

HIV/AIDS Policy Advisory Committee

**Report of the Inaugural Meeting
18–19 July 2002, Arusha, Tanzania**



Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa

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Correct citation:

Commonwealth Regional Health Community Secretariat. 2002. HIV/AIDS Policy
Advisory Committee: Report of the inaugural meeting, 18–19 July 2002, Arusha,
Tanzania. Arusha: CRHCS.

Contents

Acknowledgements	6
Background	7
Interim membership	8
Main purpose	8
Core actions and activities	9
Membership	10
Areas of expertise	11
Co-opted membership.....	11
Proposed areas for priority HAPAC action.....	11
Behavioural prevention—voluntary counselling and testing	11
Treatment, care and support	12
Adolescent reproductive health.....	13
Health systems and programme development—response plan .	14
Relationship between multisectoral HIV/AIDS councils and commissions and the health sector.....	15
Monitoring and evaluating HIV/AIDS health-sector interventions	16

Strengthening health systems for an expanded HIV/AIDS response in ECSA	17
Abbreviations and acronyms.....	19

Foreword

In the fight against HIV/AIDS, high-level political commitment has been shown to be crucial in taming the tide of the epidemic. This commitment, however, must be accompanied by good policies and it must operate in harmony with a supportive environment that encompasses civil society and its government. With this in mind, the 26th Regional Health Ministers Conference held in Maputo in 1997 resolved that the Commonwealth Regional Health Community Secretariat (CRHCS) would set up a multidisciplinary task force to review the implications of current policies concerning HIV/AIDS prevention, care and support. It also recommended that CRHCS strengthen multisectoral approaches towards HIV/AIDS control and prevention.

Discussions involving the Directors Joint Consultative Committee (DJCC) and the HIV/AIDS Programme Expert Committee (HAPEC) led CRHC to establish the HIV/AIDS Policy Advisory Committee (HAPAC) in consultation with ministries of health in the member states. In setting up this committee the Secretariat was guided by the member states to ensure appropriate regional representation and a good balance of HIV/AIDS-related disciplines.

HAPAC will work with the CRHCS HIV/AIDS programme in collaboration with DJCC, the CRHCS regional secretary and HAPEC in responding to the mandate as directed by the Conference of Health Ministers. It will work to identify priority HIV/AIDS policy issues to strengthen the health sector response of member states to HIV/AIDS and recommend policy to the community organs for adoption.

The committee intends to support CRHCS in identifying, documenting and disseminating best practices on various HIV/AIDS core interventions and to spearhead the development of mechanisms to advocate required policy change and its implementation in the member states. Capacity and mechanisms for monitoring and evaluating the adaptation and implementation of CRHC resolutions and policies by member states will be enhanced, and HAPAC will also be available to the Secretariat to respond to various requests by CRHC bodies and member states.

This publication puts on record the deliberations of the HAPAC inaugural meeting. Objectives and terms of reference for the committee have been agreed upon and are enumerated. The areas of focus of the committee are also presented. It is my sincere belief that the publication will provide a working guide for future HAPAC work in supporting policy development and implementation the ECSA region.

Dr Steven V. Shongwe

Regional Secretary

Commonwealth Regional Health Community Secretariat

Acknowledgements

This publication is a record of deliberations by the CRHCS HIV/AIDS Policy Advisory Committee at its inaugural meeting held on 18 and 19 July 2002 in Arusha, Tanzania.

Contributions of the following committee members are hereby acknowledged: Mr Alfred Chingono, Dr Della Mercedes A. Correia, Prof. Steven Kinoti, Dr Rex Mpazanje, Mr Nhlanhla Nhlabatsi, Prof. John Rwomushana and Dr R.O. Swai.

Ms Cristin Haggard and Ms Leah Sirikwa are thanked for secretarial and editorial work.

Dr Bannet Ndyanabangi

Coordinator, CRHCS HIV/AIDS Programme

Background

The 26th Regional Health Ministers Conference (RHMC) held in Maputo in 1997 resolved that the Commonwealth Regional Health Community Secretariat (CRHCS) would set up a multidisciplinary task force to review the implications of current policies concerning HIV/AIDS prevention and mitigation interventions. It was also recommended that CRHCS strengthen multisectoral approaches towards HIV/AIDS control and prevention.

In April 2000, the Directors Joint Consultative Committee (DJCC) met in Arusha, Tanzania, and recommended that the Secretariat establish a regional multidisciplinary task force to address critical issues relating to care and support including access to and affordability of HIV-related drugs.

During the HIV/AIDS Programme Expert Committee (HAPEC) meeting in Maputo on 18–20 March 2002, it was resolved that the task force be renamed HIV/AIDS Policy Advisory Committee. Initial tasks of this committee include preparing policy briefs for the various organs of CRHC on different disciplines of HIV/AIDS control such as prevention of mother-to-child transmission (MTCT) of HIV; voluntary counselling and testing (VCT), including confidentiality and stigmatization; behaviour change; treatment care and support for people living with HIV/AIDS (PLWHA) including access to antiretroviral drug (ARV) therapy; adolescent sexual and reproductive health aspects of HIV/AIDS interventions; and monitoring and evaluation of HIV/AIDS programmes.

The committee recommended that the Secretariat establish the HIV/AIDS Policy Advisory Committee in consultation with ministries of health of member states and that the Secretariat ensure appropriate regional representation and a good balance of HIV/AIDS-related disciplines. It was further agreed that the ministries of health of the member states select members of the task force using criteria that CRHCS will develop and that this new selection be accomplished by June 2002 to enable the task force have its first meeting in July 2002.

The chair of the CRHCS Expert Committee automatically becomes a member of HAPAC.

The Programme Expert Committee proposed that HAPAC . . .

- Serve as a resource and adviser to CRHCS, the health community's DJCC and the Regional Health Ministers' Conference (RHMC) on priority HIV/AIDS policies.
- Develop terms of reference and procedures of function for itself.

- Agree on criteria for selecting members by member states on a rotating basis and the disciplines to be included in the membership.

This report highlights the deliberations and outcomes of the committee's first meeting, held in Arusha, 18–19 July 2002.

Interim membership

<u>Country</u>	<u>Name</u>	<u>Area of expertise</u>
Malawi	Rex Mpazanje	Care and support (institutional and community)
Mozambique	Della Mercedes	Adolescent reproductive health
Swaziland	Nhlanhla Nhlabatsi	Monitoring and evaluation
Tanzania	Roland Swai	Health systems and programme development
Uganda	John Rwomushana	Policy and advocacy
Zambia	Vilepi Mtonga	Biomedical prevention (VCCT, MTCT, STIs, immunizations, microbicides . . .)
Zimbabwe	Alfred Chingono	Behavioural prevention (social marketing, peer education, faith-based activities, interventions . . .)
SARA/AED	Steven Kinoti	Technical adviser
CRHCS	Bannet Ndyanabangi	Secretary

Main purpose

HAPAC will work with the CRHCS HIV/AIDS programme in collaboration with DJCC, the CRHCS regional secretary and HAPEC in responding to the mandate as directed by the Regional Health Ministers' Conference. Its specific objectives are as follows:

- Identify priority HIV/AIDS policy issues to strengthen the health-sector response of member states to HIV/AIDS, and recommend them to the community organs for adoption.
- Identify, document and disseminate models of good practice for preventing and mitigating HIV/AIDS in developing and implementing policy and programmes on various core interventions.
- Develop policy briefs identified as those most urgently needed on priority issues and mechanisms for disseminating those briefs.

- Develop mechanisms to advocate required policy change and its implementation among member states.
- Develop capacity and mechanisms among member states to monitor and evaluate the adaptation and implementation of CRHC resolutions and policies.
- Regularly review progress in implementing HAPAC's agenda for reporting to various CHRC organs.
- Be available to the Secretariat to respond to various requests by CRHC organs and member states.

Core actions and activities

IDENTIFY PRIORITY POLICY ISSUES FOR STRENGTHENING THE HEALTH SECTOR RESPONSE TO HIV/AIDS OF MEMBER STATES

- Create a framework for the Secretariat to retrieve information on existing policies and the status of their implementation in member states (for example, use of short-term experts to undertake specific analyses; use of in-country organizations and individuals to collect information)
- Make presentations to HAPEC and DJCC for consensus building.
- Work to include draft recommendations into health ministry agendas and lobby for their adoption into resolutions.
- Work with member states to adopt policies and develop policy-linked programmes and activities (for example, workplace interventions)

IDENTIFY, DOCUMENT AND DISSEMINATE BEST PRACTICES ON VARIOUS HIV/AIDS CORE INTERVENTIONS

- Identify documented UNAIDS best practices, find those that are relevant to the HIV/AIDS mandate of CRHC, and promote their dissemination and use.
- Strengthen member states' capacity to document and disseminate best practices in scaling up HIV/AIDS interventions.

DEVELOP POLICY BRIEFS ON IDENTIFIED PRIORITY POLICY ISSUES

- Develop a framework and guidelines for preparing policy briefs.
- Assign relevant experts in the region (including HAPAC members) to originate specific policy briefs.

DEVELOP MECHANISMS TO ADVOCATE AND IMPLEMENT REQUIRED POLICY CHANGES AT MEMBER STATE LEVEL

- Develop presentations on specific issues for country advocacy networks, focal points and programme managers to use.

- Strengthen HAPEC's advocacy role in the member states through partnerships with civil society, the private sector and other groups (for example, support of seminars, sensitization workshops).
- Disseminate policy briefs.

DEVELOP CAPACITY AND MECHANISMS TO MONITOR AND EVALUATE THE IMPLEMENTATION OF CRHC RESOLUTIONS AND POLICIES BY MEMBER STATES

- Compile and keep updated a list of resolutions adopted by CHM and DJCC on HIV/AIDS.
- Develop monitoring and evaluation (M&E) tools and indicators.
- Facilitate country-level collection and compilation of information using the tools.
- Annually present briefs on the status of implementation of policies to DJCC and CHM.

REGULARLY REVIEW PROGRESS IN IMPLEMENTING HAPAC'S AGENDA FOR REPORTING TO VARIOUS CHRC ORGANS

- Compile an annual report on HAPAC's activities for presentation to HAPEC, DJCC, and the ministers of health.

ASSIST THE SECRETARIAT IN RESPONDING TO VARIOUS REQUESTS BY CRHC ORGANS AND MEMBER STATES

- Request DJCC and CHM to approve the terms of reference and commitment of the members of HAPAC.
- Assure commitment by HAPAC members to provide technical assistance when called upon by the Secretariat and member states.

Membership

HAPAC will comprise eight experts. Initially the first eight member states, according to their alphabetical order, will be invited by the HAPAC secretariat to nominate their representative to HAPAC in the area of expertise the secretariat will propose, in one of the eight technical areas of expertise listed below.

To give all member states equal opportunity for membership in HAPAC, each year two member states, selected in descending alphabetical order of country name, will be added while the two at the beginning of the alphabetical order will go out.

The committee will elect its own chairperson annually. However, for continuity, only representatives of member states not due to be

rotated out will be eligible. This allows the chair to remain on the committee for one year after finishing their term as chair.

Areas of expertise

- Policy and advocacy
- Health systems and programme development
- Behavioural prevention (social marketing, peer education, faith based activities, interventions . . .)
- Biomedical prevention (VCCT, MTCT, STIs, immunizations, microbicides . . .)
- Institutional care and support
- Community care and support
- Monitoring and evaluation
- Adolescent reproductive health

Co-opted membership

The committee can co-opt individuals outside the state membership if their expertise is required. The secretariat will maintain an inventory of expertise available in member states for this purpose. The secretariat will use criteria that take into account proximity, costs, regional representation, gender balance, and so on, to select co-opted members for particular meetings.

Development partners, UN agencies and international NGOs can also be co-opted depending on their comparative advantage in the issue at hand. Partners that are currently supporting HAPAC activities, such as USAID/REDSO for East and Southern Africa and the Academy for Educational Development / Support for Analysis and Research in Africa (SARA/AED) project will continue to serve as ex officio members.

Proposed areas for priority HAPAC action

Behavioural prevention—voluntary counselling and testing

VCT services are central to a health-sector response to the HIV/AIDS pandemic. VCT allows persons to know their HIV status, which encourages them to change their behaviour as necessary in primary and secondary prevention of HIV transmission.

VCT services need to be provided as part of the continuum of care for PLWHA. Where a stand-alone VCT model is used, referral networks with other HIV/AIDS care and support services need to be established and maintained. HAPAC will support member states in standardizing VCT in terms of required quality assurance for services,

commodities, facilities and personnel, including possible accreditation.

HAPAC will help member states provide and scale up VCT services in both informal and formal sectors. To ensure that VCT services are implemented as a part of the continuum of care for PLWHAs, countries need to commit themselves to providing treatment, care and support, irrespective of whether the country can currently afford the full cost of care and support services.

Treatment, care and support

A key message from the 2002 International AIDS Conference in Barcelona was that governments must commit themselves to treatment whether it is affordable or not. If policies and programmes exist and are ready for member states to implement, it is possible that the money can be raised from other programmes and sources. This is an urgent message for HAPAC to emphasize to member states of the ECSA region.

HAPAC will also advocate accelerated access to treatment, care and support.

HAPAC recommends that a feasibility study in the ECSA region be undertaken to determine what the costs of specific interventions are. However, lengthy cost-benefit analysis could hold the region back from rapid scaling up of many interventions. The relevant issues regarding treatment, care and support are the size of the problem, resources available, and existing commitment. Feasibility of current and proposed interventions should be based on patterns of spread of the virus, terrain, demographics, resources and other factors in member countries.

More specifically, a feasibility study is needed on providing ARVs in the ECSA region, to determine what the losses and costs incurred will be if ARVs are *not* made available. Policies regarding ARVs urgently need to be created and adopted. A feasibility study is therefore an appropriate starting point.

PROGRAMMES FOR TREATMENT, CARE AND SUPPORT

Programmes in member countries should be working towards increased integration, simplified protocols and policies that are more operational.

Workplace programmes are especially needed for health workers, because the health sector is the most affected by HIV/AIDS and it is crucial to care for the primary caregivers of our region. In designing these types of programmes, HAPAC will stress the concept of integration and collaboration within the health sector. The

International Labour Organisation already has some guidelines in place that HAPAC can adapt to help make workplace recommendations.

THE GLOBAL FUND AND TREATMENT, CARE AND SUPPORT

For all current and new proposals, HAPAC should emphasize that ARVs are to be included in member country applications for monies from The Global Fund to Fight AIDS, Tuberculosis, and Malaria.

An additional issue for HAPAC to discuss regarding Global Fund applications is the current capacity of health systems in member countries. The Global Fund is not intended to finance health systems. HAPAC is faced with responding to the issue of applications being denied because of lack of capacity. To gain access to the funds, capacity needs to be built, and this requires leadership from policy makers in the member states. Only two years ago, DJCC stressed capacity building, and it is important that HAPAC continues to stress this. HAPAC should further strengthen advocacy efforts through the regional advisory boards to affect Global Fund policy.

Adolescent reproductive health

In the ECSA region, youth are disproportionately affected by HIV/AIDS, so therefore youth-friendly services (YFS) need to be established. HAPAC should encourage different approaches, including establishing youth clubs, youth centres and youth-friendly clinics and incorporating HIV/AIDS information in the education curriculum.

Adolescent sexual and reproductive health (ASRH) services are currently more at a technical level than a policy level. ASRH health services in member states face many technical difficulties, and it is necessary to sort out the logistics of services. Models of good service elements need to be in place before they are scaled up and placed in the mainstream of ASRH services in the ECSA region.

HAPAC needs to encourage links in member state health systems. For example, scaling up VCT services should go hand in hand with creating sound, functional referral systems. These links must be in place to increase demand for testing within communities. Through these referral systems, VCT clients will be able to count on further support within the community. These links are currently not in place and that is a fundamental gap HAPAC needs to address.

Services for adolescents, especially in rural areas, are still insufficient in most ECSA countries. The possibility of separate clinics for adolescents or of posting different opening times needs to be considered to improve ASRH services.

Policy issues in ASRH for HAPAC to focus on could include integrating health into school curricula and incorporating material on HIV/AIDS into teacher training curricula. This integration of HIV/AIDS materials into curricula could change behaviour and knowledge in a generation or two.

Health education in schools needs to be approached from various angles. Teachers need to integrate HIV/AIDS education thoroughly. In Mozambique, for example, HIV/AIDS education takes up a substantial proportion of the total curriculum. Ministries of education and health in other countries could produce similar types of materials and curricula for teachers.

HAPAC also needs to look at sustainability of ASRH programmes. For example, in Malawi, as most YFS are donor funded, they are difficult to sustain once the donors pull out. Moreover, the donors frequently revise their programmes depending on recent trends in adolescent sexual and reproductive health (ASRH). HAPAC can recommend that the ministries run such programmes, rather than leave them to the donors

Health systems and programme development—response plan

HAPAC discussed two areas in which the health sectors need to develop an HIV/AIDS response plan: 1) greater involvement of people living with AIDS (GIPA) and 2) development of VCT services for health care providers.

GIPA AND THE HEALTH-SECTOR HIV/AIDS RESPONSE PLAN

The GIPA concept needs to be further explored and guided by national policies. In the past five years, PLWHA were appointed to HIV/AIDS committees and went to workshops and meetings. Unfortunately, they did not actively participate because they were not familiar with such things.

PLWHA can serve as advocates and ambassadors of hope. However, they need to be trained in communication and advocacy skills, so they can lobby and mobilize for HIV/AIDS policy issues.

AIDS organizations have been trying to find and mobilize people who would be good advocates, but few are available who have the needed skills. The Ambassadors of Hope is one possible group with which to collaborate to recruit potential advocates. Their regional headquarters is in Nairobi; they have national chapters, and they offer training in communications and advocacy.

VCT FOR HEALTH CARE PROVIDERS

Another area that needs improvement is VCT services for health service providers. Stigmatization of HIV positive persons is so strong that it is extremely important to create services that are friendly for the health care provider. To help fight the stigma, HAPAC stresses a multiprong approach in responding to HIV/AIDS—developing innovative new ways to carry out VCT, such as introducing community counselling exercises.

Health workers realize that VCT is not confidential because they have access to the records, and therefore they fear they cannot keep their personal information confidential. One suggestion presented is to set up a clinic solely for health workers to keep their confidentiality secure. A secure system of confidentiality needs to be devised that can care for health care providers, and even for civic, political leaders and religious leaders. Also, health care providers, and community and religious leaders, when encouraging others, need themselves to understand what it is like to be pushed to go to be tested.

Finally, HAPAC needs to explore how much it will cost for a continuum of care for infected health workers, with counselling, testing, ARVs, and so on. In addition to the cost assessment, HAPAC must take into consideration how other groups like civil servants will react if the same continuum of care is not made available to them, too. Would people not in the health field get upset about health workers having special access to care?

Relationship between multisectoral HIV/AIDS councils and commissions and the health sector

HAPAC encourages the health sector to address the HIV/AIDS epidemic actively, but first it is essential to establish roles and coordinate responsibilities within the sector. Questions that HAPAC needs to answer are 1) what is the role of the health sector in being a resource for the various other sectors? and 2) how is that role brought into the national, multisectoral arena?

Currently, some NGOs are in partnership with various HIV/AIDS councils and commissions although they are not full-fledged members of them. The existing partnerships are mainly to share information and to coordinate activities. NGOs are free to send their own representatives, and they themselves choose which committees they join.

Another issue HAPAC must address is how to deal with international NGOs that barely work with domestic NGOs. One potential policy to develop could require the international NGOs to work in partnership

with local NGOs already working on similar programmes. HAPAC needs to explore ways to encourage collaboration between international and domestic NGOs.

Health-sector responses to combating HIV/AIDS are declining, so it is now more important than ever to define and coordinate its roles, individually and collectively. HAPAC could develop a multisectoral guideline with all the different health care providers and policy makers outlining specifically what each sector's responsibilities are. Each sector needs to understand and define its responsibilities. The capacity of the multisectoral response will increase through this type of joint planning, monitoring and review. By including all the relevant ministries, none will feel left out, and all will be encouraged to develop the best possible plan.

To improve the relationship between the different sectors and the commissions, it is important to regularly bring both groups together to exchange views on how to collaborate to respond to the HIV/AIDS epidemic.

Monitoring and evaluating HIV/AIDS health-sector interventions

The first task for HAPAC is to develop a strong M&E system based on what it has learned through programme and policy implementation, and to follow that by creating a core set of indicators.

HAPAC needs to help develop M&E programmes that can document both behaviour and incidence changes. As these programmes are developed, a minimal framework is needed for each country to use as a baseline with the resources that it possesses.

HAPAC should look at health care M&E through joint meetings with commissions to clarify areas that each sector needs to monitor. M&E and indicators are of value only if they are used to respond to the epidemic, and all monitoring should be linked to action. For example, population surveys should come as part of a package that can be coupled with a specific programme.

Measuring national HIV/AIDS response is coordinated through the HIV/AIDS commissions. These commissions should develop their own M&E plans, which would help other sectors evaluate their activities, both inputs and outputs.

HAPAC should thus be familiar with what types of M&E the member states are already using. It is unnecessary to reinvent the wheel and design new programmes. Many organizations, such as USAID,

UNAIDS, and WHO, have already published indicators for HIV/AIDS M&E systems, and member states can readily adapt them.

Centers for Disease Control and Prevention (CDC) is also currently involved in putting resources into M&E in all member states. HAPAC feels that the region needs to move beyond the current capacity of the CDC approach and link data nationally. HAPAC sees that one of its responsibilities is to stimulate regional countries to adapt and adopt some of these existing M&E systems.

When, and if, ARVs are included in treatment, care and support plans, prevalence cannot be a measuring guide since increased survival of patients will lead to an increase in prevalence, yet incidence may or may not be changing. However, unless people actually carry out some cohort studies to get incidence data, they will continue collecting prevalence data.

What, then, is the core indicator, and of what is it composed? How does one evaluate each piece of data to judge how the programme is doing?

Another important issue in M&E is determining the place and relevance for national sero-prevalence surveys. If they are reasonably staggered and not too frequent, they may be of some use.

An additional question is at which level is the M&E carried out, and how is the same system used to evaluate different interventions? How can HAPAC make sure that M&E is adapted to be relevant in all the various sectors?

Finally, even with the need for developing improved M&E systems, care must be taken that adequate investment is made in interventions before a disproportionate amount of resources is invested in M&E. M&E can be expensive, for conducting it takes a lot of time.

Strengthening health systems for expanded response to HIV/AIDS

HAPAC has noted that member states are increasingly recognizing that they must strengthen the infrastructure of their health systems. In particular, they must increase the skills and capabilities of those providing health care and they must improve management skills. HAPAC will follow with keen interest how present health systems assess the impact they are making on the HIV/AIDS epidemic, and it will use their assessments to improve the skills of both the health workers and the management of them in the member states.

HAPAC noted the increasing recognition of strengthening health systems infrastructure, in particular the human capacity and management elements. It will follow with keen interest the assessments of the impact of HIV/AIDS on the health systems that are ongoing and planned, and it will facilitate use of the results in developing better human capacity and management skills in member states.

Abbreviations and acronyms

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral [drug]
ASRH	adolescent sexual and reproductive health
CRHC	Commonwealth Regional Health Community
CRHCS	Commonwealth Regional Health Community Secretariat
DJCC	Directors Joint Consultative Committee
AED	Academy for Educational Development
GIPA	greater involvement of people living with AIDS
HAPAC	HIV/AIDS Policy Advisory Committee
HAPEC	HIV/AIDS Programme Expert Committee
HIV	human immune deficiency virus
M&E	monitoring and evaluation
MTCT	mother-to-child transmission [of HIV]
PLWHA	people living with HIV/AIDS
REDSO	Regional Economic Development and Services Office [of USAID]
RHMC	Regional Health Ministers' Conference
SARA	Support for Analysis and Research in Africa
STI	sexually transmitted infection
UNAIDS	United Nations AIDS Programme
USAID	United States Agency for International Development
VCCT	voluntary confidential counselling and testing [for HIV]
WHO	World Health Organization
YFS	youth-friendly services