assistance to enable them to provide aid and care for PLWAs and orphans of PLWAs. Older persons must be used to provide education consonant with tradition and culture to families, communities and civic groups.

- 2.12. Those caring for people living with AIDS need special assistance in recognition of the special burdens and responsibilities upon them.
- 2.13. In sum, there is a need for total societal mobilization at a community level, creating a robust 'social immunity' from the scourge of HIV/AIDS. This involves a seamless continuity between breaking the silence on stigma, and providing effective prevention, treatment and care.

3. National Leadership

- 3.1. National leaders' prime responsibility is to create the conditions for community mobilization, across the nation, on a scale and with a commitment comparable to mobilizing for war.
- 3.2. Many cases of impressive national efforts exist: the challenge is to replicate them and to scale them up to cover every community. This may require national leaders to commit domestic resources to HIV/AIDS programmes and to ensure that they in fact reach local groups efficiently.
- 3.3. National leaders' personal example can transform the moral and social climate in which HIV/AIDS can be discussed and addressed openly, and denial and stigma can be overcome.
- 3.4. National strategies should include scaling up the resources and systems necessary so that anti-retroviral and other essential medications can be made available to the widest possible population as rapidly as possible. This will take leadership, hard bargaining, and the mobilization of domestic and international resources.
- 3.5. The status of women and girls at a national level needs special emphasis. Women must be closely involved in all components of HIV/AIDS programmes. National leaders must initiate special programmes and set up special institutions to promote the rights and initiatives of women. Inequitable gender relations and opportunities lie at the core of the HIV/AIDS pandemic. Since Africa's women leaders have demonstrated their readiness to lead on HIV/AIDS issues, the fostering of more women leaders of national and international stature is an important component of overcoming HIV/AIDS. Acknowledging the central importance of this issue, the Statement of the Gender Focus Group, in annex III, is an integral part of this statement.
- 3.6. National AIDS institutions and councils should be strengthened as a matter of urgency in order to assure a broad, multi-sectoral response at the national and community levels. Strong legal and regulatory frameworks are required. HIV/AIDS committees should be extended to the local level across every country. Stakeholders including PLWAs, Youth and Civil Society Organizations must be fully involved. Best cases in Africa demonstrate that highest level political leadership of national AIDS councils is a requirement.
- 3.7. Effective multi-sectoral leadership requires that every sector must achieve competence on how HIV/AIDS affects its activities and how it can contribute to a multi-sectoral plan to overcome the pandemic.

- (a) The health sector, provided with suitable resources, must play a leading role in prevention, treatment and the surveillance of the pandemic. All available measures to minimize mother-to-child transmission should be utilized.
- (b) The education sector is central to effective responses to HIV/AIDS. HIV/AIDS and sex education must be in every curriculum. Schools must be models for equitable gender relations and young people must be involved in the management of school-based initiatives focusing on HIV/AIDS. All school fees and other charges required to attend government schools must be abolished to ensure that all children can enjoy their right to education. Donors should provide special support to the education sector.
- (c) Youth out of school, including street children, should be targeted and reached by appropriate strategies. Given the impact of drug abuse on the spread of HIV/AIDS, drug abuse prevention and rehabilitation programmes targeting specifically youth in and out of school should be implemented in rural and urban areas.
- (d) The social welfare sector must provide assistance to those caring for people with AIDS, and for their dependants. Assistance including counselling should be provided for orphans.
- (e) Ministries of finance should ensure adequate resource provisioning for HIV/AIDS programmes. They should reorient budgets and administrative procedures so that funds related to HIV/AIDS programmes can be managed in the most efficient manner in order to provide funds expeditiously at all germane levels.
- (f) The trade, industry, mining sectors must shoulder their responsibilities for minimizing transmission of HIV and for non-discriminatory employment practices. Business and labour should be involved in developing and implementing national HIV/AIDS action plans. Efforts should be made to extend these activities to the informal sector.
- (g) Local production of pertinent pharmaceuticals should be encouraged.
- (h) The rural sector is particularly at risk because of high levels of illiteracy and poverty. The agricultural, livestock and fishing sectors should shoulder responsibilities, especially for education about HIV/AIDS, alongside the authorities in rural areas.
- (i) The military must confront the reality of high levels of HIV prevalence among soldiers, and take necessary steps to reduce transmission. Armies must provide for soldiers who are living with HIV. As disciplined national institutions, armies can take a leading role in HIV/AIDS control programmes. The military must take steps to eliminate the high level of sexual violence against women and girls, particularly during conflicts, and ensure that those responsible are prosecuted and punished. Similar considerations apply to other uniformed services of the state including the police and prison service.

- (j) Commercial sex workers and women forced to engage in ‘survival sex’ should be protected by the law and law enforcement officers, and provided with education and access to condoms and medical facilities.
 - (k) African research institutes should become actively engaged in research for improved treatments for HIV/AIDS and opportunistic infections, drawing inter alia on the expertise of traditional healers.
 - (l) The media should have a crucial partnership role in public education and shaping attitudes. Information and communication technology can play an important role in national, regional and global transmission of information.
 - (m) Artists and cultural leaders can play key roles in influencing public attitudes and can serve as role models.
- 3.8. People living with HIV/AIDS must be involved in national policy making and implementation in a meaningful manner.
- 3.9. Governments have a responsibility to improve capacities wherever needed for the campaign against HIV/AIDS. This includes their own effectiveness and accountability, so as to be able to fulfil their commitments to their citizens, and to be able to receive and dispense international assistance rapidly and efficiently. CSOs can play a vital role in monitoring government’s performance.
- 3.10 Civil society organizations have taken the lead in many aspects of HIV/AIDS control. Their roles must be appreciated and supported. NGOs must hold themselves to high standards of accountability and transparency. The common position of African civil society organizations represented at the Forum is important and their Declaration is therefore appended in annex III as an integral part of this statement.
- 3.11 Religious leaders and traditional leaders have immense influence over matters of personal morality and behaviour. They are encouraged to be far more active in removing the stigma of HIV/AIDS and in educating their congregations. Abstinence and fidelity would, if followed, prove an effective means of preventing HIV transmission. Religious values such as care for the stricken, tolerance and inclusion can assist in the campaign against HIV/AIDS.
- 3.12 Development and economic planning must play a crucial role in reducing vulnerability to HIV/AIDS, by means of promoting sustainable livelihoods and employment and through poverty-reducing wealth creation.

4. Regional Leadership

- 4.1. Africa’s HIV/AIDS pandemic knows no geographic, economic or social boundaries. It demands action at a continental level and leadership from Africa’s regional and subregional organizations.
- 4.2. Much can be learned from successful examples of the containment of the HIV/AIDS pandemic in different countries in Africa. The regular sharing of experiences and the provision of technical advice from elsewhere in Africa are tools towards adopting best practices across the continent.

- 4.3. Essential and comprehensive care and treatment for people living with HIV/AIDS is required. A continental strategy to ensure the affordable provision of essential anti-retroviral drugs and treatments for opportunistic infections is needed very rapidly. This requires a determined pan-African strategy in partnership with international donors and pharmaceutical companies.
- 4.4. The International Partnership against AIDS in Africa has been established to develop a more conducive framework for true partnerships and better co-ordination among key stakeholders at all levels. It is intended to assist in providing the much-needed additional resources, technical support, information sharing and co-ordination of donor efforts, under the leadership of African governments. The IPAA should be fully implemented.
- 4.5. Peace is an essential pre-requisite for effective programmes against HIV/AIDS. The extent of ongoing war in Africa seriously undermines any realistic programmes to combat HIV/AIDS in the affected areas. It is therefore imperative that African governments and regional and subregional organizations take decisive steps to create and maintain peace and security and promote democratization as a means of facilitating conflict resolution.
- 4.6. Long-distance migration, mobility, displacement and refugee flows are risk factors for HIV/AIDS that demand inter-state co-operation to develop and implement policies against HIV/AIDS. Policies and programmes aimed at migrant, mobile and displaced populations should be developed and implemented. However, no measures should be implemented that curtail freedom of movement.

5. International Partnership

- 5.1. An estimated \$US 3 billion is now required annually to contain the HIV/AIDS pandemic, including prevention, treatment, community support, research, training and surveillance. This may soon rise to as much as \$US 10 billion if anti-retroviral treatments are made available to all PLWA. These resources are available, nationally, regionally and globally.
- 5.2. The first source for resource commitment must be domestic. In the framework of multi-sectoral strategies, adequate provision for HIV/AIDS programmes should be prominently reflected in every ministerial budget. Certain national leaders have committed themselves to putting their nations on a 'war footing'. In resource terms, this implies spending more on combating HIV/AIDS than on peacetime defense expenditure.
- 5.3. This also requires mobilization of resources from every possible source such as the domestic private sector and community resources.
- 5.4. Foreign donors and international financial institutions must greatly increase their financial commitments to HIV/AIDS and development programmes. This assistance, wherever possible, should be in the form of grants, not loans, and should benefit from expedited procedures.
- 5.5. A substantial reduction in the prices of anti-retroviral drugs and treatments for opportunistic infections is required. African governments, donors and international

financial institutions must work in partnership to reduce the prices of drugs to a level commensurate with their production costs.

- 5.6. International research efforts to develop vaccines against HIV and treatments for AIDS and opportunistic infections should be substantially increased, and carried out in partnership with African communities and research institutes, ensuring that resulting benefits reach Africa.
- 5.7. There is a need for an international code of good practice to be developed and utilized to safeguard and guarantee the rights of workers with HIV/AIDS, and to specify the responsibilities of employers. The ILO should provide support and technical assistance to employers' and workers' organizations and to labour ministries to strengthen their capacity for the effective implementation of national action plans and policies. Recognizing the importance of this, the Conclusions and Recommendations of the ILO Pre-forum Tripartite Event are appended as Annex IV, as an integral part of this statement.
- 5.8. Debt relief is an important source for both money and political commitment, and as a means of mainstreaming HIV/AIDS programming into development and poverty reduction policies. The HIPC programme of debt reduction should be expanded and accelerated particularly where resources will be re-channeled to HIV/AIDS and poverty reduction.
- 5.9. Other sources of finance such as corporations and foundations, and innovative ways of generating revenue, should also be sought.
- 5.10 The African diaspora is an important source of resources, expertise and networks that can be utilized as part of a true and effective partnership. Therefore, African governments should take specific steps to scale up existing diaspora initiatives, understand the full dimension of this group and extend this support into new areas of priority. Dialogue needs to commence as an urgent priority to encourage the diaspora community to raise funds, mobilize scientific resources and expertise and combine their strengths with emphasis on HIV/AIDS.
- 5.11 International assistance efforts should be coordinated, transparent and accountable. Mechanisms to ensure the quick, effective, direct and accountable delivery of resources to local groups and programmes will be required.

The HIV/AIDS pandemic is manageable. With the required political commitment, provision of resources, and strategies that include all stakeholders as valued partners, the HIV/AIDS pandemic can be rolled back and contained. The experience of certain African countries shows that this is achievable. What has been accomplished must be sustained and spread across the entire continent. Africa's HIV/AIDS pandemic will be overcome at a continental level or not at all.

2. Implementing the consensus

After adopting the African consensus document, the plan of action described specific tasks to be taken at the national, regional and international levels was formulated as follows:

At the national level

- Each country should hold a representative national workshop by mid-February 2001, to determine how the Consensus and Plan of Action of the ADF can be turned into action at the country level.
- All governments should prepare reports for the Special Summit of the OAU on HIV/AIDS by mid-March. These should include concrete action on national initiatives at the highest level and resource allocation.
- Civil society organizations, especially PLWHAs and Youth, should strengthen their co-operation, evaluate their experience, and prepare for their contribution to the OAU Special Summit.
- By the end of 2001, each country should ensure that it has in place a National AIDS Commission (or equivalent) and a strategic plan, backed up by appropriate legislation, modalities for the involvement of PLWA and other stakeholders, and mechanisms for regular monitoring of progress.

At the regional and international levels

- The ADF 2000 provided an extraordinary opportunity for key stakeholders to put their questions to the assembled Heads of State and Government. The participation of youth, PLWHA and civil society was outstanding, leading to the demand that all stakeholders be represented at the OAU Special Summit as participants.
- Specific commitments were made for the African position in and contribution to the OAU Special Summit on HIV/AIDS and other communicable diseases in Abuja in April 2001, the OAU Annual Summit in Lusaka, the UN General Assembly Special Session on HIV/AIDS, and the UN General Assembly Special Session on children.
- The Forum repeated that wherever possible, assistance should be in the form of grants, not loans. It stressed the priority of addressing the problem of the cost and accessibility of Drugs, especially anti-retroviral and Drugs to treat opportunistic infections. The UN Secretary General was called upon to work in partnership with others on a major fundraising campaign, while international civil society was challenged to mount a campaign comparable to Jubilee 2000 aimed at making essential treatments available at reasonable cost to people living with HIV/AIDS in Africa.

Box 12: Partnership Roles

Given that ECA's mandate is to promote economic and social development in the region, and since it's accepted that HIV/AIDS is no longer only a health problem, the Commission will

take the lead in addressing the implications of development policies arising from HIV/AIDS and the actions required by all levels of African leadership.

The following roles are being considered:

- Mainstreaming HIV/AIDS in ECA's programmes, especially as related to:
 - Economic and social policy
 - Empowerment of African women
 - Regional integration
 - Information and Communication Technologies for development
 - Sustainable development
- Advocating for sound interventions in all areas of the struggle against HIV/AIDS by systematically incorporating them at all meetings/conferences convened by ECA.
- Setting up a mechanism for monitoring the implementation of the ADF 2000 recommendations at the country level.
- Assisting in establishing a framework — including benchmarks and indicators — to monitor the implementation by the United Nations system of the ADF 2000 Plan of Action.
- Articulating a clear role for ECA within the IPPA framework of action in brokering effective partnerships for an up-scaled response to the pandemic.

3. Milestones

3.1. The Abuja Summit

ECA will use the OAU Summits to lobby Head of States and Government Representatives to ensure that continued attention and commitment is given to HIV/AIDS issues at the national level. This will also allow the forging of partnerships among countries by developing national strategy to successfully combat the pandemic.

For the momentum gained at ADF 2000 to continue at the political level, ECA collaborated with OAU in preparing the Abuja Summit and other upcoming OAU meetings to anchor HIV/AIDS within the African political agenda

The outcome of the ADF 2000 was used as comprehensively as possible in preparing the HIV/AIDS document which was endorsed by the Heads of State.

3.2. Link to Special Events on HIV/AIDS

ECA will also ensure the linkage of the Forum 2000 to the up-coming special events on HIV/AIDS at the regional and global level.

These include the following:

- *The UN General Assembly Special Session on HIV/AIDS, in June 2001*

This is an opportunity for African participant to present a common position on the Consensus and a common co-ordinated demand for international assistance, debt relief, and provision of affordable drugs. ECA is to play a major role, and thus much work is needed to get ECA fully ready.

- *The OAU Annual Summit in July in Lusaka in July 2001*

It was suggested that a special session be devoted to HIV/AIDS where a report on the progress made in combating HIV/AIDS will be presented. ECA is to ensure that African Leaders will keep the HIV/AIDS in their agenda.

- *The UN Summit for Children in September 2001*

This will be a golden occasion to share what would have happened in the mean time.

HIV/AIDS is the number one threat to African children and there is a collective responsibility among all states to take all possible measures to ensure the next generation of African does not have to face the scourge of HIV/AIDS pandemic.

3.3 The international partnership against AIDS in Africa (IPAA)

The International Partnership against AIDS in Africa (IPAA) was given significant attention during the Forum, including by UN Secretary General Kofi Annan. The IPAA is emerging as an African-owned and Africa-centered international initiative that can encompass and augment existing initiatives, building upon best practices and knitting together diverse experiences and capacities.

The ADF 2000 is part of the achievements of the IPAA in term of mobilization of political commitment and action. Hence, as a regional organisation, ECA will support sub regional and regional initiatives and will take forward international actions that will further enable effective local responses. The implementation of the African Consensus and Action Plan will be grounded within the framework of the IPAA.

Future efforts will focus on the following areas:

- Advocacy for the development of new international public goods (drugs / vaccines campaigns).
- Amplifying the link between AIDS and poverty reduction through the development of PRSP and debt reduction for Highly Indebted Poor Countries (HIPC).
- Assisting African countries in integrating the HIV/AIDS dimension in economic and social policies through conducting country-specific research that will serve as a basis for policy making.
- Using the existing co-ordination mechanisms to act as a platform for advocacy
- Developing mechanisms to address cross border issues, which require sub regional perspective (ADF 2001: Regional Integration).
- Mainstream HIV/AIDS into development activities and provide support in order to stengthen local response initiatives.

3.4 Next steps for IPAA

The first full meeting of IPAA took place in Addis Ababa on 8 December, immediately after the end of the African Development Forum 2000. This was the first meeting of IPAA stakeholders since their initial meeting with UN Secretary-General Kofi Annan in Decem-

ber 1999. The five branches of the partnership are African governments, the United Nations, creditor governments and institutions, the community sector and the private sector.

Participants agreed they had made progress over the past year but still faced several challenges. These include the need for better communication between partners and for more financial and human resources. Coordination and collaboration among the many regional offices of IPAA partners and African regional technical institutions must also improve. At country level, national coordinating bodies should be strengthened while programmes are decentralized and funds channelled more effectively to communities in order to scale up programmes and achieve national coverage. They also agreed that they needed to develop a monitoring and evaluation tool for IPAA.

Stakeholders acknowledged the urgency of consolidating IPAA and moving ahead to bring other countries on board using the experience gained from the initial six countries – Burkina Faso, Ethiopia, Ghana, Malawi, Mozambique, Tanzania — in building the partnership. They reiterated the importance of national ownership of strategies and responses to the HIV/AIDS epidemic. Similarly, constituent groups should continue working together with a flexibility that recognizes national realities and differences.

UNAIDS informed participants that seven more countries were on board, several more had asked to join and some were already adopting IPAA principles and approaches. This eagerness underlined the need to include all countries in the Partnership.

Recommendations on next steps:

- Stakeholders agreed that all countries requesting support through the IPAA should intensify their national response should be supported.
- The UNAIDS Secretariat should distribute the draft monitoring and evaluation (M&E) framework to the focal persons of IPAA constituent groups for comments. Each constituent group would select one M&E expert to participate in an electronic discussion on the draft M&E framework. A meeting of M&E experts was proposed for early April in Pretoria to finalize the framework.
- The IPAA stakeholders' meeting is to be held once a year and future meetings should, wherever possible, take place in Africa and should be arranged to coincide with other regional meetings.
- The UNAIDS Secretariat should report back in three months on progress made on this list of recommendations.

The meeting broke up into four groups that made sector-specific recommendations. Proposals from the group on strengthening global and regional partnership mechanisms included the following:

- The IPAA communication strategy should include analytic updates every three months on country-level partnership activities such as resource mobilization, strategic planning and implementation status of such programmes as care and support for PLWHA.
- The role of regional bodies is to assist in building national capacities and there has to be an inventory of technical resources in the region.

- Regional offices of NGOs, donors and UNAIDS Inter-Country Teams (ICT) should improve their collaboration and coordination. In West Africa, the German aid agency, GTZ, is working effectively with regional partners, especially with the UNAIDS Inter-Country Team in Abidjan. Partners in this subregion hold annual meetings and prepare joint work plans in specific areas such as migration, youth, sex workers, and information management. IPAA should set up similar collaboration in other subregions.
- IPAA should expand and promote the principles and objectives of the Partnership in collaboration with regional bodies such as the Organization of African Unity, Economic Commission for Africa, East African Community, Common Market for East and Southern Africa, African Development Bank (ADB), Southern Africa Development Community (SADC) and the Economic Community of West African States (ECOWAS),

Recommendations of the group on IPAA support for national programme implementation included the following:

- A participatory process of drawing up the National AIDS Action Plan facilitates partnerships and improved coordination. Governments should lead the process and must involve community groups, the private sector, NGOs, donors and UN co-sponsors.
- National AIDS coordination bodies need to be strengthened, again in partnership. For example, African governments could give greater political support to the coordinating body by placing it under the office of the President; UN co-sponsors could provide technical support while donors provide core funding.
- Management practices of IPAA partners should change significantly in order to channel resources to the local level quickly and effectively.
- All partners in the national AIDS action plan must understand the capabilities and constraints they all face. Donors should complement each other by phasing their funding to cover urgent, short-term actions and longer-term activities.
- All partners should review their internal practices in order to tackle the HIV/AIDS crisis on a “war footing.” Governments need to speed up internal processes, while donors should ensure that funding procedures do not hinder action against AIDS.
- Donors have to be much better coordinated to ensure that the whole national AIDS plan is funded, not just fragments. Joint procedures and pooled funding should be the goal.

The group on strengthening Partnership mechanisms at country level proposed that:

- All partners should help ensure that the national coordinating body has adequate staffing, logistical, material and financial resources as well as technical and communication equipment.
- Guidelines for resource mobilization and coordination should be developed using information on other countries’ experiences in partnership building.

- As communication is critical for partnership development, it is important to build the capacity of the various constituent groups (especially communities) to communicate.

Recommendations of the group on resource mobilization included the following:

- The UN system must put HIV/AIDS on an emergency response status to facilitate mobilization and easier flow of resources.
- Governments should earmark a percentage of their budgets for national HIV/AIDS control activities commensurate with the level of the epidemic in their country.
- The UNAIDS Secretariat should help countries prepare for creditor round tables and the follow-up. The secretariat should inform countries of funding opportunities from the private sector, philanthropic organizations, etc.
- IPAA members should find ways to mobilize the pool of untapped or under-utilized people (Red Cross and other volunteers, out-of-school youths, church groups, the Diaspora, etc.) to fight HIV/AIDS.
- IPAA must launch massive, technical human resources development in African countries.
- As absorptive capacity is a constraint in many countries, IPAA should tackle the causes of the suboptimal use of resources.

ANNEX I: THE CONSENSUS ANNEXES

A. Youth Statement to the African Development Forum

We the young people represented at the African Development Forum 2000 state our position on Aids and leadership:

- Recognizing that poverty in Africa plays a major role in shaping both the course and the response to the pandemic;
- Horrified at the number of lives lost unnecessarily to AIDS,
- Angry that the numerous unnecessary wars on our continent are fueling the AIDS epidemic and resulting in the deaths of too many young people, and the rape of untold numbers of young women;
- Disillusioned by the fact that a generation of African leaders have betrayed us by waging wars, plundering our resources, raiding our national treasuries, and taking insufficient action on HIV/AIDS;
- Deeply saddened that due to the role of the World Bank and the IMF-imposed structural adjustment programmes, many African States can no longer provide the basic education and health services that are so critical to development;
- Disturbed that the inability of many African States to deliver on health and education services is in direct violation of the Universal Declaration on Human Rights;
- Outraged by the World Bank's decision to offer \$500 million in loans to already indebted countries to fight HIV/AIDS;
- Deeply concerned that that young people have borne the brunt of the HIV/AIDS epidemic both in terms of infections and caring for and supporting family members;
- Further concerned that young women in particular are more susceptible to contracting HIV because of patriarchal attitudes about female sexuality, and this is compounded by their biological vulnerability to infection;
- Cognizant that young people must commit themselves to changing unhealthy behaviors and assuming leadership roles in the fight against HIV/AIDS;
- Optimistic that leaders will now finally begin to listen, speak out and to act;

III

ANNEXES

- Willing to work with leaders at every level, in partnership and mutual respect to triumph over HIV/AIDS and build a new Africa.

We the young people represented at the ADF 2000 call upon leaders in Africa at all levels to do the following:

1. Prevention

- (a) Every African nation must have an inter-sectoral AIDS budget that is jointly administered by civil society and government. Young people must form a critical part of the structure that oversees this fund and must have full voting and decision-making power.
- (b) The United Nations system must create a specific agency to channel funds quickly and without red tape to young people for initiatives that are designed and managed by youth. This agency will be committed to conducting its affairs in a way that is opposed to opulence in the midst of poverty.
- (c) A tripartite partnership must be established at country level to ensure that government, civil society, and the donor community effectively coordinate activities that are focused on young people and HIV/AIDS.
- (d) Each government must create mechanisms for purchasing and distributing condoms so that prevention efforts that rely on condoms are sustainable.
- (e) Youth organizations must focus efforts on condom distribution as well as information about the other methods of prevention. Abstinence and faithfulness to an HIV-negative partner are critical to the fight against AIDS. Young women must be empowered to say no to sex against their will. If they want to initiate and engage in sex, they must be educated about assertiveness so that they can successfully negotiate condom use.
- (f) Each government must ensure that all the necessary infrastructure is in place so that young people have access to volunteer testing and counseling, information education about prevention, and care and support services for those of us living with HIV/AIDS.
- (g) African youth organizations must develop tools for monitoring national efforts in the fight against AIDS. In particular, a youth checklist for governments must be formulated to assess the youth-friendliness of government's programme on HIV/AIDS.

2. Treatment

- (a) The pharmaceutical drug manufacturers that profit exorbitantly from illness must be challenged by young Africans in solidarity with our governments as they attempt to negotiate lower prices and advocate for the use of generic drugs.

- (b) Youth organizations should strengthen their treatment initiatives by promoting good nutrition, positive living
- (c) Youth organizations should join with PLWHA groups to ensure that at a minimum, young people living with HIV have access to treatment for opportunistic infections.
- (d) Policy measures must be put in place by governments to ensure that PLWHA are not exploited financially by companies and individuals making false claims about treatments and cures.

3. Care, Support, and Stigma

- (a) Political leaders should govern by example, ensuring that they speak openly and honestly about HIV/AIDS.
- (b) Youth organizations should establish a “Movement for Acceptance” that calls attention to the marginalization of particular groups of young people. In particular this movement will focus on the dearth of access to services and information for young people living with HIV/AIDS, young women, young people living in rural areas, young people living in the street, gay and lesbian youth, young people engaged in sex work, out-of-school youth, and young people living in conflict zones.

4. Challenging Poverty

- (a) African youth organizations and structures must build alliances with young people around the world who are currently challenging the negative effects of globalization and protesting meetings held by international lending institutions.
- (b) African youth organizations must lobby the international community to ensure that loans to Africa for AIDS are rejected outright.

5. Participation

- (a) Young people must play a critical role in decision-making for all national AIDS strategies and plans.
- (b) Young people must be represented at all levels of AIDS planning and programming at both a community and government level.
- (c) Young people’s capacity to manage effective organizations must be bolstered by policy and legal environments that allow us to seek training, mentorship programmes and build strong organizations and structures.

Follow-up Actions

Young people at the Forum insist that governments, NGOs and international agencies present here today, commit concrete resources to ensuring that our efforts on the aforementioned issues can be continued. In particular we request that the Focus Group Coordinator be contacted through the ADF Secretariat, to establish a regional network of African young

people. This network will build on existing structures such as the Pan-African youth Movement, the Scouts associations, and the many youth and AIDS programmes that exist throughout the continent. It will also establish partnerships with the Commonwealth Youth Programme.

This Youth Against AIDS Network (YAAN) will be dedicated to fighting AIDS at a regional level. It will be a multilingual network with a working group comprising 2 - 3 national youth focal points from Eastern, Southern, West, Central and Northern Africa, representing both government and civil society. The Network will be committed to:

- (a) Sharing experiences of activism;
- (b) Exchanging information about participatory youth policy and research processes;
- (c) Encouraging and supporting youth networks of PLWHA;
- (d) Forming alliances with young people in African countries, in other countries of the South and with youth in the North, to challenge debt, loans and the global trade issues that negatively impact on poverty.

Keeping the Promise

Funds for the Network should be in place, either with the ECA or with a selected International youth NGO by March 2001 and a report will be submitted to the OAU Summit taking place in Abuja in April 2001.

A follow-up meeting to report on progress since the ADF and the Heads of State Summit should take place immediately prior to the 4th World Youth Forum, which will be taking place in Dakar, from 5 - 12 August 2001.

B. Declaration by African civil society organizations

Preamble

We, the African Civil Society Organizations represented at the Africa Development Forum 2000, recognize and applaud the courageous and ongoing efforts made by community-based organizations, groups of People Living with HIV/AIDS and their networks, to combat the pandemic of HIV/AIDS. We call on our governments and the international community to recognize and support these efforts, which must also be expanded to other organizations of civil society.

We call for greater focus on People Living with HIV/AIDS, youth and the media as central partners in the common struggle against HIV/AIDS.

We recognize the challenge of HIV/AIDS as the greatest threat facing the current generation in Africa. It is an all-encompassing social, economic, cultural and political crisis. HIV/AIDS is a threat that calls for all of society to be mobilized if we are to prevail.

We are encouraged that African national and continental leaders, and international donors and partners, are recognizing the scale of the challenge posed by HIV/AIDS. We urge them to do more, to match the efforts of African citizens and civil society organizations. We urge them to enter into a true partnership with African civil society: it is through such a partnership that we will succeed.

A Partnership against HIV/AIDS in Africa

We, African civil society organizations, call for our leaders, our civil society and our citizens to forge a true partnership, to work together to overcome HIV/AIDS in Africa. We submit that there is no simple plan of action that can overcome this scourge. Instead we propose a true partnership, in the form of a grand coalition of leaders, organizations and individuals at all levels, working in their different ways towards a common goal: the conquest of HIV/AIDS.

This partnership challenges our leaders, and sets down basic principles for collective action.

Challenges to our Leaders

We, African civil society organizations, call upon the following leaders to fulfil their responsibilities:

1. *National political leaders.* Our national political leaders have responsibilities to:
 - Lead by example,
 - Take a lead in combating the culture of fear, denial and stigmatization,
 - Include others by encouraging openness within government about HIV-positive status,
 - Formulate appropriate policies for national media,
 - Take a lead in non-discrimination in government employment,
 - Draft necessary legislation address issues including discrimination, employment, violence against PLWHA, sexual violence, etc; and
 - Take the necessary steps to make a strategy to combat HIV/AIDS a top national priority, -for all arms of the government.

2. *Voluntary and grassroots leaders.* Recognizing the leading role they are playing in responding to the pandemic, voluntary and grassroots leaders, including People Living with HIV/AIDS and Youth, we should continue to search for and implement innovative, effective and people-centred means of struggling against HIV/AIDS.
3. *Women leaders.* Women leaders, in government, civil society and international organizations, can play a key leadership role in mobilising society, empowering their sisters, and changing attitudes and behaviour. Male leaders have a responsibility to encourage and respect women leaders.
4. *Religious leaders.* Religious leaders have the responsibility to initiate moral and social responses to HIV/AIDS such as caring for sick people and orphans, renegotiating gender roles, promoting the social inclusion of PLWAs, fighting against stigma and human rights abuses.
5. *Business leaders.* Entrepreneurs, business people and especially transnational corporations have responsibilities to their employees, to take the necessary steps to minimise HIV transmission at the workplace, to treat employees living with HIV/AIDS without discrimination.
6. *Trade union leaders.* Based on notions of solidarity and equality, trade unions have the responsibility, to educate workers about protection and to act as a safety net for those who have been infected with HIV. The international leadership of labour organizations have a duty to support their comrades in Africa.
7. *Intellectual leaders.* Professors, researchers and public intellectuals have a responsibility and an opportunity for shaping thinking and action.
8. *Education sector leaders.* Teachers have major responsibilities to their pupils, not only while they are studying but throughout their lifetimes. Teachers should include education about HIV/AIDS in the curriculum, and should lead by example, both in their own personal conduct and by making special efforts to include and respect students who are HIV positive and those who are caring for family members living with HIV/AIDS.
9. *Cultural and social leaders.* Cultural figures and celebrities serve as role models and opinion formers, especially for youth. They can influence the cultural environment positively.
10. *Media leaders.* Journalists, broadcasters, editors, chat-show hosts, actors, script-writers for soap operas: all these individuals and their respective institutions need to be mobilized, educated and strengthened to play important roles in:
 - Educating the public,
 - Overcoming denial, stigmatization and stereotyping,
 - Providing a platform for People Living with HIV/AIDS, and
 - Promoting transparency.

11. *Military leaders.* Military and police commanders have responsibilities to ensure that their uniformed officers and troops do not transmit HIV. They also have duties towards their officers and men who are HIV positive, and their families.
12. *International leaders.* Leaders of international organizations, including African organizations, UN agencies, donor governments, or international financial institutions, have a responsibility to respond to the HIV/AIDS crisis in Africa, and to support African initiatives with generosity and fairness. International organizations should set an example of transparency and accountability in acknowledging their past records of inadequate response to the pandemic.

Basic Principles of the Partnership

We, African civil society organizations, seek to focus on the following issues:

1. *Inclusion of People Living with HIV/AIDS.* No campaign to address the challenge of HIV/AIDS can possibly succeed without the full participation of PLWHA at all levels, including policy making and policy implementation. PLWHA are human beings, members of their community and citizens, and their human rights must be respected in full. We call for participation that is comprehensive, meaningful, consistent, democratic, and immediate.
2. *Overcoming Denial, Stigma and Discrimination.* An absolutely fundamental requirement for overcoming the HIV/AIDS pandemic is eradicating denial, stigmatization and discrimination. Discrimination is manifest in many ways including employment, housing, education, foreign travel, insurance, health care and other social amenities and citizenship rights. We need to create a culture in which HIV/AIDS can be acknowledged without fear. Honesty and transparency from leaders who are themselves HIV positive is crucial. Hypocrisy and secrecy are the allies of HIV/AIDS, and they are our enemies. We call for our governments to implement the international guidelines on human rights and HIV and to put in place effective mechanisms of monitoring the implementation, including full legal backing for elimination of discrimination in law and practice, and vigorous prosecution of those who victimise PLWHA. We call for all Africans, in an individual capacity, as citizens, as members of their families and communities, to address the challenges of safe sex, gender relations, and cultural taboos.
3. *Empowerment of Women.* More than half of those infected by HIV in Africa are women. Women and girls are vulnerable because of cultural, social, economic and political gender inequalities. Rape, sexual violence and domestic violence must be targeted for elimination from our societies. Women and girls must be provided with the knowledge, skills, resources and power to be able to refuse unsafe sex. There must be no double standards when discussing commercial sex work. Women also bear the greater burden of caring for people who are suffering from AIDS. We call for a comprehensive programme for the achievement of women's rights.
4. *Resource Mobilization and Allocation.* Africa's governments are poor, but can devote more resources to HIV/AIDS. Existing mechanisms to support CSOs and community efforts are grossly inadequate. Existing resources mobilized and allocated to combat HIV/AIDS in Africa are scarce and insufficient. We call for

direct funding to CSOs and their networks. We call for African Heads of State to prioritize HIV/AIDS programmes in their legislation, policy making, financing and policy implementation across all sectors. International donors, who have far greater resources, should prioritize HIV/AIDS programmes including prevention, care and the highest quality treatment. African governments should consider receiving loans for AIDS programmes as an immoral commitment, which they should never make on behalf of their citizens. We call for donors to provide grants only.

We also note that the struggle against HIV/AIDS requires a positive environment of economic development, and we call upon international creditors to relieve Africa's unsustainable debt immediately and in full, and provide more resources towards equitable and sustainable development.

CSOs should monitor the commitments made by their Heads of State and Heads of Government to provide more resources to HIV/AIDS. Several of our leaders have pledged to put their nations on a war footing in this struggle. One way in which we shall monitor this is through monitoring spending. We expect to see spending on HIV/AIDS increase, and spending on the military decrease, in the next 12 months, so that HIV/AIDS spending exceeds military spending. If this happens then we will know that our leaders are genuine.

5. *Reduction of the Transmission of HIV.* HIV/AIDS transmission must be reduced through wide-ranging programmes of education, utilizing schools, the media, public education, traditional health practitioners and religious leaders. Youth must be fully involved and empowered at all levels. Economic factors that drive women and men to risky sexual behaviour must be addressed. Condoms should be free and widely available. Treatment for STIs should be readily available and free. Voluntary counseling and testing services should be widely available, professional and confidential. Treatments to minimize mother-to-child transmission should be universally available.
6. *Treatment.* The treatment of People Living with HIV/AIDS is a basic human right. It is also essential to any comprehensive strategy to overcome the virus. Without treatment to enable PLWHA to live longer, healthier, and more productive lives, the stigma attaching to AIDS cannot be removed. Without hope for the future, people will not go for testing, Africa cannot write off 2 million of its citizens, when care and medication that, can radically improve their condition already exist. We do not accept that the necessary drugs are too expensive, as evidence shows that they can be produced for a small fraction of their current market prices. We call upon African governments and the international community to insist on price reductions that make drugs affordable for ordinary Africans, and upon the rights under TRIPS to make use of alternatives including generic manufacture and import to achieve the lowest possible price. We call for expanding the list of essential drugs to include anti-retroviral and drugs for opportunistic infections. We denounce the means used to maintain pharmaceutical companies' excessive profits at the expense of human lives.
7. *Care.* Africans living with HIV/AIDS deserve the highest quality of care. Community-based organizations and families have been caring for PLWHA at

huge cost and with minimal support. We call for substantial support to those providing care at home and within the community for PLWHA. We call for a scaling up of assistance for treatment and care.

8. *Vaccine development.* African People Living with HIV/AIDS and their communities are partners in attempts to develop vaccines against HIV. We call for African governments to adopt the 'African Strategy for an HIV Vaccine of 14 June 2000' so as to actively participate in the global search for a vaccine and to ensure that communities can benefit from the positive product of the trials.
9. *Strengthening CSOs and their networks.* The true partnership requested to effectively respond to this pandemic demands strong, informed, skilled and organized civil society organizations. We call on governments and the international community to support CSOs and their networks financially and technically so that they can play their full role.

The Way Forward

Our common aim and vision is to ignite a social movement encompassing all civil society and governments in a true partnership to overcome HIV/AIDS. Our starting point is the efforts of the existing CSOs and their networks, including especially organizations of PLWHA and the Youth.

We are mindful of the fact that HIV/AIDS is a societal crisis and any effective response must be a social, economic and political response. Creating a mass movement means unleashing the creative energies of ordinary people to empower them to take their destinies into their own hands. The central role is played by CSOs. Governments should play their proper role in designing public policy in a way that will create an enabling environment for a social movement. Donors including international financial institutions should provide resources, in support of the modalities laid down by the African agenda.

We call upon all participants in this Conference to study the true partnership arrived at by the Civil Society Organizations, and to disseminate this through campaigns on their return to their home countries. Governments should disseminate the ideas through meetings, directives and the media. International donors should support these exercises.

We express our gratitude to the President of Nigeria and the Secretary-General of the OAU for the initiative to convene a special OAU Summit on the issue of HIV/AIDS. We, the African CSOs, consider this a significant step forward. It is a signal that our leaders are taking HIV/AIDS with the seriousness that it deserves. We consider the Summit to indicate an irreversible commitment: we shall go forward from here.

To continue with the spirit of ADF 2000, we request that the recommendations from this Forum, including the CSO consensus, be forwarded to the Abuja Summit and presented to all our Heads of State as a major contribution. In the spirit of ADF 2000, we further request that CSOs, including especially those representing PLWHA and Youth, be invited to participate fully and to speak for themselves in the Abuja Summit.

We the CSOs are committed to expanding and strengthening our existing networking and advocacy role. We call on OAU, ECA and African Development Bank together with their partners as part of the post-ADF activities to technically and financially support the existing

networks so as to enable them to effectively fulfill the leadership role at national, subregional, continental and global levels. To this end we propose the creation of a CSO Focal Point at the OAU and ECA.

We, the African CSOs, including PLWHA and Youth, reiterate our commitment to be active partners in a true partnership of collective social mobilization against HIV/AIDS in Africa. We call on our national and continental leaders and our international partners to support our efforts. We believe that if we act together, with honest commitment and common purpose, we shall overcome the HIV/AIDS pandemic in our continent.

C. Position Statements on Gender, HIV/AIDS, and Leadership

Men and women of the Gender Focus Group and Breakout Session on Gender and HIV/AIDS: Roles of Leadership in Social Mobilization, highlighted gender at the ADF 2000 Conference as a crosscutting issue. The participants urged that African leaders, confronted by the HIV/AIDS pandemic, consider the gender dimensions in all efforts to stop its devastation in the Region.

- A. These are the reasons for prioritizing this issue:
1. HIV/AIDS affects men and women differently; this arises from biologically determined differential infectivity rates, and learned cultural values and norms, including early marriage and stereotypes.
 2. Gender roles and power relations impose a disproportionate burden of care and nurturing on women.
 3. Existing policies and programmes are inadequate for addressing gender in equalities in the area of HIV/AIDS.
 4. The rights of women to protection, resources and opportunities are absent from policies and programmes, or are inadequate, inappropriate or not enforced.
 5. Existing legal frameworks also are insufficient to deal with the reproductive rights and gender aspects of HIV/AIDS.
 6. Traditional notions of masculinity lead men to engage in risky sexual behaviour, e.g., multiple sexual partners and assume positions of power vis-à-vis women, including in the negotiations for sex. This promotes the spread of the epidemic.
 7. Exploitative intergenerational sexual relationships, which are largely fuelled by poverty and economic powerlessness, are highly implicated in HIV transmission. Such relationships may be construed as one of the many forms of corruption that African societies must combat.
 8. Gender violence, which is prevalent—and condoned—in many African societies, is highly correlated with HIV transmission. Gender violence is exacerbated during civil strife and conflicts.
 9. In Africa, leaders in most spheres of life are men. Such positions of leadership confer power that facilitates men's access to sex which is often abusive. To access such positions, women are often compelled to use sex. This exposes both men and women to HIV infection.
 10. HIV/AIDS also affects men and women differently in the rural and agricultural sectors. When women are affected by HIV/AIDS, the impact on rural households is greater.

Gender-based Recommendations

Recognizing that all women and men, boys and girls in Africa are included and affected by decisions and actions to fight the pandemic, the gender-focused Meetings at ADF 2000 propose the following priority actions to Governments, Civil Society and the International Partners for immediate attention:

1. *Changing Gender Relations*

- (a) Sensitize leaders about the gender concept and the role that they can play in positively transforming gender relations within their communities.
- (b) Promote new images of masculinity that emphasize male involvement and responsibilities, respect for women's reproductive rights, nurturing and negotiated conflict resolution.
- (c) Promote understanding of women and girls' sexuality and their autonomy rights.

2. *Empowerment*

- (a) Promote empowerment of women at household, community and national levels to enable them assert their sexual and reproductive rights.
- (b) Undertake coordinated action to eliminate gender-based violence.
- (c) Provide equal educational opportunities for both boys and girls.
- (d) Parents and other traditional socializing agents within the family and community (e.g. grandparents, aunts, uncles etc...) must be enabled, through education and sensitization, to offer sexuality information and education to young persons.
- (e) Family life education both in school and out-of-school settings must cover sexuality and gender.

3. *Reproductive and Sexual Health*

- (a) Mother-to-child-transmission: programmes and research to address all aspects of MTCT should be increased.
- (b) Bio-medical research on HIV should be more gender-based. Leaders should ensure that this research is ethical, conducted increasingly by nationals, and that the information derived is locally available for public use.
- (c) Male partners, as far as possible, should be involved in decisions and activities related to reproductive health studies and programmes.
- (d) Drugs should be made available to protect both the child the woman.
- (e) Women should be involved in decision making about what drugs are developed, for whom and on pilot projects in which they participate. Leaders should ensure that they are protected.
- (f) Supportive mechanisms should be put in place, including testing, counselling and comprehensive gender-sensitive services.

- (g) The female condom and the male condom should be made available as a matter of choice for both men and women. Governments should ensure that this device which facilitates female-initiated prevention is included in the procurement of protective devices as means of limiting HIV transmission.
- (h) The decision as to what price is affordable to African couples should be determined at the regional, national and household levels.

Strengthening the Gender Dimension of Leadership

The Meetings endorse these actions to further build gender-sensitive capacity in leaders to address HIV/AIDS:

1. Include a gender perspective in all policies and programmes.
2. Review national and regional frameworks in order to render them responsive to all gender aspects of the pandemic.
3. Integrate HIV/AIDS in all mission statements, mandates, policies and programs of women's groups and movements.
4. Scale up the participation of women in decision-making by ensuring that their representation is at least 30 percent of the total on community, national and international bodies concerned with the disease.
5. Prioritize women's collectives as recipients for resources channelled to CSOs to scale up HIV/AIDS activities.

Post-ADF 2000 Gender-Specific Actions

1. Gender experts and advocates must be included in teams drawing up plans for national and international implementation of the ADF 2000 Consensus Plan of Action, including briefings of political, CSO and other leaders.
2. Women should make up 50 per cent of the delegations that go to the Abuja, OAU and UN Summits held later in 2001.
3. Women must be mobilized to prepare plans and/or step-up actions addressing HIV that can be reported in February and shared in these regional and global meetings.
4. The ECA African Centre for Women (ACW) and the ECA Subregional Offices must accelerate capacity building for HIV/AIDS through training at its Regional Leadership Institutes. Leadership skill-building must be available for men as well as women leaders.
5. UNAIDS, UNIFEM and UNFPA must increase assistance for the mobilization of women and men to address gender inequality more directly through their networks.

D. ILO pre-forum tripartite contribution to the Africa Development Forum 2000

HIV/AIDS and the World of Work

Legal and policy framework:

1. National Action Plan and Policy at the country level should have as an integral part world of work components, including workplace initiatives to combat HIV/AIDS. To this end, such plans and policies should be formulated in consultation with ILO tripartite constituents.
2. The ILO is called upon to develop an international code of good practice on HIV/AIDS in employment as a matter of priority.
3. National action plans should emphasize the link between HIV/AIDS and poverty, and therefore, take into account the importance of productive employment and income-generating activities in policies and programmes to combat HIV/AIDS.
4. Given that women are disproportionately affected by HIV/AIDS, programmes and policies to address HIV/AIDS should recognize the interplay between gender and HIV/AIDS and include action to reduce gender inequalities.
5. At the enterprise level, a joint approach by employees and workers should be adopted to counteract social exclusion and stigmatization in general and to address the problems of discrimination in particular.
6. Issues of HIV/AIDS should be integrated into collective bargaining in the context of social dialogue.

Knowledge and advocacy:

7. Government should cooperate with the social partners in the world of work in the generation and dissemination of information on the problem and impact of HIV/AIDS. The social partners can play an important role in this regard, and all possible means should be explored to collect data and information at the workplace, without jeopardizing confidentiality. In addition, data should be collected on employee benefits and social security as well as on the costs to employers of care and support programmes.
8. Incentives should be put in place to encourage voluntary testing.
9. AIDS education and training programmes should be provided to both managers and workers at the enterprise level and should enjoy the support of workers' and employers' organizations to ensure sustainability.
10. Knowledge and advocacy initiatives undertaken in the workplace should be extended to the wider community in an effort to increase impact of action to combat HIV/AIDS.
11. ILO should collect information on good practices worldwide and disseminate this to its tripartite constituents to support action against HIV/

AIDS at the country level. In addition, the ILO should organize an international tripartite meeting to promote exchange of information and experiences on such practices.

Capacity-building and mobilizing the social partners:

12. ILO should provide support and technical assistance to employers' and workers' organizations and to labour ministries to strengthen their capacity for the effective implementation of national action plans and policies. In particular, training should be provided to shop stewards and workers' educators in the area of HIV/AIDS management in the workplace.
13. The right to life is a fundamental right and every measure should be taken to protect this right. African Governments are therefore urged to take appropriate measures to guarantee access to life-saving and life-prolonging drugs at affordable price, and the possibility to produce low-cost generic drugs.
14. Resource mobilization by the international community to support the global effort to combat HIWAIDS should recognize the vital role of employers' and workers' organizations, and therefore make adequate resources available to those organizations through the ILO for the implementation of workplace initiatives and programmes.

E. The African Diaspora Focus Group Consensus Statement

The African Diaspora are networks of people living in and outside the continent, and who are of direct or indirect African descent who feel inextricably linked to Africa.

Our solidarity is based upon the high prevalence of HIV/AIDS among Africans on the continent and in the Diaspora, as well as, our mutual concern and support for family members and our communities back home.

We support the emerging consensus at the ADF 2000 conference on AIDS: The Greatest Leadership Challenge. Specifically, we draw attention to the ways in which we propose to scale up our support for Africa's fight against HIV/AIDS. We intend to do so through the forging of equal partnerships with our continental counterparts and ensure that our initiatives will be needs driven.

Our commitments:

1. Resource mobilization
 - Continued support for our families and communities affected by HIV/AIDS.
 - Ensure that current ad hoc support and small-scale organized efforts are expanded to be more strategic and proactive.
 - Tap into new sources of funding from foundations, donors, private sector, faith-based communities, and so on.
2. Networking
 - Link African Diaspora groups addressing HIV/AIDS in Africa and in the Diaspora.
 - Work with PLWHA in Africa to connect them with PLWHA in the African Diaspora.
 - Work with youth in Africa to link them with their counterparts in the African Diaspora.
3. Exploitation of intellectual capital
 - Collaborate with African researchers in the Diaspora to stimulate the advancement of basic and operational HIV/AIDS research.
 - Provide clinical, managerial and community based training, as well as, distance learning and scholarships.
4. Advocacy
 - Raise awareness about the benefits of traditional medicine and healing, and advance research and development in this area.
 - Advocate for the protection of indigenous African knowledge.
 - Advocate to redress the unequal power relation between Africa and the north.

- Advocate for debt relief and grants to enable African governments to devote more resources to the fight against HIV/AIDS and other related sectors.
 - Advocate for approaches that support regional collaboration in Africa.
 - Monitor the commitments made by governments in their national action plans.
 - Advocate for the availability of affordable drugs and for the development of the needed infrastructure to manage the drug regimen.
 - Fight against the stigmatization of and discrimination against PLWHA among our own communities in the Diaspora and beyond.
5. Lobbying
- We intend to integrate African perspectives into mechanisms and entities responsible for development of policies related to Africa.

Implications

To realize these commitments, we underline the following actions:

1. Dynamic and effective Diaspora and continental leadership.
2. Recognition of actual and potential role of the African Diaspora.
3. Match resources to needs based on comprehensive analysis of needs; developing a database inventory on the Diaspora resources; identification of interface points; establishment of clearing houses.
4. Monitoring and evaluation through case studies of best practices.

Diaspora Focus Group Members:

- Haileluel Gebre-Selassie, Postgraduate Education Officer at Deaken, University of Australia, Australia.
- John Afele, Director, international Program for Africa, Ontario Agricultural College, Canada.
- Philip Chikezie-Fergusson, President, African Foundation for Development, AFFORD, UK.
- Chizoba Nwagbara, HIV/AIDS/STDs Field Coordinator, Academic for Education Development (AED), Washington, DC., Assistant Chief/Supervisor of Epidemology Activities, Communicable Disease Control, Prince Georges County Health Department.
- Michele Gitu, Pathology Assistant, George Washington University, USA
- Raymond T. Terry, Health Systems Analyst and Coordinator, Health Services Management, University of Maryland, USA.
- Rahel Adamu, Fifty Lemons, USA
- Ramona Tasco, Chair person, African Connections, California, USA

- Gloria Addo Ayensu, Fairfax Country Health, Washington DC, USA
- Belligton Vwalilea, University Teaching Hospital, Obstetrician and Gynaecologist, Lusaka, Zambia
- Joseph N. Ngu, Diaspora Focus Group Coordinator, Economic Commission for Africa, Addis Ababa, Ethiopia.
- Tadesse Wuhib, National Centre for HIV, STD and TB Prevention, Centre for Disease Control and Prevention (CDC), USA
- Belligton Vwalilea, University Teaching Hospital, Obstetrician and Gynaecologist, Lusaka, Zambia

Your Excellencies, Heads of States, Ministers, Chiefs of Diplomatic Missions, Distinguished Representatives of International Organizations, Delegates and Guests, Your Excellencies, Heads of States, Ministers, Chiefs of Diplomatic Missions, Distinguished Representatives of International Organizations, Delegates and Guests,

It is a distinct honor to come before you today. And although I am just a physician, I come to plead the case for the role of the African Diaspora Networks in HIV/AIDS prevention and treatment.

To be clear, the African Diaspora are networks of people living within and outside the continent, who are of direct or indirect African descent, many of whom live in Australia, Canada, the United Kingdom, and the United States. I also note African Americans, Brazilians, Caribbeans, and others who historically were transported from the Continent against their will, and who, nonetheless, feel inextricably linked to Africa.

Many of us are already actively engaged in supporting our families and communities in differing ways, back at home in all parts of Africa.

Many of us have acquired an expertise in successful advocacy, born out of struggles in our respective communities. And thus there are five points of action that we will now present:

First, the African Diaspora is looking for great leadership from Africa. And we stand ready to work with you in partnership, hoping that we can both put aside past misperceptions and mis-characterizations.

In this context, we urge you to look to the African Diaspora as important sources of support. For instance, There are 2700 Nigerian doctors and 700 Ghanaian doctors working in the United States. Moreover, the National Medical Association (NMA), which I represent, is the nation's oldest and largest national, professional and scientific organization, representing the concerns of nearly 26,000 African-American physicians in the United States. Through recent resolutions, we also stand ready to support Africa in the fight against HIV/AIDS.

The Association of Ethiopian Health Professionals in Sweden (AEHPS), has channeled financial resources back to Ethiopia, and has had measurable impact on health-development in targeted communities.

50 LEMONS, a small but growing U.S.-based NGO that raises money targeted for concrete and accountable programmes in research, education, care and support.

Second, we need to create regional frameworks to collaborate and work collectively to tackle the HIV/AIDS crisis. By working together on the basis of common interest, we can leverage regional bargaining power to address HIV/AIDS and other development priorities.

As members of the African Diaspora, our experiences of living in hostile environments has taught us the importance of building bridges among diverse diaspora communities. This is an experience we stand ready to share as we build bridges based on collective solidarity. We cannot afford to be splintered.

Third, we urge you to publicly acknowledge and endorse the important role of African Diaspora Networks as strategic partners in battling HIV/AIDS. Promote the fact that we are not prodigal sons and daughters, but members of the family, who have acquired skills and can produce concrete deliverables valuable to Africa's response to HIV/AIDS, and other conditions of development.

Fourth, many members of the African Diaspora would like to return home and make more direct contributions but we are looking for a stable, conducive environment to enable us to do so. In addition, even those of us who are not ready or able to return, stand ready to contribute support through resource mobilization, technical assistance and use of knowledge networks.

Fifth, in the context of the unequal power relations between Africa and Northern development partners, the African Diaspora can help to ensure that donors do not unreasonably impose their own agendas but rather insure that the beneficiaries on the ground in Africa drive the development agenda.

Finally, we ask that when you need support, think of us first—not last. But above all, think of us.

Thank you.

F. Statement from the religious leaders

Introduction

1. Religious organizations are in an excellent position to communicate ideas and to influence to their congregations because of their daily and weekly contacts with them. Their role of service and care for people strengthens the religious organizations, and their ability to provide a strong leadership role in the fight against HIV/AIDS.

To Government

2. Insofar as religious leaders are very close to the people and promote moral education and activities, religious leaders should be seen as full partners at all levels of government and the United Nations system in the struggle against HIV/AIDS.
3. Governments should ensure that moral education is given a substantial place in the school curriculum.
4. Government should work with religious leaders hand in hand in the provision of social services that will strengthen individuals and communities in the fight against AIDS.

The Religious Leaders

5. Religious bodies must similarly demonstrate their leadership, moral rectitude, responsibility and compassion with activities of prayer, advocacy, education and care.
6. People who are living with HIV/AIDS and their families should be empowered to live as full members of their congregation and communities, and be treated with acceptance, love, dignity, and support.
7. We the religious leaders are committed to provide financial, material, and moral support for the fight against HIV/AIDS in our continent.
8. National religious leaders should establish “Inter-faith”, a council specifically addressing HIV/AIDS.
9. We also agree to commit ourselves in the fight against the factors that fuel the spread of HIV/AIDS such as the socioeconomic condition of women, alcoholism, drug abuse, prostitution, poverty, conflict and civil wars.
10. Finally, the religious leaders agree to develop detailed plans of actions once they hold the religious conference mentioned below.

To the United Nations and other Partners

11. The religious leaders call upon the ECA to collaborate with the religious groups in the implementation of the recommendations of ADF 2000.
12. The religious organizations call on ECA, UNAIDS and other UN agencies for a conference of all African religions to address the role religions can play in the

fight against HIV/AIDS. It is proposed that the African Council of Churches should be consulted if they can enlarge their scope to host a meeting that includes all faiths.

13. There is a need to build the capacity of religious institutions and leaders about the HIV/AIDS pandemic. Accordingly UNAIDS and WHO are called upon to participate in the capacity building of religious institutions on the care, management and prevention of HIV/AIDS.

ANNEX II

FACT: ECONOMIC IMPACT OF HIV/AIDS

Gradual macroeconomic impact

It was understood that the incubation period of HIV (7-10 years) meant that the impact of the epidemic was a gradual decline in economic growth. As the epidemic matured and people living with HIV suffered increasingly from opportunistic infections, the overall health status and productivity of the population declined and domestic savings also fell. Government budgets had started to reflect the rising expenditure on treatment and care of HIV/AIDS-related diseases, benefit payments for AIDS-related deaths and training of new civil servants hired to replace those who have died. In trying to meet these higher costs, fiscal deficits worsen, as few countries were able to cut other spending or raise taxes.

In countries with HIV/AIDS prevalence rates of over 10 per cent, economic output per capita fell by at least 1.0 per cent a year, according to a World Bank survey of 80 developing countries. This contraction increased to 1.4 per cent at prevalence rates of 30 per cent rate.

Further projections by the Bank indicate that at 20 per cent prevalence, economic output would shrink by 2.6 percentage points a year. At the end of a 20-year period, output would be 67 per cent less than it would have been in the absence of HIV/AIDS.

In the case of South Africa, the overall size of the economy was projected to shrink by 17 per cent by 2010, while household per capita income would fall by 8 per cent. Similarly, output in Cameroon, Kenya, Swaziland, Tanzania and Zambia might fall by up to 25 per cent over 20 years.

Household impact

HIV/AIDS has been hitting low-income households particularly hard. One study in 1997 found that the long-term cost of caring for somebody living with HIV/AIDS in Burkina Faso was equivalent to twice the national per capita income. Almost a decade earlier in Democratic Republic of Congo, the hospitalization costs for a child with AIDS were three times the average monthly income, and mean health expenditure for an HIV-positive adult was nearly four times the monthly income.

Table 1: Decline in output in AIDS-affected households in Zimbabwe

Product	Production loss (%)
Maize	61
Cotton	47
Vegetables	49
Groundnuts	37
Cattle	29

Source: Kwaramba, 1997, cited by UNAIDS

Table 2: Adult prevalence of HIV/AIDS in Africa

Country	Prevalence (%)
Botswana	35.8
Swaziland	25.25
Zimbabwe	25.06
Lesotho	23.57
Zambia	19.95
South Africa	19.94
Namibia	19.54
Malawi	15.96
Kenya	13.95
Central Afr. Republic	13.84
Mozambique	13.22
Djibouti	11.75
Burundi	11.32
Rwanda	11.21
Côte d'Ivoire	10.76
Ethiopia	10.63
Uganda	8.30
United Rep. of Tanzania	8.09
Cameroon	7.73
Burkina Faso	6.44
Republic of Congo	6.43
Togo	5.98
Dem. Republic of Congo	5.07
Nigeria	5.06
Gabon	4.16

Table 2: Adult prevalence of HIV/AIDS in Africa (Continued)

Country	Prevalence (%)
Ghana	3.60
Sierra Leone	2.99
Eritrea	2.87
Liberia	2.80
Angola	2.78
Chad	2.69
Guinea-Bissau	2.50
Benin	2.45
Mali	2.03
Gambia	1.95
Senegal	1.77
Niger	1.35
Sudan	0.99
Mauritania	0.52
Equatorial Guinea	0.51
Madagascar	0.15
Comoros	0.12
Mauritius	0.08
Algeria	0.07
Libya	0.05
Tunisia	0.04
Morocco	0.03
Egypt	0.02

Source: UNAIDS, 2000 - 2001

In Kagera, Tanzania, health spending was 8 per cent of annual expenditure in households affected by HIV/AIDS compared with 0.8 per cent in unaffected households. Besides these medical costs in the same region of Tanzania, the high costs of funerals led to changes in patterns of consumption, with food intake dropping by 15 per cent, according to a 1995 study.

In the year following an AIDS death, consumption in some households in Côte d'Ivoire fell by an average of 44 per cent, spending on schooling fell by half and spending on health care rose four-fold, a 1996 study found. In Ethiopia, mean spending on AIDS-related treatment in 1993 was equivalent to between three and eight times the average net farm income.

In Kagera, Tanzania, health spending was 8 per cent of annual expenditure in households affected by HIV/AIDS compared with 0.8 per cent in unaffected households. Besides these medical costs in the same region of Tanzania, the high costs of funerals led to changes in patterns of consumption, with food intake dropping by 15 per cent, according to a 1995 study.

In the year following an AIDS death, consumption in some households in Côte d'Ivoire fell by an average of 44 per cent, spending on schooling fell by half and spending on health care rose four-fold, a 1996 study found. In Ethiopia, mean spending on AIDS-related treatment in 1993 was equivalent to between three and eight times the average net farm income.

Impact on agriculture

It has been estimated that 10 of the 13 principal tasks in farming are done mostly by women and that women produce 60-80 per cent of the food in Africa. Just by linking these estimates with the fact that proportionately more African women are living with HIV/AIDS and are more likely to contract the disease than men, the gravity of the situation was clear. To this burden of illness must be added the household and care functions usually performed by women and which become more onerous with millions of African men also living with HIV/AIDS.

One study of labour time lost to HIV/AIDS found that a Tanzanian woman whose husband is sick spends 45 per cent less time in agricultural tasks. In Ethiopian households affected by HIV/AIDS, women and children did agricultural work for between 11 and 16 hours per week compared with over 33 hours in unaffected households, according to a 1997 study. Reflecting another aspect of the socio-economic impact of HIV/AIDS, a 2000 study in Namibia found that 25 per cent of production time in critical periods was lost due to funeral-related activities.

Such reductions in labour time have had cumulative effects. In Burkina Faso, agricultural households affected by HIV/AIDS saw their net revenue from production fall by between a quarter and a half. Further evidence of production losses came from a 1997 study in Côte d'Ivoire, which found that one method of coping with the debilitating impact of HIV/AIDS – switching from cash crops to food crops – had led to a drop in production by two-thirds of previous levels.

A study of smallholders in the Gweru district of Zimbabwe found that less land was being cultivated because of death and sickness of family members and reduced inputs due to the death of an income earner. Labour shortages meant that fewer tasks were being done, yields

Table 3: Projected losses in labour force due to HIV/AIDS in 29 African countries

Country	Percentage loss relative to situation without HIV/AIDS	
	2002	2005
Benin	-4.8	-2.0
Botswana	-30.8	-17.2
Burkina Faso	-10.5	-8.1
Burundi	-10.5	-6.5
Cameroon	-12.0	-5.5
Central Afr. Republic	-14.4	-10.3
Chad	-6.1	-5.3
Republic of Congo	-9.5	-7.9
Dem. Rep. of Congo	-7.1	-6.7
Côte d'Ivoire	-12.8	-8.0
Eritrea	-5.0	-2.8
Ethiopia	-10.5	-8.3
Gabon	-9.7	-5.0
Guinea-Bissau	-10.2	-4.4
Kenya	-20.2	-8.6
Lesotho	-10.6	-4.8
Liberia	-5.3	-2.0
Malawi	-16.0	-10.7
Mozambique	-24.9	-9.0
Namibia	-35.1	-12.8
Nigeria	-7.5	-3.8
Rwanda	-9.6	-10.7
Sierra Leone	-6.6	-6.1
South Africa	-24.9	-10.8
United Rep. of Tanzania	-14.6	-9.1
Togo	-10.6	-7.4
Uganda	-15.8	-16.3
Zambia	-2.3	-4.7
Zimbabwe	-29.4	-19.7

Source: ILO, *POPILO population and labour force projection, 2000*; UN Population Division, *World Population Prospects, The 1988 Revision, Vol. III, Analytical Report*

were falling with the increasing neglect of cultivated land and some cattle died or were stolen because they could no longer be properly herded. Some farmers also reported that they had sold animal traction and farm implements in order to meet medical and funeral expenses.

Impact on education

In three of the eight countries with prevalence rates of 5-10 per cent, more than 1 per cent of pupils experienced the loss of teachers due to HIV/AIDS-related deaths. In four countries with prevalence rates over 10 per cent, more than 2.5 per cent of students lost a teacher due to HIV/AIDS in 1999. Projections indicate that worse is to come.

It was reported that AIDS was already the leading, known cause of death among teachers in Central African Republic, and an estimated 12 per cent of teachers in South Africa were HIV-positive in 2000, while over 40 per cent of education staff in Malawi could die from AIDS by 2005.

Due to such death and sickness rates, training needs had increased. In order to keep services at 1997 levels in Swaziland, the Education Ministry estimated that it would have to train more than double the number of trainees. To replace Zambian teachers who died of AIDS-related causes by 1995, the cost of recruiting and training replacements teachers was expected to rise by 25 per cent.

According to a 1990 study in Uganda, 47 per cent of households with orphans lacked the money to send children to school compared with 10 per cent of households without orphans. Similarly, school attendance in Tanzania by students aged between 15 and 20 fell by half in households that had lost an adult female due to HIV/AIDS.

School enrolment in several countries has also been increasingly affected by the impact of HIV/AIDS. According to a simulation model, there was a 0.5 per cent fall in 6 year-old children entering school in Swaziland by 1994, increasing to 5 per cent in 2000 and 16 per cent in 2006. As seen above, the impact on orphans has been worse. In Central African Republic, for example, only 39 per cent of orphans are enrolled in school compared with 60 per cent enrolment of non-orphans in the same age group.

Indeed, studies in Uganda have shown that after the death of one or both parents, an orphan's chances of going to school are cut in half. Those orphans who did attend school spent less time there because of the pressure of having to rely increasingly on their own efforts to survive.

Impact on health

By the late 1990s, patients with HIV/AIDS-related illnesses occupied 41 per cent of hospital beds in Abidjan, Côte d'Ivoire, 43-47 per cent in Zambia and at least 50 per cent in Swaziland, Burkina Faso, Democratic Republic of Congo, Uganda and Tanzania. The figures for Zimbabwe in the same period were 50-70 per cent and anywhere between 26 and 70 per cent in South Africa.

These occupancy rates have brought increasing pressure to bear on national health budgets. By 1994, HIV/AIDS accounted for 13 per cent of the Health Ministry budget in Swaziland, while in 1998, around 10 per cent of total health spending in Rwanda was going to the same ends. By 1997, HIV/AIDS-related costs absorbed 11 per cent of the total public health budget

in Côte d'Ivoire, while a year earlier, Malawi's Health Ministry was allocating 20 per cent of its budget for curative care to HIV/AIDS. In Namibia, annual costs of care for AIDS patients are expected to take 13-17 per cent of the health budget by 2001. In Zimbabwe, AIDS-related treatment costs, excluding anti-retroviral drugs, are projected to rise to 61 per cent of the Ministry of Health and Child Welfare budget by 2005.

UNAIDS pointed out that economic data related to the impact of HIV/AIDS have not so far been collected systematically or annually. Having examined some 270 reports and studies, UNAIDS found no studies of the economic impact of HIV/AIDS on communities. It noted that further research at all levels and in key sectors would help policy makers plan more adequate responses to the epidemic.

Impact on business and labour

Most people dying of AIDS were adults in their productive, sexual and reproductive prime. Some 80 per cent of new cases of HIV in Rwanda, Tanzania, Uganda and Zambia were between 20 and 49 years old. This meant that the impact of HIV/AIDS on the workforce has been even more severe than its impact on the general population. Table 3 shows projected labour force losses due to HIV/AIDS in 29 African countries.

According to the International Labour Office (ILO), the population of the 29 African countries most affected by HIV/AIDS would be about 9 per cent smaller by 2020 than it would have been without HIV/AIDS, but the workforce would be more than 12 per cent smaller.

The economic impact of HIV/AIDS, therefore, must also be measured in terms of the quantity and quality of the workforce. It was reported that many people already living with HIV/AIDS are experienced and skilled people on the farms, in the mines and also in white-collar office jobs. The prospect seemed to be general reduction in the average level of skill, experience and training of the workforce in several African countries.

Certain sectors of the workforce were seen to be at higher risk than others. These included miners, transport workers, security forces, teachers, healthcare providers and seasonal workers in agriculture, tourism and construction. One common denominator for most of them was their mobility – ranging from the constant journeys of long-distance lorry drivers to the temporary yet regular migrations of mine workers – and separation from their families. One survey of lorry drivers in East Africa showed that 33 per cent of them were HIV positive. Prevalence rates among bar girls and sex workers at truck stops on their routes were between 44 and 88 per cent.

Concentrations of migrant, male workers – such as those found in mining or plantation agriculture – tended to have a higher incidence of HIV than the general population. Such has been the case for migrant mineworkers in South Africa. The country's Medical Research Council estimated that a quarter of miners were living with HIV/AIDS, a prevalence rate expected to reach 30 per cent by 2005. South Africa's AIDS Society believed the true figure was already closer to 45 per cent.

Another important category of workers at risk was said to be that of health workers where standard protection and sterilization procedures are not followed due to administrative laxity and widespread shortages of basic equipment. The death rate among the staff of one Zambian hospital rose 13 times between 1980 and 1990, due in significant part to HIV/AIDS. In Tanzania's Kagera district, 55 health workers died of AIDS between 1987 and 1993, a high

proportion that led other workers to refuse postings there. Besides the specific risk factors, health workers have also been facing additional stress from the growing need for HIV/AIDS-related care, especially for tuberculosis, which affects around 40 per cent of people living with HIV.

In 1999, in Tanzania, a survey of six firms found that as a result of HIV/AIDS, annual average medical and burial costs per employee had risen 3.5 and 6.1 times respectively between 1993 and 1997. In an early 1990s survey, HIV/AIDS accounted for 53 per cent of all illnesses in five Ethiopian firms over a five-year period and pushed up absenteeism and medical costs. At Anglo Coal in South Africa, workshifts lost due to HIV/AIDS doubled between 1994 and 2000.

Absenteeism has been rising as employees fall ill because of HIV, take time off to care for ailing family members or to attend funerals. Some studies of firms in East Africa showed that absenteeism accounted for between a quarter and half of costs stemming from the disruption of the production, under-use of equipment and temporary staff.

Quality control and reliability of supply were also among the problems identified. When they persist, they could jeopardize the viability of an enterprise. For example, the amount of sugar processed from raw cane dropped by half between 1993 and 1997 in a sugar estate in Kenya.

Such signals of the direct impact of the epidemic on production have been reflected in actual and projected costs. While small enterprises are dependent on a few, key employees are highly vulnerable. Firms in labour-intensive sectors or that provide significant levels of benefits have been also affected. A 1997 study in South Africa found that the total costs of AIDS-related benefits would rise from 7 per cent of salaries in 1995 to 19 per cent by 2005. For five firms in Botswana, AIDS-related costs were projected to increase seven times between 1996 and 2004, to equal 4.9 per cent of the wage bill. In Zimbabwe, the cost of AIDS to the National Railways in 1997 was equivalent to 20 per cent of profits.

HIV/AIDS has been increasing business costs in different ways. Where a firm was already committed to providing significant social benefits, the cost of such benefits has risen due to HIV/AIDS. The fewer the benefits received by staff, the greater the pressure to cope by themselves with their own HIV problems or those of family members. Such pressure had led to rising absenteeism.

Business costs included those related to insurance cover. Life and health insurance premiums were already rising with the possibility of big and early payments to policyholders. In Zimbabwe, the cost of life insurance premiums rose four-fold over a two-year period.

Where firms provided some medical services, the direct costs have been mounting rapidly. Between 1985 and 1995, health costs for employees of a flower farm in Kenya rose ten times, affecting profits so badly that the farm closed down. A similar imbalance between profits and medical benefits also hit the INDENI petroleum refinery in Zambia, a firm that was also paying salaries to relatives of sick workers as well as funeral grants. Such grants have evidently been on the rise due to the normal outcome of HIV/AIDS, and funerals have been a factor in employee absenteeism.

With absenteeism – caused by individual sickness, caring for HIV/AIDS-affected family members, funeral attendance, etc – compounding actual losses of staff, firms have been facing new demands in terms of recruitment, training and retraining. Already a complex process, the

matching of skills to production in the context of the HIV/AIDS epidemic has become more difficult as staff turnover increases. Not only have some firms had to replace lost staff, they may also have to restructure the different aspects of production, realign tasks and skills, sharpen the monitoring of human resources and train or retrain existing personnel. They have had to invest in new or different equipment or machinery, and this in turn has required more highly skilled staff seeking higher wages.

Overall, the economic impact of the HIV/AIDS epidemic has to be measured at several levels. These must include the prospect of lower earnings, declining savings and disposable income, reduced domestic investment and a fall in market demand. Productivity and production in firms are likely to fall along with skill levels, while absenteeism and staff turnover rise. With health care, social security and other social sector costs on the rise, there might be lower government revenue from individuals and enterprises. Some countries could experience a clear decline in their stock of human capital through the death of experienced workers and managers, teachers and other transmitters of functional knowledge. This overall socio-economic climate would continue to act as a disincentive to already low inflows of foreign investment.

ANNEX III

ADF 2000 MEDIA COVERAGE

Background

This year's African Development Forum (ADF) took place on 3-7 December under the theme: "AIDS: The Greatest Leadership Challenge". Approximately 1,500 delegates, including nine Heads of State and Government, civil society and private sector leaders, representatives of intergovernmental organizations and development partners, researchers, academics and the media attended it. This report gives a general idea of the way ECA's Communication Team implemented its communication strategy for the forum.

Pre-Forum activities

The Communication Team's pre-forum activities focused on:

- The Media;
 - Inviting and partly sponsoring approximately 250 African journalists and foreign correspondents (print, radio, television and electronic media) as well as journalists in the delegations and from the United Nations;
 - Facilitating the accreditation of local media and foreign journalists by liaising with the Ethiopian Ministry of Information;
 - Putting up a calendar of press releases (4);
 - Organizing a pre-forum press briefing;
 - Putting up a list of press conferences;
 - Enhancing the capacity of ECA's Media Centre and radio and television studios;
- Preparing media kits for distribution to journalists;
- Producing conference documents: nine thematic and background papers and theme-related publicity material, including the main conference brochure;
- Beginning the production of the ADF documentary;
- Marketing: placing advertisements in the press, on websites and African Internet portals; setting up television, radio and poster campaigns;
- A virtual dialogue:
 - Video-conferencing in collaboration with the World Bank. Nine countries (Benin, Côte d'Ivoire, Ethiopia, Ghana, Mozambique, Nigeria, Senegal, Tanzania and Uganda) participated in a discussion around the theme: 'National responses to HIV/AIDS';
 - An on-line discussion on the ADF2000 Website;
- Collaborating with a Sierra Leonean radio station on a live interactive radio programme on HIV/AIDS: call-in discussion on AIDS awareness in Creole.

- Briefing the local media on ADF communication strategy and the Communication Team's media facilitation at a UNAIDS Workshop for the local media;
- Pre-forum country-level workshops and seminars and;
- A pre-forum civil society meeting.

Forum activities

During the forum, the Communication Team's activities consisted of:

- Organizing daily press briefings; organizing press conferences for UNAIDS, UNICEF, UNFPA, World Bank, Artists Against AIDS and ECA's Executive Secretary; facilitating interviews with delegates;
- Facilitating broadcast media: arranging access to the conference rooms for " TV crews, radio journalists and photographers;
- Assisting the journalists, providing them with documentation, fax and phone lines and access to radio and TV studios;
- Assisting the journalists in the Secretary-General's delegation and assisting the Secretary-General's spokesperson: providing access to documents and to the Internet and conducting a daily review of the international and local press;
- Producing a documentary on ADF2000: interviewing various participants, including ministers, WHO/ World Bank officials and civil society representatives; filming parts of the conference proceedings;
- Contributing articles and human-interest stories, desktop publishing, translating and proofreading the daily newspaper;
- Updating the conference proceedings daily on the ADF2000 website: disseminating speeches, statements, press releases, daily reports and summaries;
- Recording the plenary sessions daily and making copies available to the journalists on demand;
- Broadcasting Best Practices videos daily before each breakout session;
- Covering the Staff Union Fundraising Dinner and editing a cassette for distribution;
- Webcasting video and audio clips on the ADF2000 website;
- Packaging and disseminating knowledge: distributing to all journalists a media bag containing the major background documents for the conference; providing live access to transcripts of the major speeches at the Information Centre and on-line; designing and producing an archival CD-ROM, and distributing it on the last day as well as after the conference;
- Producing badges, nameplates and signboards for UNCC;
- Collecting press clippings on ADF2000 (hard and electronic copies);

- Artists Against AIDS: organizing a live concert featuring four African artists plus Channel O presenters, and live broadcasting on Ethiopian Television and Channel O.

Post-Forum multimedia products

The Communication Team will continue its outreach thanks to:

- A series of CD-ROMs to be distributed to member States, the ADF2000 participants and the African Diaspora:
 - An update of the ADF2000 archival CD-ROM, to be distributed at the Abuja Summit in April 2001;
 - A multimedia CD-ROM on the ADF2000 Documentary, to be ready for the Abuja Summit in April 2001.
 - A multimedia CD-ROM, to be ready in the first week of May 2001;
- The editing of the ADF2000 video documentary and its distribution to major television stations in Africa from mid-March 2001.

ANNEX IV

ADF 2000 Exhibition

ADF 2000 provided exhibition space for featuring the work and the products of pharmaceutical companies, manufacturers and service providers concerned with eradication of AIDS and treatment of AIDS patients, United Nations Specialized agencies, development partners, NGOs involved in AIDS-related training, education, and counselling, and information and communication technology (ICT) firms and projects vital for dissemination of information, particularly in the health sector. Exhibitors had an excellent opportunity to bring some of the products and services being developed to fight the AIDS pandemic to the attention of Africa's leadership.

■ **List of Exhibitors**

African Aids Initiative International
African Creative Consultancy Network
Amba Pharmaceutical
Association François Xavier Bagnoud
African Women's Committee for Peace and Development (AWCPD)
Dawn of Hope
DKT
Economic Commission for Africa (ECA)
Government of Egypt
Equatorial Business Group
Food and Agriculture Organization (FAO)
Horizons Project
International Labour Organization (ILO)
J. Mitra & Co
Network of African People Living with HIV/ AIDS
No Limit for Women Project
Organization of African Unity (OAU)
Publications
Qestmed
The AIDS Support Organization
Southern Africa AIDS Training Programme
Southern Africa Network of AIDS Service Organizations
Southern Africa AIDS Information Dissemination Service
UNAIDS

United Nations Development Programme (UNDP)

United Nations Population Fund (UNFPA)

United Nations Children's Fund (UNICEF)

United Nations Fund for Women (UNIFEM)

Women Fighting Aids in Kenya

World Health Organization (WHO)

World Bank

Worldspace Corporation

■ **Art exhibition**

An exhibition of paintings by the University of Addis Ababa Art School was also on display.

ANNEX V

ADF 2000 Documentation

The following documentation from ADF 2000 is available on the Web at:

<http://www.uneca.org/adf2000>

A. Information documents

- Programme at the glance
- Small ADF 2000 Brochure
- Information for participants
- Conference Brochure/ Programme
- Exhibition manual
- Exhibition Guide
- List of ADF 2000 participants

B. Substantive working documents

- Theme 1: HIV/AIDS and economic development in Sub-Saharan Africa
- Theme 2: Lessons Africa has learnt in 15 years of responding to HIV/AIDS
- Theme 3: Scaling up the response to HIV/AIDS
- Theme 4: Leadership role and approaches for an effective HIV/AIDS response
- Summary of electronic discussion on ADF 2000
- AIDS in Africa: Country by country
- Partnership in leadership at the international level
- Partnership in leadership at the national level
- Partnership in leadership with People Living with HIV/AIDS
- Cost of scaling HIV programme activities to a national level in sub-Saharan Africa: Methods and Estimates
- The need for harmonized data and advocacy materials on HIV/AIDS in Africa with special reference to the PEDA advocacy Model
- HIV/AIDS and education in Eastern and Southern Africa: The leadership challenge and the way forward

C. ADF 2000 reports

- The African Consensus and Plan of Action: leadership to overcome HIV/AIDS in Africa
- The consensus annexes
- The popular report: Leadership at all levels to overcome HIV/AIDS

ANNEX VI

Relevant web sites

ECA:	http://www.uneca.org
UNAIDS:	http://www.unaids.org
UNDP:	http://www.undp.org
UNICEF:	http://www.unicef.org
WORLD BANK:	http://www.worldbank.org
UNFPA:	http://www.unfpa.org
ILO:	http://www.ilo.org

ANNEX VII

ADF 2000 Partners

ADF 2000 Sponsors

Canadian International Development Agency (CIDA)
Government of Japan
Kingdom of Belgium
Kingdom of the Netherlands
Kingdom of Norway
Kingdom of Sweden
Organization of Petroleum Exporting Countries (OPEC) Fund
Turner Foundation
United States Agency for International Development (USAID)

ADF 2000 Supporters

AfricaOnline
AllAfrica.com
Bank of Abyssinia
Brasseries et Glacières International (BGI)
Channel O
Commercial Bank of Ethiopia
East Africa Bottling
Ethiopian Airlines
Hilton Hotel
Kenya Airways
Lufthansa Airways
MIDROC Ethiopia
Moha Soft Drinks Industries
Multichoice
Nice Insurance
ORBIS
Sheraton Addis
Staff Union Committee – ECA (SUC)
United Bank
United Nations Women’s Association (UNWA)
WorldSpace

ANNEX VIII

ADF 2000 Co-organizers

1. UNAIDS and its seven co-sponsors

The Joint United Nations programme on HIV/AIDS is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), the World Bank and United Nations Drugs Control Programme (UNDCP). In its capacity as a secretariat, UNAIDS mobilizes the responses to the epidemic of its seven co-sponsoring organizations and supplements these efforts with special initiatives, by sharing knowledge, skills and best practices across boundaries.

20, avenue Appia
CH-1211 Geneva 27
Switzerland
Phone: +41-22 -791-3666
Fax: +41-22-791-4187
E-mail: unaids@unaids.org
Internet: www.unaids.org

2. International Labour Organization (ILO)

The International Labour Organization as a specialized UN Agency which seeks the promotion of social justice through internationally recognized human and labour rights, is also active in determining the social and economic impact of HIV/AIDS on employers and employees, labour law, social security, equality of opportunity and treatment as well as access to care and drugs.

4, Rue des Morillons
CH- 1211 Geneva 22
Switzerland
Tel.: +41-22-799-6111
Fax: +41-22-798-8685
E-mail: ilo@ilo.org
Internet: www.ilo.org

3. Organization of African Unity

In the context of its core mandate — promoting unity and solidarity of the African States, defending the sovereignty of its members, and promoting international co-operation having due regard to the Charter of the United Nations and the Universal Declaration of Human rights — the OAU has shown specific interest in HIV/AIDS issues in recent years. Several OAU meetings, be they at the Summit level or experts level, have addressed HIV/AIDS.

P. O. Box 3243
Addis Ababa
Ethiopia
Tel: +251-1-51 77 00
Fax: +251-1-51 26 22
E-mail: d.t.orjiako@telecom.net.et
Internet: www.oau-oua.org

SECRETARIAT CONTACTS

For further information, please contact the ADF 2000 Secretariat:

ADF 2000 Secretariat
Economic Commission for Africa
P. O. Box 3001
Addis Ababa, Ethiopia
E-mail: adf@uneca.org
Tel.: 251-1-516513
Fax: 251-1-516563
Website: <http://www.uneca.org/adf2000>