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APPRAISAL REPORT

Multinational

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY

**SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES (HIV/AIDS,
TUBERCULOSIS AND MALARIA)**

SOCIAL DEVELOPMENT DEPARTMENT
NORTH, EAST AND SOUTH REGION

March 2006

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This report was prepared by Mrs. B. BA, Principal Health Analyst and Team Leader, Mrs. G. GEISLER, Senior Gender Specialist and Mr. M. AYIEMBA, Senior Architect following their appraisal mission to Botswana in February-March, 2005. It was updated following further missions to Southern Africa in February and March 2006. Any further questions relating to the report may be addressed to Mr. T. B. Ilunga, Division Manager, ONSD2 (2117) or Ms. A. Hamer, Director, ONSD (2046).

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PROJECT INFORMATION SHEET

Date : March 2006

The information given hereunder is intended to provide some guidance to prospective suppliers, contractors, and all persons interested in the procurement of goods and services for projects approved by the Boards of Directors of the Bank Group. More detailed information and guidance should be obtained from the Executing Agency and the Beneficiary.

- | | | | |
|----|-----------------------------------|---|--|
| 1. | COUNTRY/REGION | : | Southern African Development Community (SADC) |
| 2. | NAME OF PROJECT | : | Support to the Control of Communicable Diseases (HIV/AIDS, TB, Malaria) |
| 3. | GRANT BENEFICIARY | : | SADC ADF Member States (Angola, Democratic Republic of Congo, Tanzania, Zambia, Lesotho, Zimbabwe, Malawi, Mozambique) |
| 4. | LOCATION | : | SADC Secretariat, Member States |
| 5. | EXECUTING AND IMPLEMENTING AGENCY | : | SADC Secretariat/DSHDSP-/Bag0095, Gaborone, Botswana, Tel : (267)3951863; Fax: (267) 397 2848 |
| 6. | PROJECT DESCRIPTION | | The project will comprise the following components: (i) Strengthening capacity to harmonize policies, protocols and guidelines for the control of communicable diseases by SADC secretariat; (ii) Increasing capacity to implement harmonized policies protocols and guidelines in SADC Member States; (iii) Upgrading of the regional communicable disease surveillance systems; (iv) Improving the sustainable availability of essential medicines; (v) Scaling up OVC Best Practices in SADC MS |
| 7. | PROCUREMENT | | In accordance with the Bank's Rules of Procedure for Procurement of Goods, Works and Services and SADC's Procurement Rules. |
| | Goods | | International Shopping (IS), ICB and NCB to be used where appropriate |
| | Consultancy services | | Short-listing |

8.	TOTAL COSTS	:	Total: UA 22.226 million Foreign: UA 7.477 million Local: UA 14.748 million
9.	ADF FINANCING (Grant)	:	UA 20.000 million
10.	OTHER SOURCES OF FINANCE	:	SADC: UA 2.226 million
11.	DATE OF APPROVAL	:	May 2006
12.	ESTIMATED STARTING DATE AND DURATION	:	August 2006 for 60 Months
13.	CONSULTANCY SERVICES REQUIRED:		Technical assistance staff, consultants, studies

CURRENCY EQUIVALENTS

1 UA = US\$ 1.43503
(As at March 2006)

THE SADC SECRETARIAT'S FISCAL YEAR

1 April – 31 March

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LIST OF ABBREVIATIONS

ADF	African Development Fund
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti –Retroviral drugs
BCC	Behavioural Change Communication
BNLS	Botswana, Namibia, Lesotho, Swaziland
BP	Best practice
CBO	Community-based Organisation
CD	Communicable Diseases
DFID	Department for International Development
DRC	Democratic Republic of Congo
EU	European Union
FBO	Faith-Based Organization
FE	Foreign Exchange
GDP	Gross Domestic Product
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
ICP	International Cooperating Partners
IEC	Information, Education, Communication
ILO	International Labor Organization
IMR	Infant Mortality Rate
IPT	Intermittent Presumptive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
LC	Local Cost
KfW	Kreditanstalt für Wiederaufbau
MDG	Millenium Development Goals
MS	Member States
NAC	National AIDS Council
NACP	National AIDS Control Programme
NEPAD	New Partnership for African Development
NGO	Non Governmental Organization
OI	Opportunistic infections
OVC	Orphans and Vulnerable Children
PID	Project Implementation Document
PMTCT	Prevention of Mother to Child Transmission
PLWA	Persons Living with AIDS
PSC	Project Steering Committee
PSI	Population Services International
QPPR	Quarterly Project Progress Report
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern Africa Development Community
SATCI	Southern African Tuberculosis Control Initiative
SATCC	Southern Africa Transport and Communications Commission
SNC	SADC National Committee
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TOT	Training of Trainers
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
RBM	Roll Back Malaria
TA	Technical Assistance
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

PROJECT MATRIX - LOGFRAME

HIERACHY OF OBJECTIVES	EXPECTED RESULTS	REACH	PERFORMANCE INDICATORS Source Method	INDICATIVE TARGETS AND TIME FRAMES	ASSUMPTIONS/RISKS
SECTOR GOAL To attain an acceptable standard of health for all citizens of SADC Member States.	<u>Longer Term Outcomes</u> An improvement in health and longevity among the people of the SADC region	SADC citizens	INDICATORS Average Life Expectancy <u>Sources</u> MS Health Statistics Communicable Diseases Surveillance	By year 2015 SADC Average Life expectancy increased by 5 years from 40 to 45 Have halted and begun to reverse the spread of HIV Have halted and begun to reverse the incidence of malaria Have halted and begun to reverse the incidence of TB	
PROJECT OBJECTIVE To contribute to regional integration through the harmonize control of communicable diseases (HIV/AIDS, tuberculosis and malaria) in the SADC region	<u>Medium Term Outcomes</u> Reduction in morbidity and mortality due to HIV/AIDS, TB, and Malaria in the SADC region	SADC citizens	INDICATORS <ul style="list-style-type: none"> • HIV prevalence • TB Incidence • Deaths from Malaria <u>Sources</u> SADC secretariat, MS disease surveillance systems	By year 2010 <ul style="list-style-type: none"> ▪ Reduction in HIV prevalence of among women aged 15-24 of 1% ▪ Incidence of tuberculosis in the region reduced by 20% ▪ malaria mortality in the region reduced by 20% 	<u>Assumption</u> Commitment by SADC to implementation of its Health Protocol; <u>Risk indicator</u> low
<u>ACTIVITIES/ INPUTS</u> <ul style="list-style-type: none"> ▪ recruit 1 communicable diseases (ATM) coordinator , 1 policy analyst, 1 gender specialist, 1 M&E specialist at SADC secretariat ▪ update priority policies, strategies and guidelines to be harmonized ▪ organize workshop with SNCs on harmonization of policies, strategies and guidelines ▪ develop guidelines for pediatric treatment of OIs and HIV/AIDS ▪ organize workshop for SADC health policy makers on harmonized policies ▪ conduct Training of SADC secretariat in gender analysis ▪ develop harmonized IEC on communicable diseases ▪ Disseminate harmonized IEC in 3 languages 	<u>Short Term Outputs</u> 1) Improved capacity to harmonize policies, protocols and guidelines on the control of communicable diseases by SADC secretariat;	SADC SHDSP Directorate, Communicable Disease Control Managers in MS	INDICATORS <ul style="list-style-type: none"> ▪ Percent of new regional communicable disease policies, treatment guidelines and protocols approved by all MS ▪ Number of SADC staff trained in gender analysis ▪ Number of SADC programs mainstreamed gender and HIV/AIDS ▪ Number of countries using new IEC modules <u>Sources</u> SADC secretariat Quarterly progress reports; Training Reports	Between 2006 and 2010 <ul style="list-style-type: none"> ▪ communicable disease policies protocols and guidelines for 3 diseases harmonized ▪ 5,000 persons trained in gender analysis ▪ Gender mainstreaming mechanisms implemented in all SADC programs ▪ IEC modules for communicable diseases developed in three SADC languages and disseminated to MS 	<u>Mitigation Strategy</u> (i)Recruitment of health unit staff to oversee implementation of Health Protocol is underway; (ii)The Implementation Plan of the SADC Health Protocol is now completed with priorities for the first five years focused on the control of communicable diseases.; (iii)WHO (Roll Back Malaria) is expected to provide the SHDSP Directorate with a Malaria Specialist who will deal with all SADC countries. <u>Assumption</u>

<ul style="list-style-type: none"> ▪ organize Training of Trainers for MS communicable diseases managers on harmonized policies, protocols and guidelines ▪ organize TOT for MS on pediatric treatment for OIs and HIV/AIDS ▪ Train MS IEC managers on harmonized IEC ▪ Workshops for national public broadcasters on IEC for communicable diseases ▪ conduct Training for MS in gender analysis 	2) Increased capacity to implement harmonized policies strategies and protocols in SADC MS	SADC SHDSP Directorate, Communicable Disease Control Managers in MS	<ul style="list-style-type: none"> ▪ Number of MS implementing new frameworks ▪ Number of ADF MS implementing standardized DOTS strategy ▪ Number of MS conducting national training on treatment of pediatric OIs and HIV/AIDS <p><u>Sources</u> SADC secretariat Quarterly progress reports; Training Reports</p>	<ul style="list-style-type: none"> ▪ Common malaria treatment protocols and guidelines utilized by all SADC countries ▪ Standardized DOTS expanded in all 8 SADC/ADF ▪ Health providers in member states trained in pediatric treatment for OIs and AIDS 	<p>The donor community continues to support the Secretariat.</p> <p><u>Risk indicator</u> Low</p> <p><u>Mitigation Strategy</u></p> <p>SADC ICPS have committed support to SADC HIV/AIDS Business Plan and signed Joint Financing Technical Cooperation Arrangement</p>
<ul style="list-style-type: none"> ▪ develop common set of indicators for communicable diseases ▪ develop draft framework for cooperation on communicable disease surveillance ▪ Develop regional CD surveillance system ▪ Train MS HMIS managers on regional CD surveillance system ▪ Install CD surveillance system in 8 ADF MS* ▪ develop regional tele-health system for all three communicable diseases (Malaria, HIV/AIDS and TB); ▪ identify regional reference laboratories to support diagnostics for communicable diseases 	3) Effective regional communicable disease surveillance system operational	MS Health Sectors MS HMIS managers	<ul style="list-style-type: none"> ▪ Common set of indicators for communicable diseases developed ▪ Number of MS utilizing Regional tele-health system; ▪ Number of regional Reference Laboratories identified; <p><u>Sources</u> SADC secretariat Quarterly progress reports;</p>	<ul style="list-style-type: none"> ▪ Common set of indicators for communicable diseases adopted by all MS ▪ Regional tele-health system established; ▪ Network of Regional reference laboratories established; 	<p><u>Assumption</u></p> <p>All Member States ensure participation of their representatives in all the processes</p> <p><u>Risk indicator</u> low</p> <p><u>Mitigation Strategy</u></p> <p>(i) Dialogue with Member States early in the project design process; (ii) Additional meetings are planned with Member States policy makers in order to discuss the project proposal including the outputs related to policy harmonization.</p>
<ul style="list-style-type: none"> ▪ Carry out feasibility studies on regional manufacturing of essential medicines ▪ Carry out study to identify bottlenecks in procurement of essential drugs ▪ Develop regional bulk procurement policy/agreements for the region ▪ Develop common tools and expertise for forecasting drug needs ▪ Train pharmaceutical managers in tools for forecasting ▪ Hold annual workshops on use of medicines for AIDS, TB and malaria ▪ Hold annual workshops for drug regulatory authorities ▪ Organize policy dialogues on regional strategy for bulk procurement and or manufacturing; ▪ Conduct study on use of indigenous medicinal plants for the treatment of communicable diseases ▪ develop an advocacy document to promote the use of indigenous medicine in the treatment of HIV/AIDS, TB and Malaria. 	4) Improved and sustainable availability of essential medicines	MS Health Sectors MS drug regulatory authorities MS pharmaceutical managers for public health sector	<ul style="list-style-type: none"> ▪ Regional policy and agreements on bulk procurement developed; ▪ Common tools for forecasting drug needs developed; ▪ Advocacy document on the use of traditional medicines in the treatment of the three communicable diseases completed; <p><u>Sources</u> SADC secretariat Quarterly progress reports;</p>	<ul style="list-style-type: none"> ▪ Regional bulk procurement policy implemented. ▪ Common drug forecasting tools in use in all MS ▪ Dissemination of advocacy document on the use of traditional medicine in all MS 	<p><u>Assumption</u></p> <p>All Member States meet their commitments to implement new policies, protocols and guidelines</p> <p><u>Risk indicator</u> low</p> <p><u>Mitigation Strategy</u></p> <p>i) ADF countries will be assisted with funding for implementation of the new policies, protocols and guidelines through training and dissemination activities;</p>
<ul style="list-style-type: none"> ▪ hold national consultative workshops in each MS with 	5) OVC Best Practices scaled up in MS	MS Health sectors CBOs NGOs involved in	<ul style="list-style-type: none"> ▪ OVC treatment and care BPs identified in all MS 	<ul style="list-style-type: none"> ▪ Documented BPs peer reviewed by MS 	

<p>stakeholders involved in OVC treatment and care interventions;</p> <ul style="list-style-type: none"> ▪ identify OVC treatment and care BPs in MS; ▪ document BPs that meet SADC criteria; ▪ Undertake National peer review of documented BPs ; ▪ Organize meeting of technical committee to review SADC BPs ▪ Develop data base of SADC Bps ▪ Implement pilot scale up of BPs; ▪ Conduct Evaluation of implementation of scaled up Best Practices. 		<p>OVC treatment & care services UNICEF</p>	<ul style="list-style-type: none"> ▪ OVC treatment and care BPs documented in all MS ▪ Mechanism for selection of BPs for scaling up developed <p><u>Sources</u> SADC secretariat Quarterly progress reports UNICEF</p>	<ul style="list-style-type: none"> ▪ SADC BPs reviewed by regional technical committee ▪ Selected OVC treatment and care best practices scaled up in pilot MS 	<p>(ii) Through consultations with policy makers and communicable disease managers MS will be asked to make specific plans for implementation as required by the SADC Health Protocol to which they are signatories.</p>
<p>Inputs</p> <p>ADF grant of UA20 million, SADC contribution of UA 2.226 million</p> <p>Categories Million UA</p> <p>- Goods 4.526</p> <p>- Services 14.939</p> <p>-Operating Cost 2.230</p> <p>-Miscellaneous 0.532</p> <p>Total 22.226</p>	<p>Project coordination team in place at SADC secretariat</p>	<p>All project beneficiaries and target populations</p>	<ul style="list-style-type: none"> ▪ Grant Agreement signed and made effective <p><u>Sources</u> SADC secretariat Quarterly progress reports;</p>	<ul style="list-style-type: none"> ▪ Project coordination staff recruited ▪ Operating costs made available 	

EXECUTIVE SUMMARY, CONCLUSIONS AND RECOMMENDATION

1. PROJECT BACKGROUND

The poverty situation in the region is largely reflected in the low levels of income and high levels of human deprivation. Communicable diseases (namely HIV/AIDS, tuberculosis and malaria) are the major contributors to the burden of diseases and poverty in the SADC countries. According to UNAIDS, the SADC Member States account for 35% of people living with HIV/AIDS in the world. 40% of people with HIV infection are co-infected with tuberculosis. Malaria is responsible for up to 30% of outpatient visits and 40% of inpatients. In response, Governments in the region established national strategic plans for the control of the spread of the three diseases. Similarly, the SADC established a framework for regional responses in order to curb the spread and minimize the impact of these diseases.

Following the dialogue between the Bank and SADC on possible ADB assistance to support communicable diseases control, the Bank fielded in September 2002 a mission to identify ways and means to assist the SADC in its endeavor to counter these diseases. In October 2002, SADC sent an official request to the Bank for funding the present project. Based on recommendations of the identification mission and the Bank's analysis of the SADC's request, a preparation mission was undertaken in November 2003. The mission concluded that the project was viable and recommended that the proposed activities be implemented in all SADC member states.

Since the available resources could be used for SADC ADF countries only, the Bank launched a search for bilateral funding to cover SADC ADB countries as well. Subsequently, it was realized that these countries were targeted by another project financed by USAID. Consequently, the appraisal mission was launched in February-March 2005 to evaluate project activities in SADC ADF member states. Furthermore, post appraisal missions were undertaken in February and March 2006 to update the report and discuss issues raised during the first presentation of this project to the Board of Directors in November 2005. The project was subsequently redesigned in view of the comments of the Board and the findings of subsequent missions. The main changes to the project include: a consolidation of activities related to building the capacity of SADC secretariat to harmonize policies and coordinate their implementation, removal of cross-border interventions and addition of an output on scaling up OVC best practices to address a major impact of the HIV/AIDS epidemic in the region. The proposed project will contribute towards SADC's goal of achieving increased economic integration and development as well as the sector goal of attaining an acceptable standard of health for all citizens within the objective of 'Health for All' by 2020 in all SADC member states. This would be achieved through, amongst others the reduction of morbidity and mortality due to HIV/AIDS, tuberculosis and malaria among the most vulnerable groups within the SADC.

2. PURPOSE OF THE GRANT

The ADF grant of UA 20 million (90.0%) of total cost will finance 100% of the foreign cost (UA 7.477 million) and 84.9% of local costs amounting to UA 12.523 million.

3. SECTOR GOAL AND PROJECT OBJECTIVE

The sector goal is to attain an acceptable standard of health for all citizens within the objective of "Health for All" by 2020 in all the SADC member states. The objective of the

project is to contribute to regional integration through the harmonized control of communicable diseases (HIV/AIDS, tuberculosis and malaria) in the SADC region.

4. **BRIEF DESCRIPTION OF THE PROJECT**

4.5.1 In order to achieve this objective, the proposed project, will build the capacity of SADC secretariat to harmonize regional communicable disease control efforts and support the implementation of harmonized policies protocols and guidelines for prevention care and treatment of communicable diseases in MS. In the long term the project is expected to result in increased life expectancy in the SADC region. In the medium term, the expected results arising from project interventions will be a reduction in morbidity and mortality due to the three major communicable diseases, HIV/AIDS, TB and Malaria. The project interventions although regional in focus will realize results at country level thereby benefiting the people of the SADC region.

4.5.2 The expected project outputs include:

- i. Improved capacity to harmonize policies, protocols and guidelines for the control of communicable diseases by SADC secretariat;
- ii. Increased capacity to implement harmonized policies protocols and guidelines in SADC Member States;
- iii. Effective regional communicable disease surveillance system operational;
- iv. Improved and sustainable availability of essential medicines;
- v. OVC Best Practices scaled up in Member States.

5. **PROJECT COSTS**

Total project cost including contingencies is estimated at UA 22.226 million, of which UA 7.477 million (33.6%) will be in foreign exchange and UA 14.748 million (66.4 %) will be in local costs.

6. **SOURCES OF FINANCE**

The project will be financed by ADF and SADC. The ADF grant of UA 20 million will finance 100% of the foreign cost (UA 7.477 million) and UA 12.523 million of local costs equivalent to 90.0% of total costs. SADC financing (local costs) amounts to UA 2.226 million or 10.0% of total costs. It will finance operating costs, office space and local transportation costs. The ADF grant will finance technical assistance, equipment, office furniture, consultancies, training and recurrent costs, drugs as well as the cost of producing various project publications.

7. **PROJECT IMPLEMENTATION**

The project will be implemented over a period of 5 years. The executing agency of the project will be the SADC Secretariat.

8. **CONCLUSIONS AND RECOMMENDATION**

HIV/AIDS, tuberculosis and malaria are major causes of mortality, morbidity and poverty in the SADC countries. In response, the SADC has adopted strategies for the control of the three diseases. The strategies are in line with the SADC's vision, which is focused on the well-being, the improvement of the standards of living and quality of life, the freedom and social justice and peace and security of the peoples of Southern Africa. The project will

contribute to SADC's efforts to reduce the incidence and prevalence of communicable diseases among its most vulnerable population groups and will strengthen its capacity to coordinate policy and monitoring of communicable diseases. Attainment of this objective will contribute to SADC's effort to improve the health status of the population and to curtail the spread of HIV/AIDS, tuberculosis and malaria. It is recommended that the Fund considers extending an ADF grant not exceeding UA 20 million to SADC to implement the project as described in this proposal.

1. ORIGIN AND HISTORY OF THE PROJECT

1.1 The SADC was formed in 1992, replacing the Southern African Development Co-ordination Conference (SADCC). It has 14 member States after Seychelles revoked its membership in 2004 and Madagascar joined the organisation. They are : Angola, Botswana, Democratic Republic of Congo (DRC), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. The region with a population of 234 million, covers a land area representing 38 per cent of Sub-Sahara Africa and is home to 30% of its population. Poverty in all its dimensions is one of the major development challenges facing the SADC region. The poverty situation in the region is largely reflected in the low levels of income and high levels of human deprivation. According to the ADB 2004 annual report, on the basis of the international extreme poverty line of US\$ 1 a day, poverty in the region ranged from 11.5 percent to 64%. The average HDI (Human Development Index) for the Southern Africa region was 0.508 which is higher than the continental average of 0.485.

1.2 Communicable diseases (namely HIV/AIDS, tuberculosis and malaria) are the major contributors to the burden of diseases and poverty in the SADC countries. According to UNAIDS, the SADC states account for 35% of people living with HIV/AIDS in the world, and 40% of people with HIV infection are co-infected with tuberculosis. Malaria is responsible for up to 30% of outpatient visits and 40% of inpatients. In response Governments in the region established national strategic plans for the control of the spread of the three diseases. Similarly, the SADC established a framework for a regional response in order to curb the spread and minimize the impact of these diseases. The regional response is in line with the SADC's vision, which is focused on the well-being, improvement of the standards of living and quality of life of the peoples of Southern Africa. It will contribute towards the goals of achieving increased economic integration and development in the SADC member states, through a reduction of the incidence and prevalence of communicable diseases (HIV/AIDS, tuberculosis and malaria) among the most vulnerable groups within the region. Included amongst the most vulnerable groups are the growing numbers of orphans and vulnerable children (OVC).

1.3 Following the dialogue between the Bank and SADC on possible ADB assistance to support communicable diseases control, the Bank fielded in September 2002 a mission to identify ways and means of assisting the SADC in its endeavour to counter these diseases. In October 2002, SADC sent an official request to the Bank for funding the present project. Based on the recommendations of the identification mission and the Bank's analysis of the SADC request, a preparation mission was undertaken in November 2003. The mission concluded that the project was viable and recommended to implement the proposed activities in all SADC member states. Since the available resources could be used for SADC ADF countries only, the Bank launched a search for bilateral funding to cover SADC ADB countries as well. Subsequently, it was realized that these countries were targeted by another project financed by USAID. Consequently, the appraisal mission was launched in February-March 2005 to evaluate project activities in SADC ADF member states. Furthermore, post appraisal missions were undertaken in February and March 2006 to update the report and discuss the issues raised during the first presentation of this project to the Board of Directors in November 2005. The project was subsequently redesigned in view of the comments of the Board and the findings of subsequent missions. The main changes to the project include: a consolidation of activities related to building the capacity of SADC secretariat to harmonize policies and coordinate their implementation, removal of cross-border interventions and addition of an output on scaling up OVC best practices to address a major impact of the HIV/AIDS epidemic in the region. The proposed project will contribute towards SADC's goal of achieving increased economic integration and development as well as the sector goal of attaining an acceptable standard of health for all citizens within the objective of 'Health for All' by 2020 in all SADC member

states. This would be achieved through, amongst others the reduction of morbidity and mortality due to communicable diseases (HIV/AIDS, tuberculosis and malaria) among the people of SADC.

1.4 All SADC countries will benefit from the project through the harmonization of policies protocols and guidelines related to communicable diseases. In addition, ADF countries will benefit from capacity building activities related to the national implementation of harmonized policies and strategies, as well as the scaling up of Best Practices in HIV/AIDS prevention, treatment and care for OVC.

1.5 The proposed project will complement two other projects : (i) the HIV SADC cross border project supported by DFID and European Union (2002-2006), which covers Namibia, Botswana, Swaziland and Lesotho; (ii)The “Making a Difference Project” which is part of the SADC/EU project on HIV and AIDS funded by the European Program for Reconstruction and Development and (iii) the USAID funded “Corridors of Hope” initiative which carries activities at some cross-border sites in Zambia, Zimbabwe, Lesotho, Namibia, Mozambique, South Africa and Swaziland. The first two projects are managed by SADC Secretariat. The foregoing projects while incorporating policy issues are operating at national level and only on HIV/AIDS. The proposed project aims to support the development and harmonization of regional policies on the three major communicable diseases which are the leading causes of morbidity and mortality in the region. The project goes further in supporting the implementation of harmonized policies among all SADC MS.

2. THE SADC

2.1 Vision and Mission

2.1.1 The SADC region has identified the combating of poverty as the overarching priority in its integration agenda. In recognition of the magnitude of the problem and in line with the commitments that Member States have made under the Millennium Development Goals and the initiative for New Partnership for African Development (NEPAD), the region has adopted poverty reduction as its main goal. The overall goal of poverty reduction efforts is to promote sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation with the ultimate objective of its eradication. The priority areas for poverty reduction include interventions for combating the HIV and AIDS pandemic; gender equality and development; trade, economic liberalisation and development; infrastructure support for regional integration and poverty eradication; sustainable food security; and human and social development.

2.1.2 The SADC vision is one of a common future in a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom and social justice and peace and security for the peoples of Southern Africa. Its Mission Statement is: “To promote sustainable and equitable economic growth and socio-economic development through efficient productive systems, deeper co-operation and integration, good governance, and durable peace and security, so that the region emerges as a competitive and effective player in international relations and the world economy”. The SADC region has identified the combating of poverty as its overarching priority in line with the commitments that Member States have made under the Millennium Development Goals and NEPAD.

2.2 Institutional Framework

2.2.1 The SADC Secretariat is the principal executive institution responsible for strategic planning, co-ordination and management of programmes. The Secretariat is headed by an Executive Secretary and has its headquarters in Gaborone, Botswana. The structure of the Secretariat includes the Department of Programmes, which is composed of the following four Directorates under which

all the sectors have been clustered : (i) Trade, Industry, Finance and Investment ; (ii) Infrastructure and Services ; (iii) Food, Agriculture and Natural Resources ; and (iv) Social and Human Development and Special Programmes. SADC is currently in the process of implementing new recruitment procedures. All regional positions (51) will be filled through open competition, on the basis of country and gender quotas. While this process is underway, seconded and regionally recruited staff whose functions continue in the new structure will be retained up to 31st March 2006, in order to avoid critical staff shortages, while the transition is in progress. Within the DSHDSP human resource constraints are also evident. Until the first quarter of 2006, the directorate had only one staff member per sector (Health, Education and HIV/AIDS) assisted by two project managers (financed by EU and DIFD). However, some of the constraints will be alleviated as one senior position for the Health Unit has been filled in addition to a health advisor on secondment from the National Department of Health of South Africa.

2.2.2 Following the 2001 Reorganisation which centralised the country based Sector Secretariats in the Directorates, a SADC HIV/AIDS Unit was established within the Department of Strategic Planning, Gender and Policy Harmonization. Together with the Gender Unit, established in 1998, it was placed directly under the Chief Director. This structure stressed the need for a multi-sectoral approach to HIV/AIDS prevention and the need to mainstream gender and poverty concerns in HIV/AIDS interventions in all four directorates. During a February 2005 Council of Ministers meeting in Mauritius new changes to the placement of units at SADC Secretariat level were adopted. The HIV/AIDS unit was transferred to the Directorate of Social and Human Development and Special Programmes (SHDSP), while the Gender Unit was moved back to the Office of the Executive Secretary where it had been originally located.

2.2.3 At the national level, SADC National Committees (SNCs) co-ordinate their respective individual Member State interests relating to SADC. However, not all the SNCs are fully functional at present. At the regional level, an Integrated Committee of Ministers (ICM) has been created to co-ordinate the work of different clusters. Most of the policies, strategies and programmes of SADC were designed independently by individual Sector Coordinating Units before they were grouped into clusters managed through Directorates. For this reason, the various policies, strategies and programmes were not properly co-ordinated leading to weak intersectoral linkages. In response, the SADC established the Regional Indicative Strategic Development Plan (RISDP – 2000 to 2015). It aims to provide a strategic direction and focus to the organisation's programmes and has the following specific priority areas : eradication of poverty ; harmonization of policies; Democratic governance and conflict prevention management and resolution ; Human resource development; Mainstreaming gender in the process of integration; and; Combating diseases, including HIV/AIDS, tuberculosis and malaria.

2.2.4 The ultimate objective of RISDP is to deepen the integration agenda of SADC with a view to accelerating poverty eradication and the attainment of other economic and non-economic development goals. RISDP aligns strategic objectives and priorities with the policies and strategies to be pursued towards achieving those goals over a period of fifteen years. However, SADC does not have enough staff to implement its RISDP. For example, the centralisation of SADC and the phasing out of the Sector Coordinating units created gaps in human resource capacity. The falling away of the gender focal points in sector secretariats at country level, for example, have not been replaced either at country or at directorate level and have created constraints for effective gender mainstreaming. The HIV/AIDS focal points that were to be placed in all four directorates have not been forthcoming, thus constraining the mainstreaming of HIV/AIDS.

2.3 Institutional Capacity

2.3.1 SADC's Member States differ widely in their political, cultural and socio-economic background. This diversity has an impact on the capacity of the Community to work together towards common goals. Depending on the areas of focus, some countries can work effectively together or contribute more than others. Likewise the speed of introduction of agreed upon changes and reforms differ from country to country. Although these differentials are common to most sub-regional organizations, they justify the need to strengthen the capacity of the Secretariat to coordinate regional programs and activities more effectively. For many years, the capacity of SADC Secretariat to play this role was relatively limited. To begin with, the mandate of the Secretariat was not very clear. The line between political decisions, reserved for governing entities (Summit, Council of Ministers etc), and technical decisions delegated to the Secretariat, was quite blurred. Consultative meetings were needed most of the time before any major operational decision was taken by the Secretariat. The restructuring process under way attempts to solve this problem. The Secretariat will be given greater autonomy and authority to implement decisions taken by political entities while remaining accountable for its operations.

2.3.2 Secondly, the Secretariat had limited resources to carry out its activities. A number of key technical functions were performed by staff seconded from the member states for a limited period of time. The Secretariat was not able to attract competent cadres from the market and offer them long-term contracts due to budget limitations. Likewise, financing of the Secretariat's operating costs was constrained by the lack of budget resources. To address these issues, the Secretariat's budget for FY 2005/2006 was increased by more than 100% over the previous year's budget. Subsequently, the Secretariat has launched a recruitment drive that will allow it to replace all seconded staff with direct recruits by the end of 2005. The budget increase will cater also for operating cost needs. Thirdly, SADC Secretariat has not been effective in implementing programs at country level. The work of Sector Coordinating Units was hardly visible on the ground. In an attempt to solve this problem, SADC National Committees have been established to replace SCUs. They will be the implementers of programs at the national level. Member states need to find a suitable linkage of these structures to national institutions and provide them with adequate resources in order to improve their effectiveness. This process is under way in a number of countries. Finally, it should be noted that major SADC development partners have been interested in reinforcing the capacity of the Secretariat to discharge its mandate. The E.U. is considering a project that will encompass several areas of institutional capacity including streamlining the structure, putting in place accounting and financial management procedures and strengthening SNCs. In addition, six staff positions (4 technical and 2 support) have been proposed under the Joint Financing and Technical Cooperation Arrangement between SADC and HIV/AIDS ICPs.

2.4 Health Situation in SADC Member States

2.4.1 The health status of people in the region is impacted by poverty, illiteracy, unemployment, and poor social and physical living conditions. In addition, health programmes have been vertical, disease-focused and based on theoretical frameworks that are not in harmony with community perspectives. The Region has an estimated 234 million people or about 30% of all people living in Sub-Saharan Africa. The impact of female illiteracy on health outcomes is well documented and has forced SADC member states to put it as one of the priorities in their respective development agenda. Mozambique has the highest rate of illiteracy, 65.8% for females and 35.4% for males. With the exception of Lesotho, female illiteracy rates are higher than that for males.

2.4.2 The average Human Development Index for the region is 0.508 (ADB 2004 annual report). With respect to access to safe water and sanitation, there is wide variation between Member States with Mozambique (42%) showing one of the lowest percentage of population access to safe water

and access to sanitation. At the other end of the scale 95% of all citizens of Botswana have access to safe water. The basic indicators of some Member States shown in Table 2.1 below reveal wide variations.

2.4.3 Life expectancy ranges from 32.5 years (Swaziland) to 72.2 years (Mauritius) with all but two countries (Madagascar and Mauritius) falling below the continental average of 51 years. According to UNAIDS, this modest life expectancy is also put under severe strain by the impact of HIV/AIDS with a decrease of ten years projected in some countries in the SADC. There is wide variation in under-five mortality per 1,000 live births ranging from a low of 17 child deaths in Mauritius to 260 deaths in Angola. Maternal mortality per 100 000 live births is also varied ranging from 1,500 maternal deaths in Angola against 230 in Namibia South Africa and Swaziland and 24 in Mauritius.

Table 2.1: Social Indicators

Region/Country	HDI* Value (0 to 1)	Life expectancy (years)	Infant mortality (per 1,000)	Maternal mortality (per 100,000)	Access to Water (% of pop.)	Access to sanitation (% of pop.)	Daily calories supply per capita	Primary school enrollment (%)		Adult illiteracy rates (%)	
								Male	Fem.	M.	F.
Developed Cty.	0.933	78.3	5.0	13.0	100.0	100.0	3,284.7	101.0	101.0	0.7	1.0
Developing Cty.	0.663	64.6	61.0	440.0	79.0	49.0	2,675.2	105.0	96.0	16.5	30.4
African average	0.484	50.8	79.3	661.4	64.4	42.0	2,379.4	98.8	84.3	27.7	44.0
Southern Africa average	0.508	39.8	81.9	580.0	70.0	50.0	2,374.1	108.8	101.7	17.4	28.1
Angola	0.381	40.2	136.2	1,500	50.0	30.0	2082.7	-	-	-	-
Botswana	0.589	36.7	54.4	330.0	95.0	41.0	2,151.4	103.0	103.0	22.2	16.8
Lesotho	0.493	33.7	88.5	550.0	76.0	37.0	2,638.3	123.0	125.0	24.8	5.2
Madagascar											
Malawi	0.388	37.7	111.3	620.0	67.0	46.0	2,154.6	149.0	143.0	23.4	49.2
Mauritius											
Mozambique	0.354	37.9	118.3	1,100.0	42.0	27.0	2,078.9	110.0	87.0	35.4	65.8
Namibia	0.607	42.3	57.2	230.0	80.0	30.0	2,277.5	106.0	106.0	15.0	15.5
South Africa	0.666	45.2	46.2	230.0	87.0	67.0	2,956.1	107.0	103.0	12.6	13.9
Swaziland	0.519	32.6	75.5	230.0	52.0	52.0	2,322.0	103.0	98.0	16.9	18.6
Zambia	0.389	32.8	101.2	650.0	55.0	45.0	1,927.4	81.0	76.0	12.7	24.2
Zimbabwe	0.491	32.3	56.4	400.0	83.0	57.0	1,942.6	100.0	98.0	5.3	12.1

Sources: ADB Statistics Division; Unesco Data Base 2004; UN Population Division, the 2002 Revision

Notes: columns 1, 5, 6, 7, and 8 data refer to 2002; columns 2, 3, 10 and 11 data refer to 2004; column 4 data refer to latest year available

Columns 8 and 9 data refer to 2001/2002

(---): Data not available

2.4.4 There is wide variation in access to health care in the Region. According to the World Bank, the percentage of the population with access to health care in Member States ranged from 24% to 99% with a mean of 69%, while for the rest of the African continent the mean is 48%. While on average SADC citizens appear to have better access to health services than those of other African countries, the variation within SADC should be noted. Other health issues such as, reproductive health, childhood and adolescent health, emergency health services and disaster management, low nutrition status, poor health care infrastructure and services, lack of well trained staff, typhoid, cholera and an increasing burden of non-communicable diseases such as cancer and hypertension, emerging diseases such as Ebola have worsened the SADC health situation.

2.5 Policy and Organization of the Health Sector

2.5.1 SADC decided in August 1997 to include health in its Programme of Action by creating a Health Unit. The rationale for this decision was the realisation that regional co-operation was critical to address health problems of the region. SADC's main goal of integration of the health sector is to attain an acceptable standard of health for all citizens and to reach specific targets within the objective of "Health for All" in the twenty first century by 2020 in all Member States through the primary health care strategy.

2.5.2 The SADC Policy Framework for Health provides a comprehensive coverage of all the key aspects of health and health services delivery in the region. It proposes policies, strategies and priorities in various areas, including HIV and AIDS and other communicable diseases. The SADC Protocol on Health, which was signed in August 1999 and entered into force in August 2004, provides a legal and broad policy framework for cooperation in twenty three (23) areas. The operationalization of the Protocol on Health is detailed in its Implementation Plan which was completed in February 2006. The Implementation Plan encompasses priorities, targets, objectives and strategies for implementation of the protocol over a 15 year period with a five year detailed plan. Among the priorities that feature in the five year plan 2006 -2010, is communicable disease control, which includes HIV and AIDS and STDs; Tuberculosis Control and Malaria Control. In addition, the implementation of the SADC HIV/AIDS strategy is detailed in the HIV/AIDS Business Plan covering the period 2005-2009. The SADC Pharmaceuticals Programme Business Plan for 2006-2010 is also being finalized. The Health and HIV/AIDS Units, under the Social and Human Development and Special Programmes Directorate, ensure the coordination of regional health sector and HIV/AIDS activities, including control of communicable diseases and HIV/AIDS. In addition, the Health Unit is mandated with coordinating the implementation of the SADC Protocol on Health. Some of the functions of the Health Unit include organizing technical sub-committee meetings, dissemination of information to all stakeholders on the implementation of the protocol, compiling reports to the ICM and mobilising technical and financial resources.

2.5.3 At country level SADC Member States are implementing health strategies based on their national health policies as well as specific policies (drug policy, human resource policy, maintenance policy, etc.) in order to reduce morbidity and mortality due to major diseases. Furthermore, Ministries of Health support the implementation of the SADC Health Protocol at national level through assigning resources when appropriate as well as reporting on progress through their SADC National Committees. The health sector organisational structure in these countries are pyramidal with the Ministry of Health and national entities (programmes, services, hospitals) at the national level, regional Directorates of Health and intermediary health structures at the regional level and health districts and basic health facilities, at the peripheral level.

2.6 Health Care Financing

2.6.1 The public financing of health care in the region varies in accordance with countries' economic status and performance. Table 2.2 shows, for each country the total expenditure on health as a percentage of GDP and the public expenditure on health as a percentage of government expenditure.

Table 2.2 : Health Expenditure for SADC Member States (2002)

Country	Total Expenditure on Health as % of GDP	Public Expenditure on Health as % of Government Expenditure
Angola	5.0	4.1
Botswana	6.0	7.5
DRC	4.1	16.4
Lesotho	6.2	10.9
Madagascar	2.1	8.0
Malawi	9.8	9.7
Mauritius	2.9	8.3
Mozambique	5.8	19.9
Namibia	6.7	12.9
South Africa	8.7	10.7
Swaziland	6.0	10.9
Tanzania	4.9	14.9
Zambia	5.8	11.3
Zimbabwe	8.5	12.2

Source: SADC

2.6.2 Most SADC member states are faced with an array of health care financing problems that leave their health systems far from achieving the objectives of good health status, equity, efficiency, acceptability and sustainability. The principal problem identified by most Member States in SADC is a shortage of government budgetary resources for health care due to an increasing need and demand for health services. For effective implementation of national health policies adequate resources are required. It was against this background that African heads of States re-committed themselves to allocating at least 15% of annual budgets to the improvement of the health sector (“Abuja Declaration 2001”). Further, the Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases, (African Union Assembly 2003) also commits countries to promote private and public sector partnerships and calls for improvements in disbursements by international funds such as the Global Fund.

2.6.3 At the regional level SADC Heads of State and Governments signed a Declaration on HIV and AIDS (Also known as the Maseru Declaration) which commits countries to a range of prevention, treatment, care and support activities and calls for the establishment of a Regional Fund for HIV and AIDS). The modalities for the establishment of the regional fund for HIV/AIDS is currently being explored with assistance from Kreditanstalt für Wiederaufbau (KfW).

2.7 Health problems

2.7.1 There are many health problems impeding the well being of SADC populations that include the following : (i) the heavy burden of major diseases particularly HIV and AIDS, TB, malaria, cholera and cancer as well as the emerging communicable diseases such as Ebola; and the threat of Avian flu; (ii) the burden of poliomyelitis, measles, hepatitis B, diphtheria, pertussis, dysentery, schistosomiasis and plague; (iii) unaffordability, insufficient accessibility to essential drugs, including antiretroviral drugs ; (iv) low quality of care and inadequate resources for the provision of sufficient health services and training of health personnel; (iv) the lack of understanding or appreciation of gender dimensions and their mainstreaming in health interventions; (v) the loss of health professionals arising from the impact of the HIV/AIDS pandemic and brain drain ; (vi) low access to water and sanitation; (vii) high levels of malnutrition particularly among children, women and the elderly; (viii) insufficient support to existing networks of People Living With HIV & AIDS to promote positive living.

2.7.2 Major contributors to the disease burden in the region are HIV/AIDS, malaria and tuberculosis. The magnitude and impact of these three diseases and governments’ responses are discussed in greater detail in chapter 3 of the present report. SADC as a regional institution and Member States are implementing regional and national responses, respectively, to fight these diseases. Emerging communicable diseases such as Ebola and Marburg have mostly hit DRC and Angola. With WHO’s assistance, countries are developing responses against these diseases while SADC has included related actions in its RISPD. Concerning poliomyelitis and measles, in spite of the development of national immunization programmes, they are not yet eradicated in the region and remain a threat to children.

2.7.3 Considering human resource constraints, the workforce in the health sector has great influence on health service delivery as well as health outcomes. There are several fundamental constraints to the realisation of SADC objectives for human resources, namely, the shortage of trained professionals; the migration (‘brain drain’) of highly trained and mobile human resources to other countries ; the absence of a regional human resource policy to ensure that the available human health resources are adequately utilised and equitably distributed; and rural and urban discrepancies in health personnel distribution.

2.7.4 Based on a UNICEF Study (2003), malnutrition was reported to be high in the region with about one third of children being underweight and an even higher number being stunted. It was estimated in 2001 that over 700 000 child deaths in SADC countries were associated with malnutrition. The rates of stunting among children have either stayed the same or worsened in the following countries: Zambia, Tanzania, Zimbabwe, Swaziland, Malawi, Lesotho, Mauritius and South Africa. Countries that have been experiencing food deficits since 2002 (Lesotho, Malawi, Swaziland, Zambia, Zimbabwe and Mozambique) have been reporting general deterioration in nutritional status. Vitamin A deficiency was found to be ranging from 16.1% in Zambia to 59% in Malawi. Furthermore, the nutritional status of OVC has been found to be much worse than that of other children, particularly in countries that experience seasonal or episodic food insecurity. As of 2003, most of SADC countries had started distribution of Vitamin A supplements to young children. SADC countries are being assisted by the SADC Secretariat and its development partners to deal with the above-mentioned health issues through staff training, extension of health services coverage, sensitization of decision makers on health and gender issues, etc.

2.8 Donor Interventions

2.8.1 SADC's response to the HIV/AIDS epidemic, tuberculosis and malaria is receiving support from a number of donors. The projects supported by DFID and EU are being implemented by SADC through its Social and Human Development and Special Projects Directorate (SHDSP). The major on-going projects are summarized hereunder:

Table 2.3 : Donor Interventions

Donor	Amount	Activities
BTC	EURO 260.000	Support for two years position of the HIV and AIDS Manager and specific public health activities, such as Study to assess the economic impact of HIV & AIDS in the region
USAID	\$315 000	support the Health Sector in its HIV/AIDS activities, and to review policies that have an impact on HIV/AIDS in MS
DFID	Pounds 7.5 mill.	reduce HIV/AIDS related risk behaviour among Botswana, Namibia, Lesotho and Swaziland people
EU	Euro 7.6 mill.	increase the capacity of SADC sectors in identifying multisectoral solutions for HIV/AIDS
ILO	\$3.5 million	develop and implement policies and build capacity for addressing the issue of AIDS at work place and through BCC programmes in Swaziland, Botswana, Lesotho and South Africa

2.8.2 The USAID funded "Corridors of Hope" Initiative which will end in 2006, seeks to promote practical regional collaboration and practical activities on the main transport corridors in the Southern African Region since 1999. Based on regional assessments, which included socio-cultural epidemiological and even ethnological data collection at main border sites, the project has been supporting a range of activities at cross-border sites. The target groups of the project are migrant men and women, as well as resident populations particularly adolescent girls. The project has included the following interventions : strengthening of STI services through training of health workers in syndromic management and drug supply and appropriate services for the target groups, improved condom promotion and distribution, reinforcing behaviour change through targeted media and communication mobilization and through peer group education, and adolescent friendly reproductive health services as well as voluntary testing centres at border sites and on trucking routes. The project is working with a number of NGOs. The project has activities at cross-border sites in Zambia and Zimbabwe, Lesotho, Namibia, Mozambique, South Africa and Swaziland.

2.8.3 DFID's "Regional STI/HIV and AIDS project" is implemented through the SADC HIV/AIDS unit with a funding of £ 7.65 million over 5 years. It is a pilot project to help contain the spread and impact of HIV and AIDS in four countries, namely Botswana, Lesotho, Namibia and Swaziland. The objective of the project is to strengthen the ability of women, men and young people particularly at risk of infection to reduce their high risk behavior. The project seeks to

achieve this objective through (i) behavior change communication, (ii) the management of STIs, (iii) the social marketing of condoms and (vi) the coordination of country policies and strategies regarding HIV/AIDS. The project components concentrate on high transmission Areas, particularly along major transport corridors and cross-border sites and works with cross-border migrants, such as truck drivers, returning miners, farm workers, traders and tourists as well as with local populations. The project works at three levels – regionally, nationally and locally. Project activities are carried out by non-governmental organizations. While the project activities target the management of STIs, Tuberculosis and malaria management are not part of the activities. In the period beyond 2006, DFID along with SIDA and other HIV/AIDS ICPs has committed to support the Joint Financing and Technical Cooperation Arrangement (JFTCA). The support will be towards fast tracking the implementation of SADC's HIV/AIDS Business Plan and possibly the Pharmaceutical Business Plan when it is finalized.

2.8.4 The “Making a Difference Project” is part of the SADC/EU project on HIV and AIDS funded by the European Program for Reconstruction and Development. This five year project with total EU funding of Euro 7.61 million is provided under two separate project agreements concluded between the EU, the SADC Secretariat and the South African Government. The project aims to strengthen the capacity of SADC and the various SADC sectors to develop and implement HIV/AIDS projects, to support advocacy and policy making, to promote strategies that benefit the population in SADC, and finally to also ensure that HIV/AIDS has greater visibility in SADC. The project identifies and supports innovative sub-projects and programs, which are implemented by various partner organizations and institutions, including regional and international NGOs, and universities. The sub-projects include support for orphans and vulnerable children, an initiative targeting the transport sector and HIV/AIDS affected and infected nurses and midwives, it handles stigma and discrimination, tackles the impact of HIV/AIDS on agriculture and food security, integrates HIV/AIDS into water sector activities. Surveys and databases are also funded through this project.

2.8.5 The International Organization for migration (IOM) Regional Office for Southern Africa works in four broad areas of migration management: migration and development, facilitating migration, regulating migration, and addressing forced migration. IOM works closely with governmental, inter-governmental and non-governmental partners. IOM recent activities with regard to the above broad areas within Southern African countries include efforts to manage irregular migration in the SADC region. With the concurrence of Governments, IOM Border and Migration Management Surveys have been initiated in 2004 in order to identify gaps in capacities and suggest remedies. IOM believes that migrants are more vulnerable because they are often subjected to discrimination, xenophobia, exploitation and harassment, and enjoy little legal or social protection in most communities. To address their vulnerabilities IOM has developed the *Partnership on HIV/AIDS and Mobile Populations in Southern Africa*. The three-year program (2004-2006) is jointly financed by Sida and EU/SADC. HIV/AIDS issues are mainstreamed along the Angola/Zambia border as part of the repatriation and reintegration of refugees. A proposal for funding similar activities along Zimbabwe and South Africa border at Beitbridge crossing point targeting migrant workers returning from South Africa will be financed by the UK/Dutch government beginning June 2005.

2.8.6 The International Labor Organization (ILO) activities are both at regional and country level within SADC focusing mainly on the commercial farming sector. Under the Project Tripartite Agreements ILO in collaboration with the SADC/governments is to: develop and implement policies and build capacity for addressing the issue of AIDS in the work place and safeguard the rights of workers through Behavioral Change Communication programs. Currently these activities are being carried out in Swaziland, Botswana, Lesotho and South Africa. A baseline survey carried out in the four countries at a cost of US\$ 3.5 million concentrates on the severity of HIV/AIDS

infections amongst farm workers. The project is addressing the issue of legal frameworks in the sector.

2.8.7 The Global Fund was created to fight HIV/AIDS, TB and malaria and has to date committed US\$ 3 billion in 128 countries to support aggressive interventions against all three communicable diseases. In the SADC region the Global Fund has financed 18 projects in 10 member countries against HIV/AIDS, 10 Malaria initiatives in 7 member countries, and 7 TB initiatives in as many member countries. In addition, some of the HIV/AIDS projects also have TB components. The table attached in annex 4 includes the global fund resources allocated to SADC countries. Most of the Global Fund resources are used in procuring commodities. SADC and its Member States will use efficient coordination mechanisms in order to avoid duplication of activities financed by different partners. Annex 11 includes a donor interventions' matrix.

2.8.8 A recent funding mechanism for SADC is the Joint Financing and Technical Cooperation Arrangement (JFTCA) between SADC and the International Cooperating Partners HIV/AIDS Group. Under this arrangement priority aspects of the implementation of the SADC Business Plan on HIV and AIDS will be funded. Additional resources may also become available from the SADC HIV/AIDS Trust Fund when it becomes operational. Consultations are currently underway regarding the format and operational modalities of the Fund.

3. COMMUNICABLE DISEASES (HIV/AIDS, TB AND MALARIA) WITHIN THE SADC REGION

Most communicable diseases are endemic in the SADC Countries and pose a potential threat to the region, especially since increased regional integration has led to a phenomenal rate of mobility of the population, allowing for possible wider transmission of communicable diseases. Diseases of particular public health importance are HIV, tuberculosis, malaria, poliomyelitis, measles, hepatitis B, diphtheria, pertussis, cholera, dysentery, schistosomiasis and plague.

3.1 Policies and strategies to control communicable diseases (HIV/AIDS, TB and Malaria) in SADC Member States

3.1.1 In order to reduce the morbidity and mortality due to HIV/AIDS, TB and Malaria, many SADC Member States have developed policies, strategies and plans. The scope and content of these policies and strategies differ from country to country. In addition, not all countries have the capacity to adequately implement the existing policies and strategies. As a result, the burden of HIV/AIDS, TB and malaria continues to increase. For instance most of the SADC countries have adopted the Directly-Observed Treatment Strategy ("DOTS"), the internationally-recommended strategy, and many are implementing well-developed plans to expand the DOTS. However, the region is far from achieving global targets for TB control, which are 70% case detection of infectious cases and 85% cure of these by end of 2005, and which have to be sustained in order to halve the prevalence and death rates by 2015.

3.1.2 The SADC Policy Framework for Health provides a comprehensive coverage of key issues in health policy and services delivery in the region. The SADC Protocol on Health provides a legal and broad policy framework for cooperation in many areas which include some of the major health challenges in the region such as HIV/AIDS/STI, Tuberculosis and Malaria control. SADC has a comparative advantage to review, harmonize and/or develop inter-countries and regional policies and strategies in order to assist Member States in reducing the transmission of HIV/AIDS, TB and Malaria.

3.2 HIV/AIDS within The SADC Region

Magnitude of HIV/AIDS within the SADC region

3.2.1 Based on the UNAIDS' 2005 report, Sub-Saharan Africa has just over 10% of the World's population but is home to more than 60% of all people living with HIV. Countries in the SADC region are the worst affected. The eight countries with the highest prevalence rates in the world, ranging from 14.2 to 38.8 percent of the adult population, are SADC Member States. The Table 3.1 below summarizes key HIV/AIDS data in the SADC region.

3.2.2 While accurate figures are hard to come by, the percentage of women attending antenatal clinics who test positive for HIV is increasing. Four Member States (Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe) have more than 20% of women attending antenatal clinics who are HIV positive. Children and young people are especially hard-hit by the epidemic. In recent years the under-five mortality rates of the countries in the SADC region have increased by 20–40%, due to HIV/AIDS. The number of excess AIDS-related deaths among South Africans aged 15–34 is projected to peak in 2010–2015, with an estimated 17 times as many deaths as there would have been in the absence of AIDS. Data from countries such as Angola and DRC which are emerging from years of civil conflict, show lower HIV/AIDS prevalence rates most likely due to underreporting. On the contrary, conflicts contribute to the increase of HIV/AIDS cases because of rapes, increase in the number of sex workers due to poverty, lack of preventive services, etc.

Table 3.1 : HIV/AIDS Situation in SADC Region

Country	Population (000) 2003 (2)	Adults & children Living with HIV/AIDS (1)	Prevalence rate (%) (1)	Deaths due to AIDS (1)	Women living with HIV(1)
Angola	13,625	240,000	5.5	21,000	130,000
Mauritius	1,221	-	-	-	-
Tanzania	36,927	1,600,000	9.6	160,000	840,000
DRC	52,771	1,100,000	4.2	100,000	570,000
Malawi	12,105	900,000	14.2	84,000	460,000
Zimbabwe	12,891	1,800,000	24.6	170,000	930,000
Zambia	10,812	920,000	16.5	89,000	470,000
Swaziland	1,077	220,000	38.8	17,000	110,000
Namibia	1,987	210,000	21.3	16,000	110,000
Lesotho	1,802	320,000	28.9	29,000	170,000
South Africa	45,026	5,300,000	21.5	370,000	2,900,000
Botswana	1,785	350,000	37.3	33,000	190,000
Mozambique	18,863	1,300,000	12.2	110,000	670,000
SADC*	210,892	14,260,000		1,199,000	7,550,000

Source : (1) UNAIDS, 2004

(2) World Health Report, WHO (2005)

3.2.3 The risk of HIV/AIDS infection in the world is higher for women and for young women in particular, for reasons that are both biologically and socially grounded. In Sub-Saharan Africa, on average there are 13 women living with HIV for every 10 infected men and the gaps continue to grow (UNAIDS, 2004 report). In most countries, women are being infected with HIV at an earlier age than men. Differences are more pronounced among the young (15 – 24 years) with on average 36 young women living with HIV for every 10 young men in Sub-Saharan Africa. Women are more vulnerable to HIV/AIDS because they have lower incomes, less entitlements to assets and savings and therefore little power to negotiate safe sex. They are more likely to be poorly educated, and their heavy workloads undermine their uptake of technologies and services.

3.2.4 Children infected and affected by HIV and AIDS are amongst the most vulnerable groups in the SADC region. Children under the age of 15 who are infected with HIV, number just over 1 million in all the countries of the region and constitute about 8% of those living with HIV and AIDS. In addition, children (upto 18 years) who have lost one or both parents as a result of AIDS

are estimated to number 5.2 million in the countries of the region. While a growing number of children infected with HIV are surviving beyond the age of five, an unknown number are acquiring HIV infection as a result of sexual violation as well as other sources of transmission. Although the vast majority of children who are infected with HIV in pregnancy or at birth do not survive and contribute to the high infant and child mortality rates in the region, a small number are beginning to benefit from life saving treatments including ARVs. Treatment regimens for children are however less well developed and access to treatment for children even where drugs are free is still poor in most countries of the region. Thus providing ARV treatment to children in order to reduce child mortality, is one of SADC's priority activities planned for implementation by 2010. However, children who are infected with HIV and are orphaned are less likely to access health services including treatment for opportunistic infections, let alone ARVs.

3.2.5 A number of different factors explain the general picture of HIV/AIDS in the SADC region, including its rapid spread, high prevalence and uneven distribution. The main risk factors for HIV-transmission rates in the region include population movement (including the uniformed forces); trade and transport routes; gender inequity and inequality; poverty and unequal distribution of wealth; lack of social cohesion in some areas; broad sexual mixing patterns and multiple partnerships, including commercial sex; various cultural factors (i.e. low rates of male circumcision; practice of 'dry sex'; female initiation rituals that stress submissiveness of women, sexually and otherwise, to men); high levels of untreated sexually transmitted infections and reproductive tract infections; and relatively low rate of condom use. These factors enable identification of high risk environments, and hence population groups to be at high risk, and also suggest issues that need to be tackled to reduce risk environments and make them safer.

Impact of the HIV/AIDS Epidemic

3.2.6 In many countries, AIDS is erasing decades of progress in life expectancy. The average life expectancy in sub-Saharan Africa is currently 47 years. Without AIDS, it would have been 62 years. Life expectancy at birth in Botswana has dropped below 40 years—a level not seen in that country since before 1950. Children and young people are especially hard-hit by the epidemic. Among children, Orphans and Vulnerable Children (OVC) are likely to experience the worst impacts of the pandemic, including poverty, discrimination, sexual and labour exploitation, food insecurity and ill health. Moreover, households with orphans have been found to be poorer because of the increased dependency ratio. Poverty in turn limits the ability of households with OVC to meet their basic needs including food, health care and education. This further deepens poverty among households headed by women particularly in countries with the highest numbers of orphans, as women are more likely to take responsibility for orphans. Orphans are part of a much larger health and development crisis engendered by HIV/AIDS in the SADC region. Thus in countries where large proportions of children are orphaned by HIV/AIDS as is the case in many of the SADC countries, there is an increased likelihood that the epidemic has had an adverse impact on a far larger number of children who are not orphans. These other vulnerable children include those who are living with HIV/AIDS, those whose parents are sick with HIV/AIDS and also children who are vulnerable because of poverty, civil conflict, discrimination or exclusion.

3.2.7 One of the visible effects of the HIV/AIDS epidemic in some of the countries of the region has been a decline in school enrollment. This is expected to not only undermine efforts to achieve MDG targets related to education but also HIV/AIDS control efforts as a good basic education ranks among the most effective and cost-effective means of prevention. Among the factors contributing to the decline in school enrolment are: the removal of children from school, especially girls to care for ill parents and family members; an inability to afford school fees and other expenses; AIDS related infertility and a decline in birth rate leading to fewer children and more

children getting infected and either not living long enough to start school or not surviving the years of schooling.

3.2.8 Southern Africa remains the epicenter of the global AIDS epidemic and it is projected that serious epidemics will continue for some time in some of the countries of the region. As a result, the numbers of OVC are expected to continue to increase and consequently continue to erode household, community, institutional and national capacities to cope. There are nonetheless innovative and effective interventions to prevent and treat HIV and AIDS as well as mitigate its impact on communities and children in the region. Support is needed however to ensure that these interventions are scaled up and emulated across countries of the region.

Response to the HIV/AIDS Epidemic

3.2.9 In response to the epidemic, each government has developed its own national strategic plans to lower the incidence of HIV infections. Similarly, SADC recognized that a regional response to the epidemic is essential in curbing its spread. To this end, the SADC Council of Ministers approved the SADC HIV/AIDS Strategic Framework and Programme for the period 2004-2007. The overarching goal of the Framework is to decrease the number of HIV/AIDS infected and affected individuals and families in the SADC region so that HIV/AIDS is no longer a threat to public health and to the socio-economic development of Member States. The Framework has identified HIV/AIDS as a crisis that requires a multi-disciplinary and multi-sectoral approach. The paradigm shift from considering HIV/AIDS as solely a health issue to the recognition that the pandemic is crosscutting requires that every development sector in SADC should use its areas of highest comparative advantage to address it. The multi-sectoral HIV/AIDS strategy brings together seven sectors in the member states (namely, Culture and Sports; Employment and Labor; Health; Human Resources; Mining; Tourism; and Transport).

3.2.10 SADC has also developed a concept paper and a business plan to define HIV/AIDS activities to be implemented in the upcoming years with donor support. The five year Strategic Business Plan (2005-9) has been further refined and priorities for 2005-2007 identified for implementation. The financing of the prioritized SADC HIV/AIDS Business Plan will be largely supported by the SADC HIV/AIDS ICPs under the Joint Financing and Technical Cooperation Arrangement (JFTCA) between SADC and the International Cooperating Partners HIV/AIDS Group. Some of the key outputs of the HIV/AIDS Business Plan include development of a series of instruments developed by the HIV/AIDS Unit for use by MS. These include the SADC Framework for HIV and AIDS Mainstreaming and more recently the Framework for HIV/AIDS Coordination and the Framework for developing and sharing Best Practices on HIV and AIDS in the region. The framework provides a working definition for a SADC HIV and AIDS Best Practice as well as the criteria that must be met for an intervention to qualify as a Best Practice. It also provides guidance on documentation of BPs to facilitate their dissemination.

3.2.11 The SADC Heads of State and Government in the Maseru Declaration of 2003 called for the establishment of a regional HIV/AIDS fund. SADC is currently being assisted by KfW to assess the feasibility and operational modalities of such a fund. Meanwhile some MS have already pledged funds, notably South Africa, Swaziland, Angola, Namibia and Zimbabwe. At this stage it is not yet clear when the fund will become operational.

3.2.12 At the national level, all MS have established structures that are mandated to lead and coordinate a multi-sectoral response to HIV and AIDS. To facilitate effective regional collaboration, an annual forum of National AIDS Councils/Commissions from all MS has been initiated to share information and best practices, review progress towards the development, harmonization and implementation of regional policies, guidelines and programmes and discuss other priority regional

response issues. Ministries of Health however remain the lead agencies responsible for implementing the health sector response to HIV and AIDS. In addition MS in the region have adopted the “Circles of Support” approach to addressing the OVC crisis. This is also supported by SADC.

3.3 Tuberculosis within the SADC Region

Magnitude of TB

3.3.1 The SADC region has the world’s worst TB and HIV/AIDS epidemics. The burden of TB has greatly increased over the past 15 years, while the resources needed to cope with the epidemic have dwindled. It was estimated that 2,301,000 TB/HIV co-infected persons resided in four high incidence TB countries: South Africa, Democratic Republic of Congo, Tanzania and Zimbabwe, representing one-fifth (21.6%) of the global TB/HIV co-infected pool. These four countries alone contributed 29% of the total estimated African incidence of TB of 1,586,000 cases. The figure has not changed significantly over the past few years. The estimated TB death rates per 100,000 total population were 283 in Zimbabwe and 166 in South Africa. The Zimbabwean TB death rate was three times higher than the African rate of 88 and nine times higher than the world average of 32.

3.3.2 Three countries, Botswana, Namibia and South Africa, are meeting the case detection target of 70%, but six, Malawi, Mauritius, Swaziland, Tanzania, Zambia and Zimbabwe, had less than 50% case detection. Table 3.2 below shows the status of case detection, “DOTS” coverage and treatment outcomes in the region in 2001 – 2002.

Table 3.2 TB Case Detection, DOTS Coverage and Treatment Outcomes, 2001 – 2002

Country	Number of TB cases notified in 2002		Notification rate, 2002 (per 100,000)		DOTS Detection rate, 2002 (%)		Treatment outcomes of new smear-positive cases (PTB+) registered in 2001 (%)					
	All	New PTB+	All	New PTB+	All	New PTB+	TS	Died	Failed	Def	TF	NE
Angola	29996	18087	228	137	91	70	66	2	26	3	2	0
Botswana	10204	3334	577	188	88	73	78	7	1	6	9	0
DRC	70625	44518	138	87	36	52	77	6	1	10	5	1
Lesotho	10111	3167	562	176	77	61	71	11	1	5	6	6
Madagascar	16082	10940	95	65	41	62	69	6	1	18	5	0
Malawi	24595	7686	207	65	48	36	70	19	2	6	3	0
Mauritius	139	86	11	7	18	25	93	2	2	3	0	0
Mozambique	25544	15236	138	82	32	45	77	10	1	9	3	0
Namibia	12698	4535	647	231	86	76	68	8	2	15	8	0
South Africa	215120	98799	481	221	86	97	65	7	2	12	12	2
Swaziland	6748	1410	631	132	59	31	36	10	0	8	9	37
Tanzania	60306	24136	166	67	46	43	81	10	0	4	4	0
Zambia	54220	16531	507	153	76	56	75	12	0	6	7	0
Zimbabwe	59170	15941	461	124	68	46	71	12	0	8	9	0

Source: WHO Report 2004. Global Tuberculosis Control: Surveillance, Planning, Financing ; TS : Treated Successfully ; Def : default ; TF : Transitory failed ; NE : Not evaluated ; PTB+:New smear-positive cases

Impact of TB

3.3.3 Mortality figures represent a tragic loss of the most productive young lives in the SADC region, a region that is also undergoing significant social, economic and political disruption, and is prone to natural disasters such as droughts and floods. These conditions are eminently conducive to the development of tuberculosis and propagation of HIV. The massive increase in TB cases has

resulted in great overloading of health systems in most countries. Coupled with health sector reforms and loss of health care workers (brain drain, illness and death) many health systems are barely able to cope. In some countries, the number of cases increased more than ten times in the decade 1990 to 2000.

Response to the TB Epidemic

3.3.4 In response to the TB epidemic, each country in the region has established a National TB Control Program (NTP). However, NTPs in SADC countries are at different levels of development, funding and strength. Concerning the response at regional level, the Southern African Tuberculosis Control Initiative (SATCI) was established in 1995 in South Africa, which hosted the former SADC Health Sector Secretariat and it addresses TB and HIV/AIDS as a joint epidemic. SATCI is a sub-committee of the SADC Health Sector and represents NTPs of all 13 member states. SATCI was established as a joint action of NTP managers towards cross border support and standardization of control strategies and has the ability to take the lead with promoting joint action on tuberculosis. SATCI needs to build its capacity for program management at country and regional levels.

3.3.5 Though all SADC countries have adopted the WHO-recommended DOTS strategy, the practice of DOTS varies greatly between countries. The Washington Commitment to Stop TB (October 2001) endorsed the need for rapid expansion of DOTS to reach the global targets by 2005 and the development goals of the United Nations Millennium Declaration for 2010 (50% reduction of mortality and prevalence). Most SADC countries have developed strategic plans for the implementation of DOTS services, though some are yet to implement these plans or are at different stages of being implemented. Thus, there is need to improve, harmonize and expand DOTS services. Drug supply has improved in the sub-region, though it is not sustainable in the long-run. Most countries purchase their own medications, often in partnership with donor agencies. The Global Drug Facility, which was launched in 2001, has recently approved emergency support for Angola, Madagascar and Zambia, and has already provided free drugs to DR Congo and Zambia. Average treatment success rates for smear positive cases in the sub-region have slowly improved, ranging from 53% in Namibia to 93% in Mauritius, with an average of almost 75%.

3.4 Malaria within the SADC Region

Magnitude of Malaria

3.4.1 Of the 234 million people who live in the SADC region, 74% live in malarious areas where they are at risk of contracting malaria. The intensity of malaria transmission varies considerably and includes malaria-free areas as well as unstable (epidemic-prone) and stable (highly endemic) transmission areas. An arc can be drawn from South Africa in the south-east through Botswana and to Namibia which shows the border between malaria-free areas and unstable transmission/epidemic prone areas. The Highveld of Zimbabwe and a few isolated upland areas (>2000m), principally in Tanzania, are also malaria-free. The division between unstable and stable transmission areas runs north along the South Africa-Mozambique and Zimbabwe-Mozambique borders and then along the northern borders of Zimbabwe, Botswana and Namibia. To the north of this line, there are also areas of unstable transmission, such as the Northern and Southern Highlands of Tanzania, and large towns and cities. Increased potential for epidemics in Southern Africa especially Botswana, South Africa, Swaziland and Namibia continues due to increasing climatic variation and climate extreme such as drought, cyclones and floods. In Zimbabwe and Angola decreasing access and coverage to malaria control intervention compound the climatic risk. Annual malaria forecasting continues to be supported through collaboration with the SADC drought monitoring centres.

3.4.2 In the high transmission countries, Angola, DRC, Malawi, Mozambique, Tanzania and Zambia, pregnant women and children under-five years are the most vulnerable to malaria due to their limited immunity. It is estimated that 22 million under-five year olds are at a high risk of malaria-related morbidity including severe anaemia as well as malaria-related mortality. In these countries up to 30% of deaths among under-fives are attributed to malaria. Five and a half million pregnant women are at risk of severe anaemia and malaria-related mortality as well as miscarriage and delivering low birth weight babies. Recent estimates suggest that in these countries, malaria is responsible for 30-50% of inpatient hospital admissions, 50% of outpatient visits, and incurs 40% of total public expenditures on health. In the low transmission countries – Botswana, Namibia, South Africa, Swaziland and Zimbabwe, abnormal rainfall events as well as other factors can cause malaria outbreaks. If these are not detected in time and effectively controlled, they can develop into epidemics and can cause high levels of morbidity and mortality.

Impact of Malaria

3.4.3 In the SADC region, malaria is the second leading cause of morbidity and mortality and responsible for up to 30% of outpatient attendances, 40% of inpatient admissions, 30 million cases of malaria and 400,000 deaths per annum. Malaria affects the productivity of the private and public sectors. Key businesses that are particularly affected by malaria are agriculture, tourism, mining and construction industries. Employers are affected by the problem of a sick workforce causing declining productivity and costs of providing sick pay. Ultimately, the burden of malaria impacts negatively on the economic performance of Southern Africa, which has considerable potential.

Response to Malaria

3.4.4 A high level of political commitment was demonstrated by SADC leaders who signed the Abuja Declaration in 2000 where 44 African head of states met to discuss strategies to tackle malaria as a single public health issue. In addition to the Africa Malaria Day commemorated on 25 April each year, throughout the region countries now commemorate the SADC Malaria Day on 9th November, where public events, education campaigns are sponsored by Member States which is a demonstration of the commitment of resources and actions against malaria in the spirit of the Abuja declaration. Other key policy commitments by African heads of states and governments include: the African Region Malaria Control Strategy in October 1992; the Global Malaria Control Strategy in October 1992; the Harare Declaration June 1997; the African Initiative for Malaria Control in May 1998; and the Global Roll Back Malaria in 1998.

3.4.5 The political leadership in the region has continued to demonstrate its commitment to improve the health of the population by increasing budget allocations to the health sector. However there is need to complement these through a regional initiative on malaria control as the regional governments' resources are increasingly stretched due to the compounding effects of socio-economic crises and HIV/AIDS. There are some incomplete estimates of current resources for scaling up Roll Back Malaria from WHO. Other resources are available from other multilateral organizations such as UNICEF and bilateral funding from DFID, AusAID, USAID, JICA, and Italian Cooperation. There is still need for better financial tracking systems and periodic financial appraisals of current investments and gaps.

4. THE PROJECT

4.1 Project Concept and Rationale

4.1.1 The SADC region has some of the highest rates of morbidity and mortality due to HIV/AIDS, tuberculosis and malaria. Furthermore, these diseases are both a cause and consequence of poverty in the SADC countries, and have undermined development and health gains of the last two decades. In response, individual Member States have developed different strategies for the control of these diseases with varying degrees of effectiveness. In addition, SADC through its Health Protocol has outlined strategies and activities for the control of the three diseases. These are premised on the principle that a coordinated regional effort is necessary to complement national strategies. The SADC Protocol on Health has twenty three areas of cooperation, and among those prioritized for implementation in the first five years (2006-2010) is Communicable Disease Control. Under the area of Communicable Disease Control, the plan sets out objectives and expected results for the control of HIV/AIDS, TB and Malaria as the major diseases affecting the largest number of people in the region. Despite a well articulated plan for regional interventions in the control of these diseases, the major challenge remains capacity constraints. While the SADC Directorate for Social and Human Development and Special Projects (SHDSP) is mandated with the responsibility of coordinating the implementation of the plan, it does not have adequate human resources to mobilize financial and technical resources required to realize this. The lack of regional coordination in itself may undermine national efforts to control communicable diseases. It is thus imperative that regional communicable diseases control be supported in order to enhance the effectiveness of national efforts.

4.1.2 Encouraging steps have been taken by SADC MS in adopting regional approaches in the control of HIV/AIDS, tuberculosis and malaria. However, effective inter-country control measures require regional coordination guided by policies and legally binding protocols that are agreed upon by all Member States. While some of the policies and protocols to effect regional coordination are in place, resources to support their implementation are inadequate. Some of the efforts at inter-country coordination have already yielded results, such as the reported decline in malaria incidence as a result of cross border malaria control initiatives between South Africa, Mozambique and Swaziland. However, existing health policies in many countries do not adequately address regional and inter-country issues. The regional coordination of communicable diseases control by SADC, will therefore add value to national programs. It will neither substitute nor compete with these much larger efforts.

4.1.3 The approach adopted during the different Bank's missions was participatory and consists of holding meetings with SADC officials and especially with staff of the DSHDSP. The outcomes of these discussions have led to a proper design of the project. In addition, in order to better understand regional issues, to learn lessons from on-going similar projects and to assess the different challenges related to these activities, the appraisal team visited the following countries: Zimbabwe, Swaziland, Mozambique, South Africa, Zambia and Botswana. During these visits the mission met public servants, project beneficiaries, donors (EU, DFID, WHO, IOM, ILO, SIDA, UNAIDS, USAID etc.) as well as NGOs. Furthermore, post appraisal missions were undertaken in February and March 2006 to update the Appraisal report and discuss the issues raised during the first presentation of this project to the Board of Directors in November 2005.

4.1.4 The proposed project will support SADC's efforts in harmonizing national strategies for the control of communicable diseases and standardizing treatment protocols. In addition, the health sectors of MS will benefit from capacity building activities in support of the implementation of harmonized policies, protocols and guidelines. The project is designed to assist in the implementation of the SADC Health Protocol and will contribute to the reduction of transmission of

the three major communicable diseases in the region. In addition, the project is aligned with specific outputs of the SADC business plan on HIV and AIDS and the Pharmaceutical Business Plan.

4.1.5 The Vision Statement of the Bank Group identified regional cooperation and economic integration as important themes for Bank's operations. The pivotal role that cooperation and integration can play in promoting Africa's sustainable development, economic growth and poverty reduction, is also recognized in the Bank Group's Economic Cooperation and Regional Integration Policy approved by the Board of Directors in March 2000. The proposed project conforms to the Bank Group's Health Sector Policy, Strategies for the Control of HIV/AIDS and Malaria, the Bank's Southern Africa Regional Assistance Strategy Paper approved by the Board of Directors in October 2004 and the Bank Group's Guidelines on Financing of Multinational Operations.

4.1.6 Given the need to strengthen on-going cooperation with regional integration organizations, the proposed project will be financed through grant resources from the ADF allocation for financing of multinational operations. It will be implemented within the framework of the ADB/SADC Cooperation Agreement signed in 1999 and which is aimed at promoting economic integration and development in the member countries.

4.1.7 To date, the cumulative amount of Bank Group financing for projects in SADC Member Countries is around UA 5 billion. With respect to multinational operations, the Bank in 1992 accorded the SADC Secretariat a grant of US\$ 2.5 million as drought relief assistance from the Special Relief Fund. Assistance in the form of TAF Grants has also been given for studies on inter-state highway projects and regional power supply projects. With financial assistance from the Nordic countries, the Bank, during 1991 – 1993, conducted a major study – “Economic Integration in Southern Africa” (SEISA) which explored the prospects and opportunities for economic integration in the region. In 2000 the Bank accorded a grant of UA 1.58 million to assist the SADC in its effort to reduce operational constraints in the Beira Corridor, including border delays, HIV/AIDS transmission and road accidents (SATCC project).

4.1.8 In addition the Bank accorded the following grants: in 2000 a grant of UA 0.928 million for Capacity building for Disability Rehabilitation (Malawi, Zambia and Zimbabwe); in 2002 a grant of UA 2.667 million for SADC Emergency Humanitarian Drought WFP and a grant of UA 1.033 million for Support to SADC Agricultural Research. Moreover, the Bank Group is financing a number of important ongoing social and HIV/AIDS projects in SADC countries, which are contributing to the well-being of SADC populations. All these interventions were implemented to the satisfaction of the Bank Group.

4.1.9 The main lessons learned from the “technical assistance to Southern Africa Transport Project” (SATCC), other ADB social projects with the SADC countries and other donor interventions are the following: (i) the design and implementation of regional projects typically take longer than expected because of greater coordination requirements which are time- consuming and because of the complex operational and political environment in which they work; (ii) the institutional framework is key and needs to be dealt with early in the project preparation process ; (iii) the capacity of SADC Secretariat and other institutional entities needs to be strengthened; (iv) the need for public-private partnership during design and implementation of projects ; (v) the implementation of regional projects should be flexible in order to cater for realities and changes on the ground. All these lessons have been taken into account in the project design.

4.2 Project Area and Project Beneficiaries

4.2.1 The proposed project will focus on the SADC secretariat to enable it to fast track the coordination of policy development, harmonization and implementation relating to the three major

communicable diseases, namely HIV/AIDS, TB and Malaria. At institutional level, the project beneficiaries include the Directorate of Social and Human Development and Special Programmes (SHDSP) which is mandated to coordinate the implementation of the Health Protocol in collaboration with the SADC Gender Unit as well as the health sectors of the 14 SADC member States which are responsible for implementing national plans in accordance with the SADC Health Protocol.

4.2.2 At national level project beneficiaries include communicable disease program managers, managers of health IEC, pharmaceutical managers, drug regulatory authorities and national broadcasters in all SADC MS. At individual level, the project will also benefit OVC who are among the groups most acutely affected by the HIV/AIDS pandemic. The ultimate beneficiaries of the project are people (men, women, adolescents and children) who are directly or indirectly affected by the major diseases of HIV/AIDS, as well as tuberculosis and malaria in SADC countries. They represent the whole population of SADC Member States estimated at 234 million people.

4.3 Strategic Context

4.3.1 The SADC region has identified the combating of poverty as the overarching priority in its integration agenda. SADC's main goal of integration is *to attain an acceptable standard of health for all citizens to reach specific targets within the objective of "Health for All" in the twenty first century by 2020* in all Member States. The SADC Protocol on Health, which was signed in August 1999, fulfils the integration objectives of SADC in line with the Regional Indicative Strategic Development Plan (RISDP), whose purpose is to deepen regional integration. In addition, the 15 year Implementation Plan for the SADC Protocol on Health takes cognizance of existing SADC commitments notably the HIV/AIDS Business Plan, as well as international commitments and targets, and has aligned them with regional outcomes expected in 2020. These international commitments include the Millennium Development Goals, UNGASS Declaration of Commitment on HIV/AIDS, WHO Health for All by 2020, and Declarations arising out of meetings of African Heads of State and Government.

4.3.2 Progress with regards to morbidity and mortality in the SADC region varies considerably, pointing to the differences in economic, political, social and disease profiles that pertain in each country. With regards to child mortality, three patterns emerge in the region, countries where there has been no change since 1990, those with decreases in mortality and those that have had an increase in mortality. Maternal mortality on the other hand has worsened or remained at unacceptably high levels in many countries of the region. Maternal mortality is particularly sensitive to health service delivery and may also reflect the general decline in the quality of health services. However, the increases in maternal and child mortality are also attributed to HIV/AIDS and malaria. With regards to the MDG targets related to HIV and AIDS, malaria and other diseases, most of the countries of the region are performing poorly.

4.3.3 Although coverage of communicable diseases interventions varies considerably across countries, it is largely considered to be sub-optimal given the scale of the diseases. Most countries of the region have less than 25% of eligible PLWHA receiving ARVs, with the exception of Botswana and Namibia. Further, only three countries, Mauritius, Tanzania and Zambia have TB successful treatment rates exceeding 80%. With regards to malaria interventions only Malawi has a significant proportion of children sleeping under bed nets, at 36%. In the remaining countries where malaria is endemic, less than 10% of children under-five years sleep under a bed net.

4.3.4 The multi-sectoral mainstreaming of HIV/AIDS, which has been adopted as policy by SADC, requires institutional links between gender and HIV/AIDS mainstreaming and coordination between the two activities for positive outcomes. The proposed project will strengthen the SADC

HIV/AIDS Unit in its ability to address the specific gender concerns related to the targeted diseases and to effectively liaise with the Gender Unit to sustain an integrated approach that links poverty, gender and HIV/AIDS concerns and spans all sectors/directorates and to strengthen the capacity at country level to achieve similar outcomes. Furthermore, the provision of a gender expert will ensure mainstreaming of gender in communicable disease control policy instruments as well as programs and monitoring tools. All three communicable diseases have gender dimensions in the risk of exposure to infection, access to treatment and resources for prevention and survival. Thus gender results that ensure reduction in gender disparities in risk of infection, in access to treatment and resources for prevention as well as survival should be expected downstream at implementation level. It is also expected that the piloted best practices in OVC care will foster equality in the treatment of boys and girls and recognize and reduce the vulnerabilities that girls who head households are exposed to.

4.4 Project Objective

The objective of the project is to contribute to regional integration through the harmonized control of communicable diseases (HIV/AIDS, tuberculosis and malaria) in the SADC region.

4.5 Project Description

4.5.1 The proposed project, which will be implemented over a period of 60 months, will build the capacity of SADC secretariat to harmonize regional communicable disease control efforts in support of MS, strengthen information systems required for effective coordination, support the implementation of harmonized policies protocols and guidelines for prevention care and treatment of communicable diseases in MS and support the scaling up of OVC treatment and care best practices in selected MS. In the long term the project is expected to result in increased life expectancy in the SADC region. In the medium term, the expected results arising from project interventions will be a reduction in morbidity and mortality due to the three major communicable diseases, HIV/AIDS, TB and Malaria. The project interventions although regional in focus will realize results at country level thereby benefiting the people of the SADC region.

4.5.2 The expected project components include:

- i. Improving capacity to harmonize policies, protocols and guidelines for the control of communicable diseases by SADC secretariat;
- ii. Increasing capacity to implement harmonized policies protocols and guidelines in SADC Member States
- iii. Upgrading of the regional communicable disease surveillance systems
- iv. Improving the sustainable availability of essential medicines
- v. Scaling up OVC Best Practices in SADC MS

4.5.3 All the activities to be implemented under these components and described below, are drawn from the SADC Heads of State Declaration on HIV/AIDS (Maseru Declaration), the SADC Health Protocol Implementation Plan (2006) and specific communicable disease business plans and documents.

4.6 Detailed Description of Components and Activities

Component 1: Strengthening capacity to harmonize policies protocols and guidelines for the control of communicable diseases by SADC secretariat

4.6.1 The achievement of this component will entail activities to support the SADC secretariat primarily through the provision of a team of experts to build the capacity of the Directorate of HSDSP in its efforts to coordinate regional communicable diseases activities. The team will also provide day to day management and technical support for project activities. Thus activities undertaken under this component include human resource support to SADC secretariat as well as consultancy services for development and advocacy for harmonized policies protocols and guidelines related to the three diseases. These activities are summarized below under each disease.

Services

4.6.2 With regards to human resources capacity building of the SADC secretariat, the project will finance technical assistance over five years for the following: 1 communicable diseases coordinator, and 1 Gender expert. In addition the following positions will be financed over two and a half years: 1 health policy analyst, 1 finance officer, 1 Monitoring and Evaluation expert and. Furthermore, short term consultants in specialised areas will also be recruited to support specific activities. The project will also finance consultancy services for ad hoc assignment, mid-term review, post evaluation and audit services.

4.6.3 With regards to capacity building for coordination of policy harmonization and implementation activities, the project will support the following training workshop activities : (i) project launching workshop; (ii) post evaluation dissemination workshop and ; (iii) SADC secretariat (HSDSP) staff training (trips to the Bank, in country and regional workshops and seminars).

4.6.4 The team based in the SADC secretariat, Directorate of Human and Social Development and Special Programs (HSDSP) will support the review, updating and development of priority policies protocols and guidelines to be harmonized and implemented within the life of the project. To this end the project will finance high level consultations and workshops with SADC policy makers (including Ministers of Health). These will include the following:

- i. consultations with appropriate SADC National Committees (SNCs) to present the project and proposed workplan and ensure participation and support of relevant stakeholders in hamonization processes;
- ii. 3 regional workshops for health policy makers to ensure support from MS for activities to be carried out, as well as to review progress and review final products.

4.6.5 The work of the team of experts will include coordinating and managing the development of draft harmonized policies, protocols and guidelines for the three diseases (HIV/AIDS, TB, Malaria). The development of policies protocols and guidelines for each disease will be subcontracted to regional institutions and consultants.

4.6.6 The project will also finance interventions to strengthen SADC staff capacity in mainstreaming gender and HIV/AIDS. In order to build the capacity of the SADC Secretariat in gender mainstreaming, the gender expert will coordinate gender/poverty mainstreaming work within the SADC Secretariat through the Gender Unit. Activities will include sensitization drives and the holding of intermittent workshops for SADC staff, monitoring of other directorates to ensure that projects placed there comply with the SADC HIV and AIDS policy framework and

complement activities of other directorates, including the Directorate for Social and Human Development and Special Programs.

4.6.7 As a contribution to the harmonization of gender policies the project will finance activities related to the finalization of a Regional Gender policy, which has been drafted by the SADC. To this end the project will finance two regional workshops for review and adoption of the document by Member States.

4.6.8 Malaria : the project will fund harmonization of policies protocols and guidelines for the control of malaria in the SADC countries in the following areas : (i) Strategies for IEC, for the control of malaria in resident communities using Intermittent Presumptive Treatment (IPT), Insecticide Treated Nets (ITNs), Insecticides in indoor Residual Spraying (IRS) and personal protection ; (ii) Strategies for case management including laboratory capacity, drug availability and referrals, drug monitoring, procurement of Malaria control commodities; and for the response to malaria epidemics and emergency. Interpretation, translation, administrative and reproduction cost will be borne by the project.

4.6.9 Tuberculosis (TB) : the project will finance the harmonization of policies and strategies for the control of TB in the SADC region in the following areas : development of regional guidelines ; harmonization of regional TB control policies and protocols ; harmonization of regional treatment regimens ; development of regional TB laboratory Quality Assurance Network for microscopy, culture and drug susceptibility testing ; establishment of regional mechanism for collaborative TB/HIV activities and conducting a workshop to strengthen Southern African Tuberculosis Control Initiative (SATCI).

4.6.10 The project will assist SADC in the revival of the Southern African Tuberculosis Control Initiative (SATCI) by financing regional meetings for SATCI members. The project will bear the costs related to consultancy services and two regional meetings. The project will also fund the harmonization of regional treatment regimens for TB as well as the establishing of a regional mechanism for collaborative TB/HIV activities. Consultancy services will be financed to review existing regimens and mechanisms and two regional workshops will be held to discuss and adopt the documents by Member States representatives. In addition, the project will assist SADC in developing a regional Advocacy, Communication and Social Mobilization Strategy for TB control. Consultancy services and regional working group meetings will be financed by the project.

4.6.11 HIV/AIDS : The project will assist in the review and harmonization of policies and guidelines on prevention of STI and HIV infection ; care and support of people infected and affected by HIV and AIDS ; treatment of HIV and AIDS and opportunistic infections.

4.6.12 The project will assist SADC in developing regional guidelines for behavioral change and communication (BCC). The cultural risk factors, BCC policies and existing programs will be assessed and reviewed by using relevant consultancy services, by financing the costs of two regional workshops and related costs for review and adoption of the documents by Member States. The project will also fund the development of regional guidelines for programming HIV/AIDS in the uniformed forces. Thus the project will support the costs for consultants and two regional technical reviews. The participants of these meetings will be SADC staff, MS and NGOs representatives. In addition the project will assist SADC in the review and harmonization of guidelines for Prevention of Mother to Child Transmission (PMTCT). The project will also support the development of guidelines on paediatric HIV/AIDS treatment. Existing programs will be reviewed and guidelines will be drafted and harmonized by qualified consultants and member states representatives. In addition two regional meetings will be held to review and adopt the guidelines

(participants will come from SADC's MS) and other workshop related costs will be borne by the project (i.e. translation, reproduction, interpretation, etc.).

4.6.13 The project will finance the review and harmonization of regional guidelines for STI/HIV and behavioral surveillance systems. The existing programs in these domains will be reviewed, guidelines drafted and harmonized by consultants with experience on these matters. Two regional workshops, to validate the outputs of these consultancies, will be facilitated by these consultants and related costs paid by the project. The development and harmonization of regional guidelines for promotion and utilization of condoms will be developed by relevant consultants and financed by the project. Existing guidelines will be reviewed and harmonized by competent consultants who will also draft regional guidelines and will facilitate a regional meeting with the participation of MS in order to clear these documents. In addition the development and the harmonization of policies for HIV/AIDS care and support, for STI/HIV/AIDS treatment and HIV/AIDS/TB for migrant/mobile and displaced populations will be part of the project activities. The project will finance consultancy fees related to the subject and a technical workshop, with the participation of MS staff.

Goods

4.6.14 The project will procure the necessary office equipment (computers, printers, laptop, projectors, photocopiers, furniture for offices).

Operating Costs

4.6.15 The operating costs of the project including the recruitment of 1 secretary and local transport hire for project supervision, will be supported by ADF.

Component 2: Increasing the capacity of SADC MS in the implementation of harmonized policies strategies and protocols

4.6.16 This component will entail all training activities for communicable disease managers from all MS. The training of program managers for communicable diseases will be subcontracted to regional training institutions and may run concurrently. Interpretation, translation, administrative and reproduction cost will be borne by the project.

Services

4.6.17 The project will finance 4 regional training workshops for MS health sector managers responsible for each of the 3 communicable diseases and health sector IEC managers. In addition, a regional workshop to sensitize national public broadcasters on regional IEC messages on communicable diseases will be funded. The trainings to be funded include:

- i. 1 regional workshop for HIV/AIDS program managers from 14 MS in new harmonised policies, protocols and guidelines for the prevention, care and treatment of HIV/AIDS;
- ii. 1 regional Training of trainers workshops on Paediatric HIV/AIDS treatment for MS health sector managers;
- iii. 1 regional workshop for TB program managers from 14 MS in new harmonised policies, protocols and guidelines for the prevention, care and treatment of TB;
- iv. 1 regional workshop for Malaria program managers from 14 MS in new harmonised policies, protocols and guidelines for the prevention, care and treatment of Malaria;

- v. 1 regional workshop for IEC program managers from 14 MS in new harmonised IEC guidelines for the prevention, care and treatment of HIV/AIDS, TB and Malaria.
- vi. The project will also finance the required training of national health personnel in 8 ADF countries as part of the implementation of the new policies, protocols and guidelines.

Component 3: Upgrading of regional communicable disease surveillance systems

4.6.18 This component entails activities that will result in an effective communicable disease surveillance system at SADC and within MS through the establishment of a regional communicable disease surveillance system for all three communicable diseases (Malaria, HIV/AIDS and TB).

Services

4.6.19 The project will finance the creation of a tele-health system to facilitate transmission of data between SADC secretariat and Member States; and financing of the identification of regional reference laboratories to support the improvement of diagnostic capacity for communicable diseases and training activities. As part of the establishment of the communicable disease surveillance system, the project will finance a consultancy to develop a regional surveillance system, In addition, the following activities will be funded:

- i. A workshop for MS on the development of a common set of indicators for communicable diseases in consultation with CD managers and national epidemiologists, and
- ii. publication of a handbook/manual on indicators for communicable diseases.
- iii. 4 regional networking meetings for communicable disease managers and international experts;
- iv. Publication of a regional quarterly journal on communicable diseases;
- v. Webpage on SADC website for updates on communicable diseases;
- vi. The project will also finance Consultancy services to develop a framework for cooperation on communicable disease surveillance in the region; and
- vii. 1 Training workshop for MS HMIS managers in the surveillance system.

4.6.20 In order to support the communicable disease surveillance system, the project will also finance the set up of tele health facilities in ADF countries and the SADC secretariat. The following additional activities will be financed:

- i. A study on the location and capacity of reference laboratories,
- ii. Regional consultations on a framework for rationalising utilization of resources and development of proposals on a network of reference laboratories to support improved communicable diseases diagnostic capacity in the region.
- iii. A workshop for Ministers of Health for the approval of the framework and proposals will also be financed.

Goods

4.6.21 The project will finance the procurement and installation of hardware and software for the surveillance system, telehealth, geographic information system equipment and diagnostic equipment for reference laboratories at the SADC secretariat and ADF countries.

Component 5: Improving the sustainable availability of essential medicines

4.6.22 This component entails support toward the development of mechanisms to ensure the sustainable availability of essential medicines in the SADC region. This will be achieved through studies and preparation of the required policies and frameworks. Furthermore, bottlenecks and constraints in the procurement and supply management of essential health commodities in SADC member states will be identified. In addition, relevant policies, tools, expertise and mechanisms for quantification and forecasting of needs for procurement and distribution of medicines will be developed, as appropriate, to assist MS to improve their efficiency in order to ensure a more regular supply of quality assured medicines. Relevant information from SADC member states and globally on procurement and supply management will be shared among MS, while harmonized procedures for medicines procurement will be established to ensure the lowest medicines prices in as many countries as possible within the SADC region. Further, National regulatory bodies from SADC MS will benefit from sharing information regularly on quality assurance issues in the region.

Services

4.6.23 The project will finance the following activities:

- i. Study to identify bottlenecks and constraints in the procurement and supply management of essential drugs;
- ii. Harmonization of regional procurement mechanisms for essential drugs;
- iii. Development of regional bulk procurement agreements;
- iv. Development of common tools and expertise in forecasting needs, procurement and distribution of drugs
- v. Training of MS pharmaceutical managers on harmonized tools for forecasting, procurement and distribution,
- vi. 5 annual networking workshops for pharmaceutical managers from MS on the use of medicines for HIV/AIDS, tuberculosis and malaria,
- vii. 5 annual workshops for drug regulatory authorities from MS on quality assurance
- viii. A Feasibility study on regional manufacturing of essential drugs,
- ix. Applied research on the use of indigenous medicinal plants and nutritional supplements in addressing major communicable diseases,
- x. A regional workshop to present results of studies and develop strategies on improving access to medicines,
- xi. the development of a policy document on improving access to medicines in the region,
- xii. the development of an advocacy document to promote use of indigenous medicines.

Component 5: Scaling up OVC Best Practices in SADC MS

4.6.24 The achievement of this component will entail support towards implementation of the SADC Best Practices Framework in the thematic area of OVC prevention treatment and care. The activities to be undertaken include the documentation, peer review and assessment of best practices (BPs) in OVC treatment and care interventions and scaling up of best practices that meet regional criteria in selected MS. The project will finance the identification and documentation of best practices in the treatment and care of OVC in MS with technical support from UNICEF through its country offices. Identified best practices that meet criteria stipulated in the SADC Best Practice Framework, will be documented in a prescribed format in preparation for regional peer review. In addition to the criteria that include affordability, sustainability and cultural sensitivity, the project

will ensure that only BPs that adequately address gender equity are considered for scaling up. This will be done through the involvement of the project gender expert in the review processes. The project will finance peer review processes by a technical committee convened by the Social and Human Development Directorate of SADC. SADC will also develop a mechanism for selecting BPs for scaling up with assistance from UNICEF. Finally, funding will be made available for the dissemination of selected best practices to all MS as well as the scaling up of up to five Best Practices on a pilot basis. Inputs that will be required for scaling up of BPs include technical assistance, training, training materials, communication equipment and supplies, office equipment and supplies, drugs, medical supplies, garden supplies and seedlings and nutrition supplements, and transport. The selection of BPs for scaling up will be subject to approval by the Bank. SADC will source additional funds required for scaling up of BPs. The project M&E expert will be involved in the monitoring and evaluation of the implementation of the scale up of the selected BPs.

Services

4.6.25 The project will finance the following activities:

- i. Convening of technical committee to review SADC BPs;
- ii. 1 Regional workshop to disseminate selected BPs to all MS;
- iii. Development of a data base on best practices.
- iv. Technical assistance from UNICEF to identify OVC treatment and care BPs in MS through 1 national consultative workshops in each MS with stakeholders involved in OVC treatment and care interventions;
- v. TA from UNICEF to document BPs that meet SADC criteria;
- vi. National peer review of documented BPs and submission for regional peer review with TA from UNICEF;
- vii. TA from UNICEF for scaling up of 5 BPs on a pilot basis;
- viii. Evaluation of implementation of scaled up Best Practices.

Goods

4.6.26 The project will procure the following goods required for scaling up Best Practices: drugs, nutrition supplements, equipment and supplies.

Operating Costs

4.6.27 The operating costs associated with scaling up of Best Practices will include administrative costs associated with convening workshops, logistics and transportation, as well as UNICEF project support costs.

4.7 Environmental Impact

The project is categorized III, according to the Bank's environmental policies. By virtue of its design, the project will not undertake any activities with any negative environmental impacts. Firstly, a significant portion of the project budget will support the harmonization of control measures for communicable diseases. Other project activities will entail capacity building, meetings and studies.

4.8 Project Costs

4.8.1 The total cost of the project, net of taxes and customs duties, is estimated at UA 22.226 million, i.e. US\$ 32.413 million, of which UA 7.477 (33.6%) million is in foreign exchange and the

equivalent of UA 14.748 (66.4%) million is in local Costs. For the purpose of costing, all items have been priced in US dollars and converted into Units of Account (UA) at the exchange rate applicable at the Bank for the month of March 2006. A summary of project cost estimates is given below in Table 4.1 by component and in Table 4.2 by category of expenditure. Detailed cost estimates are included in the Project Implementation Document (PID), annex IX

Table 4.1
Summary of Project Cost Estimates by Component

Project Components	Country, USD (millions)			UA (Millions)			% Foreign Exchange
	Foreign Exchange	Local Costs	TOTAL Costs	Foreign Exchange	Local Costs	TOTAL Costs	
1 Strengthening capacity to harmonize Policies & Strategies	1.480	9.899	11.379	1.015	6.788	7.803	13.0%
2 Strengthening implementation of harmonized policies/strategies	1.024	2.756	3.780	0.702	1.890	2.592	27.1%
3 Upgrading of regional surveillance system	4.762	1.532	6.294	3.265	1.051	4.316	75.7%
4 Improving the sustainable availability of essential medicines	0.466	2.893	3.359	0.320	1.984	2.304	13.9%
5 Scaling up OVC Best Practices in SADC MS	2.329	1.615	3.944	1.597	1.108	2.705	59.0%
Total Base Cost	10.061	18.696	28.757	6.899	12.820	19.719	35.0%
Physical Contingency	0.503	0.948	1.451	0.345	0.650	0.995	34.7%
Price Contingency	0.340	1.864	2.204	0.233	1.278	1.512	15.4%
Project Total	10.904	21.508	32.413	7.477	14.748	22.226	33.6%

4.8.2 Cost estimates are based on unit costs discussed with the SADC Secretariat. Physical contingencies are set at 10% for all categories of expenditure. Price contingencies are estimated at 5% % inflation per year on an overall basis for local costs and at 3.5% for foreign exchange costs. Price escalation due to the local currency exchange rates fluctuations has a lesser influence because the project budgets are set in United States dollar (US\$). The provisional list of goods and services with cost estimates is shown in annex VI.

Table 4.2
Summary of Project Cost Estimates by Category of Expenditure

Categories of Expenditure	Country, USD (millions)			UA (Millions)			% Base Costs	% Foreign Exchange
	Foreign Exchange	Local Costs	TOTAL Costs	Foreign Exchange	Local Costs	TOTAL Costs		
A – Goods	5.671	0.779	6.450	3.888	0.534	4.423	19.9%	87.9%
C – Services	3.866	12.497	16.362	2.651	8.569	11.220	50.5%	23.6%
D - Operational Costs	0.525	5.420	5.945	0.360	3.717	4.077	18.3%	8.8%
Base Cost	10.061	18.696	28.757	6.899	12.820	19.719	88.7%	35.0%
Contingencies	0.503	0.948	1.451	0.345	0.650	0.995	4.5%	34.7%
Sub-Total	10.564	19.644	30.208	7.244	13.470	20.714	93.2%	35.0%
Escalation	0.340	1.864	2.204	0.233	1.278	1.512	6.8%	15.4%
Final Cost	10.904	21.508	32.413	7.477	14.748	22.226	100.0%	33.6%
Percentage				33.6%	66.4%			

4.9 Sources of Financing and Expenditure Schedule

4.9.1 Table 4.3 presents the sources of finance. The project will be financed by ADF grant resources and by SADC. The ADF grant of UA 20.00 million equivalent to 90.0% of total costs (UA 22.226 million) will finance 100% of the foreign cost (UA 7.477 million) and 84.9% (UA 12.523 million) of local costs. SADC financing of 15.1% (UA 2.226 million) of local costs or 10.0% of total costs, will cover logistics for workshop participants, operating costs related to provision of office space and local transportation.

4.9.2 In addition, SADC will be responsible for payment of all taxes and duties arising during the course of the project implementation over and above the counter part contributions as shown in table 4.3 below.

Table 4.3
Sources of Finance

Source	USD million				Total	UA million			%
	F.E.	%	L.C.	%		F.E.	L.C.	TOTAL	
ADF	10.904	100.0%	18.262	84.9%	29.167	7.477	12.523	20.000	90.0%
SADC	0.000	0.0%	3.246	15.1%	3.246	0.000	2.226	2.226	10.0%
	10.904	100.0%	21.508	100.0%	32.413	7.477	14.748	22.226	100.0%
% Distribution	33.6%		66.4%		100.0%				

4.9.3 Tables 5.1 and 5.2 show the expenditure schedule by component and by category of expenditure and source of financing respectively.

Table 4.4
Expenditure Schedule by Component
(In Millions of UA)

COMPONENT/CATEGORY	2007	2008	2009	2010	2011	Total
1. Strengthening capacity to harmonize policies & strategies						
A. Goods	0.03	0.06	0.06	0.03	0.00	0.178
C. Services	0.98	1.64	2.30	0.98	0.66	6.563
D. Operating Costs	0.32	0.54	0.54	0.43	0.32	2.166
Total COMPONENT I	1.34	2.24	2.90	1.44	0.98	8.907
Percentage (%) per year	15.0%	25.2%	32.6%	16.2%	11.0%	100.0%
2 Strengthening implementation of harmonized policies, protocols and strategies						
C. Services	0.31	0.52	0.72	0.31	0.21	2.060
D. Operating Costs	0.13	0.22	0.22	0.18	0.13	0.881
Total COMPONENT II	0.44	0.74	0.94	0.49	0.34	2.941
Percentage (%) per year	15.0%	25.0%	32.0%	16.55	11.5%	100.0%
3. Upgrading of Regional CD surveillance system						
A. Goods	0.57	1.34	1.34	0.57	0.00	3.823
C. Services	0.10	0.17	0.24	0.10	0.07	0.687
D. Operating Costs	0.04	0.06	0.06	0.05	0.04	0.241
Total COMPONENT III	0.71	1.57	1.64	0.72	0.10	4.751
Percentage per year	15.0%	33.0%	34.5%	15.3%	2.2%	100.0%
4. Improving the sustainable availability of essential medicines						
C. Services	0.30	0.49	0.69	0.30	0.20	1.978
D. Operating Costs	0.11	0.16	0.16	0.13	0.10	0.648
Total COMPONENT IV	0.39	0.66	0.85	0.43	0.30	2.626
Percentage per year	15.0%	25.0%	32.5%	16.2%	11.2%	100.0%
5. Scaling up OVC Best Practices in SADC MS						
A. Goods	0.12	0.29	0.29	0.12	0.00	0.828
C. Services	0.22	0.36	0.50	0.22	0.14	1.442
D. Operating Costs	0.11	0.18	0.18	0.15	0.11	0.730
Total COMPONENT V	0.45	0.83	0.98	0.49	0.25	3.000
Percentage per year	15.0%	27.8%	32.6%	16.2%	8.5%	100.0%
Total Project Cost	3.33	6.04	7.31	3.57	1.97	22.226
Percentage (%) per year	15.0%	27.0%	33.0%	16.0%	9.0%	100.0%

Table 4.5
Expenditure Schedule by Source of Finance
(In Millions of UA)

SOURCE/YEAR	2007	2008	2009	2010	2011	Total	% of Total
ADF							
A. Goods	0.72	1.69	1.69	0.72	0.00	4.830	21.7%
C. Services	1.88	3.14	4.39	1.88	1.26	12.555	56.5%
D. Operating Costs	0.39	0.65	0.65	0.52	0.39	2.615	11.8%
Sub-Total	3.00	5.48	6.74	3.13	1.65	20.000	90.0%
Percentage (%) per year	15.0%	27.0%	34.0%	16.0%	8.0%	100.0%	
SADC							
C. Services	0.03	0.04	0.06	0.03	0.02	0.175	0.85
D. Operating Costs	0.31	0.51	0.51	0.41	0.31	2.050	9.2%
Sub-Total	0.33	0.56	0.57	0.44	0.33	2.226	10.0%
Percentage (%) per year	15.0%	25.0%	26.0%	20.0%	15.0%	100.0%	
TOTAL PROJECT							
A. Goods	0.72	1.69	1.69	0.72	0.00	4.830	21.7%
C. Services	1.91	3.18	4.46	1.91	1.27	12.731	57.3%
D. Operating Costs	0.70	1.17	1.17	0.93	0.70	4.666	21.0%
Total	3.33	6.04	7.31	3.57	1.97	22.226	100.0%
Percentage (%) per year	15.0%	27.0%	33.0%	16.0%	9.0%	100.0%	

5. PROJECT IMPLEMENTATION

5.1 Executing Agency

5.1.1 The SADC Secretariat will be the project-executing agency. Additional staff will be recruited as part of technical assistance to build the capacity of the Directorate of Social and Human Development and Special Programs (SHDSP) financed by the HIV/AIDS ICPs under the JFTCA. These include experts in Partnership coordination, Policy development, Data base management a Finance officer as well as two support staff. This is in addition to the core staff of the Directorate, who include, the Head of the HIV/AIDS Unit, the Senior Programme Officer Health and Pharmaceuticals, the Health Advisor on secondment from the South African Department of Health and the HIV/AIDS Technical Collaboration and Research officer. The staff to be recruited by this project include: 1 communicable diseases coordinator, 1 Policy analyst, 1 Gender expert, a senior finance officer and a secretary. The SHDSP is responsible for the implementation of project activities and preparation of financial progress reports, monitoring and evaluation reports, and such other reports required by stakeholders. Its key tasks include the overall coordination and management of project operations, including HIV/AIDS, Malaria and Tuberculosis programme planning and implementation, training, monitoring and evaluation. It will review the annual work plans developed by implementing organizations, interregional organizations, member countries for presentation and approval by the steering committee. The staff of the SHDSP who will be involved in the project will be given training in ADF procedures.

5.1.2 The SHDSP will prepare annual workplans for the project. The work plans and related budgets will be reviewed by the Project Steering Committee before being forwarded to the Bank for approval.

5.1.3 SADC Secretariat will be assisted by a procurement agent for the procurement of all goods and services financed under the project.

5.2 SADC's Capacity to Implement Projects

5.2.1 As indicated above, the SADC Secretariat is building its capacity to implement its RISDP. To this effect and with regards to the health sector the Secretariat has three senior positions including the health advisor on secondment from the South African Department of Health. The additional staff will therefore be needed to complement and strengthen the capacity of the Directorate to implement the project under consideration. National level implementation of policies

which is the mandate of MS, will be further reinforced by the the participation of Ministers of Health in the various consultative activities planned in the project.

5.2.2 The organization chart of the SHDSP is shown in Annex III. This is consistent with the views of SADC HIV/AIDS ICPs which suggests that SADC capacity should be strengthened to enhance its coordination capacity in accordance with its mandate. Furthermore, the stakeholders consulted, namely the SADC ICPs, are in agreement that SADC's coordination role should be supported as articulated in the organizations HIV/AIDS Business Plan. Overall, the new SADC/ICP partnership clearly signals the confidence donors place in SADC and its ability to successfully complete the restructuring process. The fact that the ICPs have embarked on a coordinated effort to support the SADC restructuring would suggest that the organization will not lack financial and logistical support for implementation of programs. Furthermore, while the SHDSP Directorate will be responsible for the day to day management of the project, additional technical assistance has been proposed under the JFTCA. The technical assistance includes experts in policy development, monitoring and evaluation, partnership coordination and data management. The services of the M&E and policy development experts financed under the JFTCA will also be engaged in this project.

5.3 Institutional Arrangements

5.3.1 A Project Steering Committee (PSC) will be established and chaired by the Director, SHDSP to provide strategic and policy guidance for the implementation of the project. A formal link between SADC Secretariat and National committees will be realized through the Project Steering Committee. Its membership will comprise the Director of SHDSP, representatives of the countries national program managers for the control of communicable disease (HIV/AIDS, TB and malaria). The PSC will incorporate any other experts or members from within SADC or outside as and when required. The PSC will meet twice every 12 months at the expense of the project to review progress and approve annual work plans and budgets. The establishment of the PSC by SADC shall constitute one of the conditions precedent to first disbursement of the grant. The PSC will be responsible for overseeing the implementation of project activities and will assume some of the following functions: oversee project operations and provide both policy and operational guidance; review and approve annual work plans and budgets; review and assess project performance through Quarterly and Annual Progress Reports; approve project operation guidelines that promote best practices and ensure participation of beneficiary communities; and review and recommend appropriate actions to resolve issues and conflicts that may emerge. In addition, a procurement agency will be contracted to manage all project procurements.

5.3.2 Implementing Partners (IP): The project will be primarily implemented through contracts with regional institutions, UNICEF, and consultants. SADC Secretariat will be responsible for assessing selected Implementation Partners to evaluate their capacity to implement various activities in a timely and sound manner and meet their contractual obligations.

5.3.3 Consultancy contracts will be awarded for review and drafting of harmonized policies, strategies and protocols, establishment of information system, establishment of surveillance system and development of M & E system etc to individuals, firms and institutions with proven track record in policy development, capacity building and service delivery in key output areas.

5.3.4 Workshops and training both at SADC and in country for management, operation staff and beneficiaries will be awarded to institutions, national and regional networks with the capacity, experience and expertise in the subject area. All training and workshops under the project will be conducted on the basis of programs, which should be approved by the Bank on annual basis.

5.3.5 UNICEF will sign a Memorandum of Understanding (MOU) with SADC Secretariat for implementation of the activities entrusted to them. UNICEF is the lead organization within the UN system for supporting States to provide protection care and support for children affected by HIV and AIDS. UNICEF has been working with MS in the region to develop National Plans of Action for OVC and has provided support to cost them. The services of UNICEF have also been contracted to develop a regional policy on OVC. A draft MOU between SADC and UNICEF regarding OVC is currently under discussion. UNICEF's comparative advantage is further strengthened by the fact that the organization has country offices in all the SADC MS. These country offices have staff with expertise and experience in supporting government and other development partners to develop effective interventions in the area of HIV/AIDS prevention, care and support for children. UNICEF will use the services of NGOs, CBOs and FBOs where necessary.

5.4 Supervision and Implementation Schedules

5.4.1 The project will be implemented over a period of 5 years (60 months) starting from the date of effectiveness of the grant. The overall implementation schedule in Annex V gives the tentative timing for the various activities of the project and key implementation targets are summarized in table 5.1.

Table 5.1
Summary of Implementation Schedule

ITEM	ACTIVITY	TARGET	ACTION BY
A.1	Appraisal	03/2005	ADF/SADC
A.2	Post Appraisal	03/2006	ADF
A.3	Negotiation	04/2006	ADF/SADC
A.3	Board Presentation	05/2006	ADF
A.3	Publication of General Procurement Notice	07/2006	ADF/SADC
A.4	Grant Signature	06/2006	ADF
A.5	Effectiveness	08/2006	SADC
A.6	Launching mission	09/2007	ADF/SADC
A.7	Quarterly Progress Reports	04/2007 – 12/2011	SADC
A.8	Extended Supervision Mission	05 – 06/2008	ADF/SADC
A.9	Mid-term review	2009	ADF/SADC
A.10	End-of-project evaluation	12/2011	SADC
A.11	Borrowers Project Completion Report	06/2012	SADC
A.12	Project Completion Report	09/2012	ADF/SADC

5.4.2 The project will require close and frequent supervision, especially during the initial stages of implementation, and has therefore been catered for. As part of the start-up activities the project will sponsor a 3-day participatory project start up workshop. In addition, support to the project will be made available from the ADB regional office in Maputo and country offices in SADC MS.

5.4.3 The Start-up Workshop will aim to achieve the following objectives: to strengthen cross-sector collaboration for HIV/AIDS/TB/Malaria programs' planning and implementation; create a shared vision of HIV/AIDS/TB/Malaria programs success; reach a consensus on critical project tasks and activities; clarify roles and responsibilities of the implementing groups and plan next steps to ensure continued collaboration and to monitor progress. The workshop will include all the key stakeholders including representatives from governments, non-governmental organizations, private sector, training institutions, and uniformed forces.

5.4.4 The Fund will supervise the project at least 1.5 times a year during the entire life of the project. A mid-term review will be undertaken in the third year of the project to assess the participatory process and performance of the project activities in accordance with current Bank norms.

5.5 Procurement Arrangements

5.5.1 Procurement arrangements are summarized in Table 5.2 below. All procurement of goods, and services financed by the Bank will be in accordance with Bank's *Rules of Procedure for Procurement of Goods and Works*, or as appropriate, *Rules of Procedure for the Use of Consultants*, using the relevant Bank Standard Bidding Documents.

5.5.2 *Goods*: The procurement of tele-health surveillance equipment, GIS equipment, laboratory diagnostic equipments all valued in aggregate at UA 3.823 million will be carried out through International Competitive Bidding (ICB). Drugs including that of ARVs, nutritional supplements, VCT kits, equipment, reagents and supplies all valued at UA 0.827 million will be procured through International Shopping mode of procurement. Procurement of office goods intended for project use at the SADC Secretariat, which include furniture; general office equipment; computers; printers; scanners; photocopiers; all valued at UA 0.178 million will be procured through National Shopping, as goods are standard specification commodities readily available in Botswana.

Table 5.2
Summary of Procurement Arrangements

	Project Categories	ICB	Others	Short List	NBF	Total
1	Goods					4.830
1.1	Furniture		0.015 (0.015)			0.015 (0.015)
1.2	office equipment, computer, etc		0.163 (0.163)			0.163 (0.163)
1.3	Equipment for tele-health centres	1.826 (1.826)				1.826 (1.826)
1.4	GIS equipment & Databases	0.874 (0.874)				0.874 (0.874)
1.5	Laboratory Diagnostic equipment	1.123 (1.123)				1.123 (1.123)
1.6	Drugs, ARVs & supplies		0.528 (0.528)			0.528 (0.528)
1.7	Nutrition supplements		0.112 (0.112)			0.112 (0.112)
1.8	Voluntary Counseling & Testing Kits		0.075 (0.075)			0.075 (0.075)
1.9	Health equipment, reagents & Supplies		0.112 (0.112)			0.112 (0.112)
2	Consulting Services & Training					12.731
2.1	Technical Assistance (TA)			1.579 (1.579)		1.579 (1.579)
	Procurement Agent			0.686 (0.686)		0.686 (0.686)
2.2	Consultancy services:					
	i) Project monitoring & Evaluation			0.462 (0.462)		0.462 (0.462)
	ii) Review, drafting & harmonization of policies, guidelines and protocols			0.840 (0.840)		0.840 (0.840)
	iii) Implementation of harmonized policies, guidelines and protocols			0.692 (0.692)		0.692 (0.692)
	iv) Development of regional surveillance system			0.361 (0.361)		0.361 (0.361)
	v) Improved and sustainable availability of essential drugs			1.013 (1.013)		1.013 (1.013)
	vi) OVC Best Practices scaled up in SADC			0.087 (0.087)		0.087 (0.087)
2.3	Training/Workshops:					
	i) Participatory Workshops		0.177 (0.177)			0.177 (0.177)
	ii) Regional workshops/conferences		5.676 (5.501)			5.676 (5.501)
	iii) Country level training		0.773 (0.773)			0.773 (0.773)
2.4	Audit services			0.098 (0.098)		0.098 (0.098)
3	Operating Cost					4.666
3.1	Personnel costs			0.028 (0.028)		0.028 (0.028)
3.2	Office expenses				1.172 (0.00)	1.172 (0.00)
3.3	Field travel and related costs		0.966 (0.966)			0.966 (0.966)
3.4	Material, reproduction, venue costs		2.500 (1.622)			2.500 (1.622)
	TOTAL COST	3.823 (3.823)	11.097(10.044)	6.133 (6.133)	1.172 (0.00)	22.226 (20.00)

* Shortlist applies to the use of consulting services only.

** Other may be LIC, International or National Shopping or Direct Purchase.

*** Figures in brackets are amounts financed by the Fund.

Table 5.3
Other modes of Procurement

Procedure	Goods/Services	Max per contract	Max in Aggregate
International Shopping			
	Drugs, ARVs & supplies		0.528
	Nutrition supplements		0.112
	Voluntary Counseling & Testing Kits		0.075
	Health equipment, reagents & Supplies		0.112
National Shopping	Furniture		0.015
	office equipment		0.163
Direct Purchase	Project Support costs (UNICEF)		0.193

5.5.3 *Consulting Services & Training*: Procurement of consulting services related to Technical Assistance (valued at UA 1.579 million), project monitoring and evaluation (valued at UA 0.462 million), review, drafting and harmonization of policies, protocols, guidelines and strategies (valued at UA 0.840 million), implementation of harmonized policies, guidelines and strategies (valued at UA 0.692 million), development of regional surveillance system (valued at UA 0.361 million), improved and sustainable availability of essential drugs (valued at UA 1.013 million), scaling-up Best Practices of OVC in MS (valued at UA 0.087 million) and audit services performed by firms and individuals will be undertaken in accordance with the Bank's "Rules of Procedure for the Use of Consultants" on the basis of short-listing. Consulting Services assignments estimated to cost equivalent of UA 50, 000 and above will be selected through procedure based on technical quality with price consideration. Consulting Services estimated to cost less than UA 50,000 will be acquired through the selection procedure based on establishing the comparability of technical proposals and selection of the lowest financial offer. Assignments estimated to cost equivalent of UA 350,000 or more would be advertised for Expression of Interest (EOI) in the Development Business (UNDB) and in at least one newspaper of wide national circulation in every SADC member states. In addition, EOI for specialized assignments may be advertised in an international newspaper or magazine. In the case of assignments estimated to cost less than UA 350,000 the assignment will be advertised nationally in members' state. Project audit services will be procured through a shortlist. The selection procedure will be based on establishing the comparability of technical proposals and selection of the lowest financial offer.

5.5.4 The services of UNICEF will be procured through Single Source selection procedures (Direct Purchase) for the procurement of the main commodities related to Output V and consultancy services. UNICEF will be providing technical support to the project at country level and its responsibilities vis-a-vis SADC Secretariat through the project staff will be clearly stipulated during the meeting between the Bank and its representatives. For the purpose of costing the UNICEF support is estimated at maximum of 12% of the value of related activities within the output.

5.5.5 Regional and in-country (Management and operational) training of SADC Secretariat staff, selected representative of member states and those at the country level comprising participatory launch workshop (valued at UA 0.177 million), regional training workshops (valued at UA 5.676 million) and national training (valued at UA 0.773 million) will be procured through a short list.

5.5.6 *Miscellaneous*: Provision has been made under the project to cater for operating costs to cover support staff salaries (UA 0.028 million), office expenses including cost of renting vehicles on periodic basis, communication, rental for office accommodation, supplies and other sundries vehicles (UA 1.172 million), expenses related to project implementation (UA 0.966 million).

5.5.7 *National Procedures and Regulations*: SADC's procurement procedures and regulations have been reviewed and determined to be acceptable.

5.5.8 *Executing Agency*: The SADC Secretariat will be responsible for the procurement of goods and services under the project. The resources and capacity of SADC Secretariat are limited to carry out the procurement envisaged under the project. The recruitment of additional human resources and contracting an external procurement agency will strengthen the capacity of SADC Secretariat. A provision has been made to finance these services. Selection and appointment of additional staff of SHDSP Directorate will be undertaken in accordance with the Bank's Rules of Procedure for the Use of Consultants.

5.5.9 *General Procurement Notice*: The text of a General Procurement Notice (GPN) will be agreed upon with the SADC and will be issued for publication in Development Business, upon the approval by the Board of Directors of the Grant Proposal.

5.5.10 *Review Procedures*: The following documents are subject to review and approval by the Bank: Specific Procurement Notices; Prequalification Invitation Documents; Tender Documents or Requests for Proposals from Consultants; Tender Evaluation Reports or Reports on Evaluation of Consultants' Proposals, including recommendations for Contract Award; Draft Contracts, if these have been amended from the drafts included in the tender invitation documents.

5.5.11 *Post Review*: In view of some small contracts that will be processed contracts for goods up to an amount of UA 20,000 will be subject to post review in accordance with Banks Rules of Procedure of Procurement of Goods and Works. In this regard, the Bank will review for prior approval the first ten (10) contracts. Then subsequently, procurement documents, including solicitations of price quotations, evaluation sheets and contract awards will be kept at the SADC Secretariat for periodic review by ADF supervision missions. This task will be included in all terms of reference for field missions. One year after effectiveness, ADF will review the correctness of the procurement activities. This review will determine the need for modifications and improvement of procurement arrangements. Information on procurement processing will be collected by the SADC Secretariat quarterly and shall be included in detail in the PQPR to be submitted to ADF.

5.6 Disbursement Arrangements

5.6.1 The Special Account (SA) method and the Direct Payment (DP) method will be used for disbursement. Funds for the operating costs of the SHDSP Directorate, workshops, travel and project audits would be disbursed through the special account method of disbursement from which SADC would make payment for approved expenditures by ADF.

5.6.2 SADC will open one (1) Special Account (SA) in foreign currency to receive the ADF grant, and one (1) Local Currency Account (LCAs) in a bank acceptable to the ADF. The LCA will be used to receive transfers from the first Special Account for operating costs and SADC counterpart contribution. Funds to be utilized for the operating costs and salaries of staff to be assigned to the project will be withdrawn from the special account and the counterpart account. The ADF will replenish the SA after the project has used at least 50% of the previous deposit and provide valid justifications for its use to the Bank. The SHDSP will maintain records at all times of all disbursements made by the Bank and the SADC. The opening of the SA's and the two LCAs will be a condition precedent to first disbursement for the grant.

5.7 Monitoring and Evaluation

5.7.1 The monitoring and evaluation of project activities, including implementation progress and expenditure will be the responsibility of the SADC Secretariat as a regular management function through the SHDSP. The Monitoring and Evaluation expert will strengthen the capacity of SADC to

carry out these functions and will submit to the Fund on a quarterly basis, reports on progress made on the implementation of the project components funded by the ADF and reports on project expenditures in accordance with Bank's format.

5.7.2 The Monitoring and Evaluation officer will assist the SADC in developing a set of indicators to be used in monitoring and evaluation of the project implementation. They will include targets, process and outcome indicators as well as input and output indicators. The M & E Officer will also assist in designing systems for collection and analysis of data relating to these indicators. A team of independent consultants will undertake the actual monitoring of activities. The Fund will closely monitor implementation of the project through regular follow-up, review and supervision missions; the latter would be undertaken at least 1.5 times a year. A Mid Term Review (MTR) will be undertaken by the ADF 30 months after first disbursement of funds. The MTR will examine progress made in achieving project objectives in accordance with the implementation plan, as well as examine the need for project revision. On the basis of the indicators used in the matrix and the expected results during the life of the project (outputs) and at the end of the project (outcome), regular performance reviews will be undertaken to assess progress toward achievement of project results.

5.7.3 To facilitate the MTR, SHDSP will prepare and submit to the Fund, prior to the review mission, an interim report on utilization of the grant and progress made in carrying out project activities. When the grant is fully disbursed and the project has come to an end, SHDSP will prepare and send to the Fund, a Project Completion Report (PCR) indicating costs, benefits, achievements, and lessons learned from implementation of the Project. At the close of the project an end-project evaluation will be carried out to assess to what extent the objectives of the project had been achieved which will inform and feedback into the SADC regional policies and strategies for the control of communicable disease. Upon review of the Borrowers PCR the Bank will undertake a mission to prepare Project Completion Report so as to evaluate the potential impact of the project and the lessons learned from its implementation.

5.8 Financial Reporting and Auditing

The Executing Agency will maintain the project's accounts by category of expenditure and source of funding and put in place a system of internal control to ensure prompt recording of transactions, timely production of accounts and reports and safeguard project assets. Financial records will be maintained in accordance with internationally acceptable accounting procedures. The SHDSP will prepare monthly financial statements that will be consolidated by them into quarterly financial statements to be included as a section of the Quarterly Progress Reports. The Department of Finance of the SADC Secretariat will have advisory and monitoring responsibility for the project accounts, it will oversee the project accounting units activities to ensure compliance with accounting procedures. An independent audit firm acceptable to the Fund will audit the financial statements of the project annually. The Secretariat will submit the audit report to the Fund for review and comments within six months after the end of each financial year in December. An allocation has been made in the project to cater for the costs of engagement of an independent external auditor.

5.9 Aid Coordination

5.9.1 The SHDSP ensures the aid coordination for the regional control measures of HIV/AIDS, tuberculosis and malaria. The proposed project will form part of the on-going concerted effort by donors to provide assistance to SADC in its endeavour to curtail the spread of infectious diseases (namely, HIV/AIDS, tuberculosis and malaria) in the region. The EU, DFID, Belgium, GTZ and UNAIDS are among the most active donors that have been involved in assisting the SADC in the

region. The representatives of these donors in Gaborone meet periodically to coordinate their assistance to SADC. The Bank consulted widely with all of SADC's concerned development partners involved in the areas of regional integration, capacity building, and control of infectious disease in the region. The information obtained from this consultation was used productively in designing this project. The ADF, through this project, is expected to take part in this endeavour and complement the support of other donors.

5.9.2 Donors supporting the SADC Secretariat have welcomed ADF's intervention. WHO continues to provide support to SADC with technical assistance in a number of areas including participating in the appraisal mission for the current project. This project also complements the Joint Financing and Technical Cooperation Arrangement (JFTCA) between SADC and the International Cooperating Partners HIV/AIDS Group. Under this arrangement priority aspects of the implementation of the SADC Business Plan on HIV and AIDS will be funded. Additional resources may also become available from the SADC HIV/AIDS Trust Fund when it becomes operational. Consultations are currently underway regarding the format and operational modalities of the Fund. ADB has been invited to participate in the Joint Steering Committee of the ICPs and thereby strengthen Aid coordination efforts in the SADC region.

5.9.3 The Joint Task Force, (JTF) established in 2003 in connection with reviewing RISDP, and consisting of a broad group of International Cooperating Partners (ICP) and SADC representatives, is chaired by the Chief Director of SADC. The purpose of the JTF is to improve coordination between ICPs and SADC in order to achieve more effective aid delivery and greater impact of ICP assistance.

6. PROJECT SUSTAINABILITY AND RISKS

6.1 Recurrent Costs

6.1.1 The project is an integral part of SADC's RISDP in which all the collaborating partners are taking part. SADC's budget (USD37 543 966) for the financial year 2005/2006 has been increased by more than 100% over last year's budget. To avoid generating additional recurrent costs, the project will not put in place a new structure, but it will increase the effectiveness of the existing structure at the regional (SADC) level. Thus the project will generate minimal recurrent costs.

6.1.2 The project's outputs are designed to ensure sustainability of the intervention following completion of the project. The PSC will ensure coordination of the project activities. The programme managers for the control of HIV/AIDS, TB and malaria in the countries will play an active role in the PSC.

6.2 Project Sustainability

6.2.1 Outputs of the project (regional policies, protocols and guidelines for the control of communicable diseases harmonized, policies, protocols and guidelines implemented by MS, regional communicable diseases surveillance system operational, improved access to essential medicines and OVC best practices scaled up), are sustainable because of the strong commitment of SADC to the control of communicable diseases, which is one of the key cornerstones of its goal of attaining of an acceptable standard of health for all the citizens. In addition, structures and institutions that are responsible for implementation of the various project activities are already in place at regional and national levels. No new or parallel structures will be created by the project. Moreover while the role of the SADC secretariat beyond the life of the project will be the continued

monitoring of policy implementation by MS, this will be done by the core staff. At national level, the sustainability of the project is ensured as policy interventions are aligned with MS health sector plans and policies. Thus the project is providing resources to boost the capacity of SADC to play its coordination and monitoring role more effectively and for MS to be more responsive to regional imperatives.

6.2.2 Furthermore, by expanding and harmonizing HIV/AIDS/TB and Malaria efforts throughout the region, SADC will augment the effectiveness of national investments in prevention, care, treatment, and mitigation. By identifying and encouraging the sharing of information and promising approaches across countries and in different settings, the likelihood increases that such activities will be scaled up and attract additional funding from many sources, including donors and technical assistance entities, the governments, and affected communities. It will provide operational and policy inputs to national programs in terms of what is done and learned under this project.

6.2.3 The project will increase the institutional capacities of the SADC Secretariat and national health sectors, by financing a number of training activities to develop policies, implement programs, collect and analyze data as well as monitor and evaluate the effectiveness of interventions. The three epidemics require a long-term effort to be effectively controlled and contained. Therefore, this increased capacity would enhance sector sustainability by enabling a long-term, well targeted, and multi-sectoral response. Cost recovery mechanisms are not considered in this project, as they would hamper the immediate response necessary to strengthen the sector, and unacceptably delay project implementation. However the on-going Bank financed projects in SADC countries will further reinforce the strengthening of national health systems and there by ensuring sustainability of project's benefits. In addition the SADC secretariat will ensure that Middle Income MS meet the cost of their participation in all regional training activities and meetings. The involvement of UNICEF country offices in activities to scale up OVC Best practices also ensures sustainability because the organization has a mandate to continue working in that area.

6.2.4 Selection of Bank's intervention is based on priority areas identified in the RISDP as well as in discussions with the major donors supporting SADC's efforts to curtail the spread of communicable diseases. The Bank's intervention will be complemented by the support of other donors to the Plan.

6.3 Project Assumptions and Risks

6.3.1 The project risks are summarized in the MPDE matrix and are as follows: (i) SADC Secretariat is not committed to implementation of its Health Protocol; (ii) the donor community does not continue to support The SADC Secretariat; (iii) Governments do not ensure participation of their representatives in all the processes; (iv) Member States do not meet their commitments to implement new policies, protocols and guidelines at country level.

6.3.2 Concerning the first risk, the mitigation measure is that SADC has shown commitment by adopting a 2005 budget increased by more than 100% over the 2004 budget. During 2005 to 2006 SADC will undertake wide staff recruitment. During 2006, the Implementation Plan of the SADC Health Protocol was completed with priorities for the first five years focused on the control of communicable diseases. In addition, WHO (Roll Back Malaria) is expected to provide the SHDSP Directorate with a Malaria Specialist who will deal with all SADC countries.

6.3.3 With regard to the second risk, the mitigation measure is that most donors with whom the Bank discussed during project design, are willing to continue supporting SADC and have pledged further support to finance priorities of the SADC HIV/AIDS Business Plan through the JFTCA.

6.3.4 Concerning the third risk, SADC is mitigating it by discussing and involving Member States early in the project design process. Other meetings are planned with Member States policy makers in order to discuss the project proposal including the outputs related to policy harmonization.

6.3.5 With regard to the last risk, the mitigation measures are the following: (i) ADF countries will be assisted with funding for implementation of the new policies, protocols and guidelines through training and dissemination activities; (ii) Through consultations with policy makers and communicable disease managers MS will be asked to make specific plans for implementation as required by the SADC Health Protocol to which they are signatories.

7. PROJECT BENEFITS

7.1 Economic Impact

7.1.1 Disruption in the social and human capital accumulation process, resulting in the loss of domestic savings, is the essence of what causes HIV/AIDS to adversely affect the economic development process. Social and political changes, social norms, violence and extensive migrations, sex inequality are among major factors in the SADC region contributing to high rates of HIV infections. These high rates of infection reduce economic growth and the capacity of society to provide services, and this in turn accelerates the numbers of people infected. The limited resources available to Governments and civil society to finance health and other services are of necessity reallocated from other priority areas to HIV/AIDS, thus reducing economic efficiency and compromising prospects for the SADC region to improve. High morbidity results in extensive labor absenteeism at all levels, coupled with premature mortality, which translate into significant losses in labor productivity.

7.1.2 The project is technically, economically and socially justified. The results will translate into savings in lives as well as reduced burden of illness. Reduced burden of illness at individual, household and community level contribute to increased productivity, thus resulting in the well being of individuals and households and a reduction of health expenditure.

7.1.3 The project, by financing HIV/AIDS activities will contribute to the increase of growth and income in SADC countries. Indeed for those countries with national HIV/AIDS prevalence rates of 20% or more, GDP growth has been estimated to drop by an average of 2.6 percentage points annually. Nationally focused studies have forecast that, by 2015, the economies of Botswana and Swaziland would grow by 2.5 and 1.1 percentage points less, respectively, than they would have in the absence of the epidemic. AIDS pushes people deeper into poverty as households lose their breadwinners, livelihoods are compromised and savings are consumed by the cost of health care and funerals. Research shows that, in two-thirds of Zambian families where the father died, monthly disposable income fell by more than 80%. The epidemic is putting increased burden on already fragile health systems by increasing demand for health services while health-care personnel themselves are being affected by HIV/AIDS. Malawi and Zambia, for example, are experiencing 5–6 fold increases in health worker illness and death rates. To compensate for such losses, an estimated 25–40% more doctors and nurses need to be trained in southern Africa in 2001 – 2010.

7.1.4 Currently malaria is a major impediment to socio-economic development and exhibits a positive correlation with poverty in the SADC region. Malaria impacts on the economy at a number of levels including within households and communities, the private sector, government and the macro economy. Households and communities bear the direct costs for prevention and treatment as well as indirect costs such as absenteeism from work or school. Such factors both cause and deepen poverty.

7.1.5 Indirect benefits are expected for all SADC populations as a result of improved and more effective and gender responsive HIV/AIDS/TB/Malaria and related health policies, protocols, and service delivery. This will occur as good practices in one SADC country are shared with others, from information exchange and harmonization of approaches, and knowledge generated from SADC financed studies and surveys which are customized to benefit the SADC region. The underlying premise of SADC is that good ideas will be integrated into national programmes, and vice versa. The project will make a substantial investment in the M & E system. It includes programme, biological and behavioural aspects. The monitoring should produce sound information on which activities are effective and should be scaled – up, and which are not and need to be modified or discontinued.

7.2 Social Impact

7.2.1 The proposed project responds to Governments’ major concerns as stated in the RISDP. It will contribute towards SADC’s goal of attaining an acceptable standard of health for all citizen within the objective of ‘Health for All’ by 2020 in all SADC member states. The project will facilitate the development of responses to the needs of people who are highly susceptible to the impact of communicable diseases, and who require regional-level assistance, such as mobile populations and displaced people. Further, although responses to OVC are implemented at national level, the identification, documentation and sharing of best practices based on regionally agreed criteria will stimulate efforts to scale these up. The harmonization of numerous policies, protocols and guidelines currently used by 14 SADC MS, the development of harmonized IEC content, will ensure implementation of communicable disease control programs that will benefit the entire population of the SADC region estimated at 234 million. In addition, managers of communicable disease programs in SADC MS will be trained in the harmonized policies, protocols and guidelines. Further training will be done within countries to ensure national implementation of the new tools.

7.2.2 The project is expected to have far reaching social effects, both through the capacity building at SADC headquarters and the harmonization of policies protocols and guidelines and their implementation. The capacity building at SADC Secretariat, particularly with its stress on ensuring a multi-sector/gender and poverty integrated approach to HIV/AIDS, TB and Malaria, will profit not only the project and its components but also other departments in SADC ensuring that HIV/AIDS/gender/poverty mainstreaming is advanced. The placement of a gender specialist in this directorate will increase the available gender expertise in SADC and ensure that all program implementation yields tangible gender equity results including a reduction in gender disparities in communicable disease risk, of infection, access to treatment and prevention resources and survival. In addition, the expert’s terms of reference will be reviewed by the Bank and closely monitored.

7.2.3 Moreover, the harmonization of policies and approaches will go a long way in mainstreaming gender and poverty concerns in policy and program approaches not only within SADC Secretariat but also in member countries and this will facilitate reaching target groups in an appropriate manner, and help close gender gaps and address the special needs of risk groups, namely: pregnant women, mothers and their children. Implementation of the project will facilitate prevention and early treatment, as well as the restoration of a satisfactory health condition, particularly among very young children and vulnerable populations. As such, it will develop available human resources, which will consequently be more productive. Indeed, considerable labor productivity gains will result directly from reduction of the burden of diseases due to HIV/AIDS, TB and malaria.

7.2.4 The project will have positive social impacts by assisting and empowering national and regional institutions to deal more effectively with the HIV/AIDS/TB/Malaria epidemics. The existing widespread poverty and lack of knowledge play a role in making individuals vulnerable to

communicable diseases. The project will promote access to prevention; care and mitigation services for the vulnerable groups in the SADC region through supporting the harmonization of policies protocols and guidelines related to the control of communicable. The project will also benefit from efforts undertaken by MS in areas such as poverty reduction and education. Furthermore additional benefits will be derived from synergies with other ongoing ADB financed projects and those in the pipeline in individual MS and SADC.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

HIV/AIDS, tuberculosis and malaria are major causes of mortality, morbidity and poverty in the SADC region. As a result, the SADC adopted strategies to control the three diseases. The strategies are in line with SADC's vision, which is focused on the well-being, improvement of standards of living and quality of life, freedom and social justice and peace and security for the peoples of Southern Africa. The project is technically feasible, economically viable, socially sound and environmentally safe. It responds to SADC's needs to implement the RISDP. The project will strengthen the implementation of the Plan *by providing technical assistance, training, consultancy services, equipment, goods, supplies, and operating costs*. Attainment of this objective will contribute to SADC's effort to improve the health status of the population and to curtail the spread of HIV/AIDS, tuberculosis and malaria. It will complement the support of other donors in their endeavor to assist the SADC to minimize the impact of communicable diseases. Its objectives and activities are in line with the Treaty establishing SADC, the Bank Group's Health Sector Policy, Strategies for the Control of HIV/AIDS and Malaria and the Bank Group's Guidelines on Financing of Multinational Operations.

8.2 Recommendations

It is recommended that the Fund consider extending an ADF grant not exceeding the sum of UA 20 million for SADC as described in this proposal, subject to the following conditions:

A. Conditions Precedent to Entry into Force of the Grant Agreement

The grant Agreement shall enter into force on the date of signature by the Recipient and by the Fund.

B. Conditions Precedent to First Disbursement of the Grant

Prior to first disbursement of the Grant, SADC shall have:

- i) Opened one (1) Special Account (SA) and two (2) separate Local Currency Accounts (LCA) in a Bank acceptable to the Fund. The first LCA will be used to receive transfers from the Special Account for operating costs, while the second LCA will receive SADC's counterpart contribution (paragraph 5.6.2);

C. Other Conditions

SADC shall:

- i) Constitute a Project Steering Committee (PSC) chaired by the Director of the SHDSP and comprising of communicable diseases coordinator, managers of national control programme

for HIV/AIDS, tuberculosis, malaria, representative of technical institutions and private sector (paragraph 5.3.1);

- ii) Within six (6) months from the date of effectiveness of the Grant Agreement, prepare and submit to the Fund, an acceptable training program, implementation schedule and budget for the training for the first year of project implementation. Provide the same documents to the Fund at the beginning of each following year (paragraph 4.6.12).
- iii) Within four (3) months from the date of effectiveness of this Protocol of Agreement, enter into a Memorandum of Understanding (MoU) with UNICEF for the implementation of activities related to Orphans and Vulnerable Children (OVC) best practices scaled up in SADC MS. Such MoU shall be submitted to the Fund's prior approval (paragraph 5.3.5)

ANNEX 1 MAP OF SADC

SADC SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES.

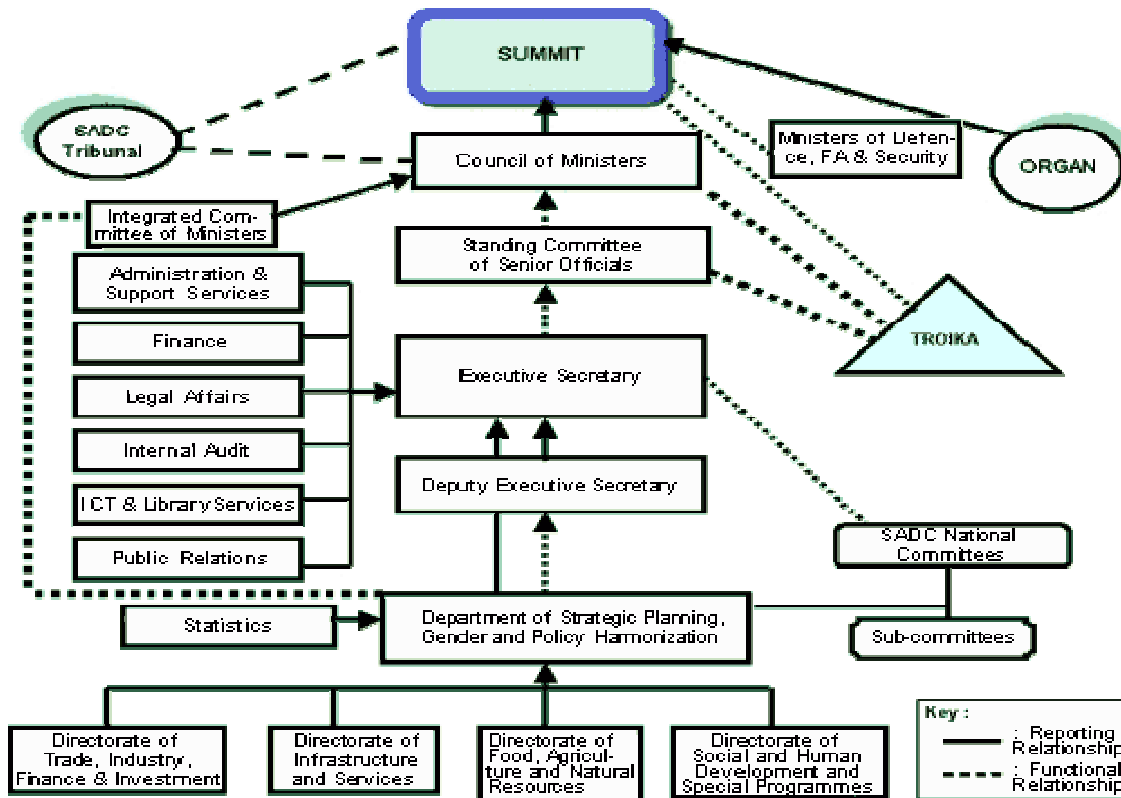


This map was provided by the African Development Bank exclusively for the use of the readers of the report to which it is attached. The names used and the borders shown do not imply on the part of the Bank and its members any judgment concerning the legal status of a territory nor any approval or acceptance of these borders.

SADC

MULTINATIONAL : SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES
(HIV/AIDS, TUBERCULOSIS AND MALARIA)

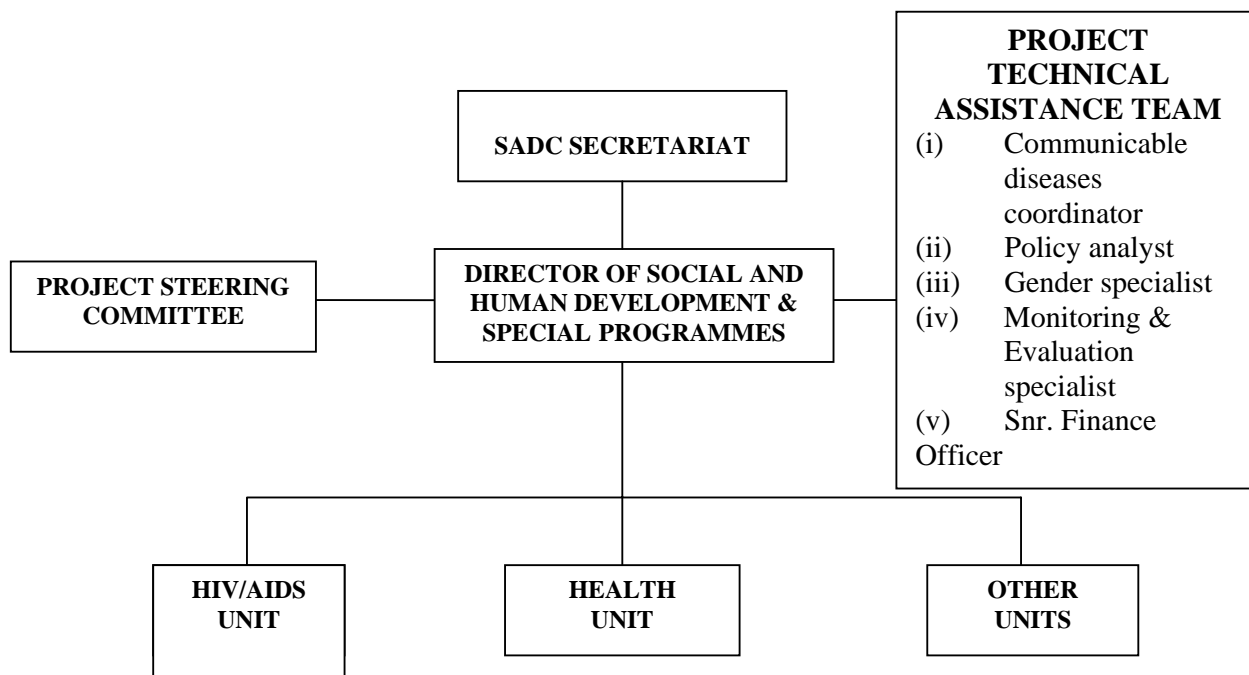
ORGANIZATIONAL CHART OF SADC



SADC

MULTINATIONAL : SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES
(HIV/AIDS, TUBERCULOSIS AND MALARIA)

SHDSP DIRECTORATE ORGANOGRAM



SADC

MULTINATIONAL : SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES
(HIV/AIDS, TUBERCULOSIS AND MALARIA)

GLOBAL FUND SUPPORT TO SADC MEMBER STATES (US\$)

Country	Title of project	Component	* 2-year max	*5-year max
Angola	Support to National Malaria Control	Malaria	28,473,354	38,383,00
Angola	Reducing the Burden of TB	Tuberculosis	7,350,590	11,163,763
Angola	Reducing the Burden of HIV/AIDS	HIV/AIDS	27,670,810	91,966,080
Botswana	Scaling up of Botswana Multi-Sectoral Response to HIV/AIDS	HIV/AIDS	18,580,414	18,580,414
Congo	Tuberculosis Prevention, Support and Capacity Building	Tuberculosis	6,408,741	7,972,113
Congo	Support to Congolese Initiative on HIV/AIDS Prevention and Care	HIV/AIDS	34,799,786	113,646,453
Congo	Strengthening the Fight against Malaria	Malaria	24,966,676	53,936,609
Lesotho	Strengthening Prevention and Control of HIV/AIDS	HIV/AIDS	10,557,000	29,312,000
Lesotho	Strengthening TB Prevention and Control	Tuberculosis	2,000,000	5,000,000
Namibia	Scaling up the Fight against HIV/AIDS	HIV/AIDS	26,082,802	105,319,841
Namibia	Scaling up the Fight against Tuberculosis	Tuberculosis	904,969	1,532,603
South Africa	Enhancing Care of HIV/AIDS infected and Affected in Kwa/Zulu/Natal	HIV/TB	26,741,529	71,968,018
South Africa	Strengthening National Capacity for Treatment, Care and Support related the HIV and TB through BC (Soul City)	HIV/TB	14,354,000	70,354,000
South Africa	Strengthening National and Provincial Capacity for Treatment, Care and Support related to HIV, TB and Malaria	HIV/TB/Malaria	8,414,000	25,110,000
South Africa	Strengthening and Expanding HIV/AIDS Prevention in Western Cape	HIV/AIDS	15,521,457	66,509,557
Swaziland	Coordinated Country Response to Fight Malaria	Malaria	978,000	1,864,500
Swaziland	Coordinated Country Response to HIV/AIDS	HIV/AIDS	29,633,300	54,872,400
Swaziland	Coordinated Country Response to Fight Tuberculosis	Tuberculosis	1,348,400	2,507,000
Swaziland	Up Scaling key Components of the National HIV/AIDS Response	HIV/AIDS	16,398,800	48,283,310
Tanzania	Scaling up District HIV/AIDS Response	HIV/AIDS	5,400,000	5,400,000
Tanzania	Implementation of Insecticide treated Nets	Malaria	8,790,612	16,659,252
Tanzania	Access to Voluntary Counseling and Testing	HIV/AIDS and Tuberculosis	23,951,034	86,987,868
Tanzania	Malaria Control	Malaria	54,201,787	90,468,963
Tanzania	Mitigating HIV/AIDS Impact for Orphans and Vulnerable Children (Condoms, Care, Treatment and National Coordination)	HIV/AIDS	103,191,298	293,263,191
Tanzania(Zanzibar)	Implementation of New Malaria Treatment Policy	HIV/AIDS	781,220	1,153,080
Tanzania(Zanzibar)	Participatory Response to HIV/AIDS for Youth	HIV/AIDS	1,116,000	2,302,637
Tanzania(Zanzibar)	Scaling up TB Services	Tuberculosis	959,482	1,699,867
Tanzania(Zanzibar)	Malaria Control through Artemisinin Based Combination Therapy and Treated Nets	Malaria	5,089,361	9,586,972
Zambia	Zambia National AIDS Network	HIV/AIDS	42,298,000	92,847,000
Zambia	Churches Health Association Program to Combat Malaria	Malaria	17,891,800	39,273,800
Zambia	Scaling up Antiretroviral Treatment	HIV/AIDS	26,770,776	253,608,070
Zambia	Scaling up Intervention for Malaria Prevention and Control	Malaria	20,279,950	43,495,950
Zimbabwe	Scaling up Disease Prevention for HIV/AIDS, TB and Malaria	HIV/AIDS	10,300,000	14,100,000
Zimbabwe	Improving and Scaling up Malaria Interventions	Malaria	6,716,250	8,877,500

Source: The Global Fund, www.theglobalfund.org/

* It is noted that the rate of disbursement has been slow and the fund principally supports the procurement of health related commodities.

ANNEX 6
SUMMARISED LIST OF GOODS AND SERVICES (UA millions)

Category of expenditure	ADF			SADC	Total				%	%	
	FE	LC	Total	LC	FE	LC	Total	%	Bank	SADC	
A. GOODS											
OUTPUT I											
1.1 Furniture	0.012	0.003	0.015	0.000	0.012	0.003	0.15	0.3%	100.0%	0.0%	
1.2 Office equipment (computers, printers, scanners etc)	0.129	0.034	0.163	0.000	0.129	0.034	0.163	3.4%	100.0%	0.0%	
OUTPUT III											
1.3 Equipment for surveillance system	1.634	0.192	1.826	0.000	1.634	0.192	1.826	37.8%	100.0%	0.0%	
1.4 Equipment for GIS & Databases	0.782	0.092	0.874	0.000	0.782	0.092	0.874	18.1%	100.0%	0.0%	
1.5 Emergency upgrade of Laboratory Diagnostic equipment	1.004	0.118	1.123	0.000	1.004	0.118	1.123	23.2%	100.0%	0.0%	
OUTPUT V											
1.4 Drugs, ARVs & supplies for OVC	0.420	0.109	0.528	0.000	0.420	0.109	0.528	10.9%	100.0%	0.0%	
1.5 Nutrition supplements suitable for children	0.089	0.023	0.112	0.000	0.089	0.023	0.112	2.3%	100.0%	0.0%	
1.6 Voluntary Counseling & Testing (VCT) Kits	0.060	0.015	0.075	0.000	0.060	0.015	0.075	1.6%	100.0%	0.0%	
1.7 Equipment, reagents & supplies	0.089	0.023	0.112	0.000	0.089	0.023	0.112	2.3%	100.0%	0.0%	
TOTAL GOODS	4.219	0.611	4.830	0.000	4.219	0.611	4.830	100.0%	100.0%	0.0%	
B. SERVICES											
OUTPUT I											
2.1 Technical Assistance (TA)	0.142	0.855	0.997	0.000	0.142	0.855	0.997	7.8%	100.0%	0.0%	
2.2 Procurement Agent	0.098	0.588	0.686	0.000	0.098	0.588	0.686	5.4%	100.0%	0.0%	
2.3 Consultancies: Review/drafting & harmonization of policies,	0.186	1.116	1.302	0.000	0.186	1.116	1.302	10.2%	100.0%	0.0%	
2.4 Regional training workshops/conferences	0.331	2.512	2.842	0.175	0.331	2.687	3.018	23.7%	94.2%	5.8%	
2.5 Project monitoring and evaluation	0.066	0.396	0.462	0.00	0.066	0.396	0.462	3.6%	100.0%	0.0%	
2.6 Audit Services	0.14	0.084	0.098	0.00	0.014	0.084	0.098	0.8%	100.0%	0.0%	
OUTPUT II											
2.7 Consultancy: Effective implementation of harmonized policies,	0.135	0.557	0.692	0.000	0.135	0.557	0.692	5.4%	100.0%	0.0%	
2.8 Regional training/workshops	0.532	0.836	1.368	0.000	0.532	0.836	1.368	10.7%	100.0%	0.0%	
OUTPUT III											
2.9 Consultancy: Regional surveillance system	0.051	0.309	0.361	0.000	0.051	0.309	0.361	2.8%	100.0%	0.0%	
2.10 Regional training/workshops	0.047	0.280	0.326	0.000	0.047	0.280	0.326	2.6%	100.0%	0.0%	
OUTPUT IV											
2.11 Consultancy: Improved and sustainable availab/ drugs	0.145	0.868	1.013	0.000	0.145	0.868	1.013	8.0%	100.0%	0.0%	
2.12 Regional training/workshops	0.138	0.828	0.965	0.000	0.138	0.828	0.965	7.6%	100.0%	0.0%	
OUTPUT V											
2.13 Technical Assistance (TA)	0.400	0.182	0.582	0.000	0.400	0.182	0.582	4.6%	100.0%	0.0%	
2.14 Consultancy: Scaling-up of Best Practices of OVC prevention,	0.060	0.027	0.087	0.000	0.060	0.027	0.087	0.7%	100.0%	0.0%	
2.15 National training/workshops	0.532	0.242	0.773	0.000	0.532	0.242	0.773	6.1%	100.0%	0.0%	
TOTAL SERVICES	2.876	9.679	12.555	0175	2.876	9.855	12.731	100.0%	98.6%	1.4%	
C. OPERATING COST											
OUTPUT I											
3.1 Staff salaries	0.000	0.028	0.028	0.000	0.000	0.028	0.028	0.6%	100.0%	0.0%	
3.2 Office expenses	0.000	0.000	0.000	1.172	0.000	1.172	1.172	25.1%	0.0%	100.0%	
3.3 Project supervision and related costs	0.124	0.842	0.966	0.000	0.124	0.842	0.966	20.7%	100.0%	0.0%	
OUTPUT II (Material, reproduction, venue, administration costs)	0.092	0.485	0.577	0.305	0.092	0.789	0.881	18.9%	65.4%	34.6%	
OUTPUT III	0.024	0.125	0.149	0.091	0.024	0.217	0.241	5.2%	62.0%	38.0%	
OUTPUT IV	0.062	0.328	0.391	0.257	0.062	0.586	0.648	13.9%	60.3%	39.7%	
OUTPUT V	0.081	0.424	0.505	0.225	0.081	0.649	0.730	15.6%	69.2%	30.8%	
TOTAL OPERATING COST	0.382	2.233	2.615	2.050	0.382	4.283	4.666	100.0%	56.1%	43.9%	
PROJECT TOTAL	7.477	12.523	20.000	2.226	7.477	14.748	22.226				

SADCMULTINATIONAL : SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES
(HIV/AIDS, TUBERCULOSIS AND MALARIA)OPERATIONS AND INDICATIVE PIPELINE OF PROJECTS, 2000 –2006

Year	Project	Amount (UA millions)	Status
	Projects approved		
2000	Technical Assistance to SATCC	1.580	Ongoing
2000	Capacity Building for Rehabilitation (Malawi, Zambia and Zimbabwe)	0.928	Ongoing
2000	SADC Emergency Humanitarian Drought WFP	2.667	Completed
2002	Support to SADC Agricultural Research	1.033	Ongoing
	Planned operations 2005-06		
2005	HIV/AIDS Project	20.000	Appraisal
2005	Shared Watercourses support Project	12.460	Under preparation
2005	Agriculture water management for Food Security	50.000	Under preparation
2005	Institutional Support for establishing the surveillance unit	3.000	Request received from SADC
2006	Regional Support to Combat Foot & Mouth disease	TBD	Identification

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**MULTINATIONAL : SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES
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SADC**MULTINATIONAL : SUPPORT TO THE CONTROL OF COMMUNICABLE DISEASES
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MISSIONS & MEETINGS	Mission's dates	IWG date	IDWG date	SMC date
Identification mission	September 2002	15.10.2002	NA	NA
Preparation mission	November 2003		19.02.2004	NA
Appraisal mission	27 February-24 March-2005	25 April, 2005	6 May, 2005	24 May, 2005
Post Appraisal missions	February – March, 2006	15 March		4 April 2006

Note : POPR 's clearance on 13 May, 2005

NA : Non applicable

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MATRIX OF DONOR INTERVENTIONS

DONORS	HIV/AIDS, TB, Malaria prevention and care activities	Capacity building SADC Secretariat, Policy harmonization and training of Member States Staff in the areas of health and HIV/AIDS
Belgium	Study to assess the economic impact of HIV and AIDS and specific public health activities.	Support two years of HIV and AIDS position within the Directorate of Social and Human Resource Development and Special Programs
DFID	Finance a Regional STI/HIV/AIDS project in Botswana, Lesotho, Namibia and Swaziland (BNLS). The project will end in 2006. Activities : Management of Sexually transmitted diseases, Behavior Change, Social marketing of Condoms. Management of Malaria and TB activities are also financed.	Coordination of country policies and strategies regarding HIV/AIDS in the countries
EU	« Making a difference Project ». The project identifies and supports innovative sub-projects and programs implemented by various NGO and other institutions. Project closure is planned for end 2006. Activities: Support to orphans and vulnerable children, targeting the transport sector, support to HIV/AIDS affected and infected nurses and midwives, dealing with stigma and discrimination, impact of HIV/AIDS on agriculture and food security and integration of HIV/AIDS activities within water projects.	Surveys and database
USAID	Project : “Corridor of Hope Initiative”. The target populations are migrants men and women as well as resident population particularly girls adolescents at cross borders. Activities : STI services, training, drug supply, condom promotion and distribution, Behavioral change, adolescent reproductive health, voluntary testing. Activities implemented by NGO in cross border sites in Zambia and Zimbabwe, Lesotho, Namibia, Mozambique, South Africa and Swaziland	
ILO	Focus on the commercial farming sector. Activities : Development and implementation of policies and capacity building to address issues of AIDS at work place in Swaziland, Botswana, Lesotho and South Africa. A baseline survey carried out in these countries concentrates on the severity of HIV/AIDS among farm workers. Issue of legal frameworks in the farming sector is addressed.	
IMO	Activities are focused on migration management. Surveys conducted to identify gaps and suggest remedies. To deal	

	<p>with migrant vulnerability a “Partnership on HIV/AIDS on mobile population in Southern Africa program (2004-2006) is jointly financed by Sida and EU/SADC, to mainstream along the Angola/Zambia border.</p> <p>Similar activities along Zimbabwe and South Africa Border at Beitbridge crossing border will be financed by UK/Dutch Government</p>	
Global Funds	<p>18 HIV/AIDS projects (some including TB) in 10 SADC member countries, 10 malaria initiatives and 7 TB initiatives in 7 countries.</p> <p>No specific cross-border has been targeted and most resources are used for procurement of commodities.</p>	
ADF	<p>Activities related to the strengthening the capacity of SADC Secretariat to coordinate policy development, harmonization and implementation on communicable diseases</p> <p>Specific activities include among others : policy development and harmonization, training of communicable diseases managers, establishment of surveillance system, studies on reference laboratories and drug manufacturing and procurement in the region etc.</p> <p>SADC Secretariat.</p> <p>Project activities will start August 2006.</p>	<p>Harmonization of policies and strategies for the control of HIV/AIDS, TB and Malaria. Specific outputs include: improved capacity to harmonize policies, protocols and guidelines for the control of communicable diseases by SADC Secretariat, increased capacity to implement harmonized policies protocols and guidelines in SADC Member States, effective regional communicable disease surveillance system operational, improved and sustainable availability of essential medicines</p>