The SADC/EU Project on HIV and AIDS

Project supported by EDF & EPRD

The SADC/EU Project on HIV/AIDS

The European Union (EU) Funded Project on Regional Support for an Expanded Multi-sectoral Response to HIV and AIDS in the SADC region.

This is a five-year Project to strengthen the SADC response to the epidemic. The HIV and AIDS Unit of the SADC Secretariat is responsible for the implementation of the project, with the EU providing funding to the amount of €7 614 000 under two separate project agreements concluded with the SADC Member States and the Government of the Republic of South Africa.

Objectives

- Strengthen SADC's capacity to mount an integrated and coordinated regional response.
- Supporting best practices on regional strategies and programmes on HIV and AIDS.

Target Groups

Member States and the SADC Secretariat are the main beneficiaries of this project.

Project Components

Strengthening the SADC Response through:

Developing, implementing and monitoring the SADC Strategic Framework and Operational Plan to curb and counter the impact of the epidemic on the SADC region.

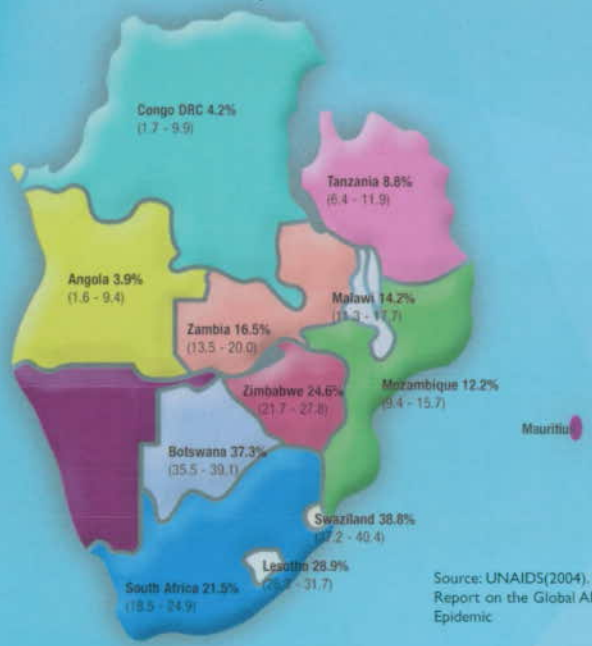
Advocating a stronger SADC response through developing regional policy instruments.

Facilitating the sharing of experiences between Member States to ensure a coordinated and expanded regional response.

Building the capacity of the SADC Secretariat to mainstream HIV and AIDS into their areas of work.

Fact Sheet
HIV and AIDS in SADC

- SADC is at the epicentre of the HIV and AIDS epidemic. According to WHO the estimated HIV prevalence for Southern Africa in 1997-1998 was 20.3%, increasing to 23.5% in 1999-2000 and to 25.7% in 2001-2002. [1]
- HIV prevalence in the SADC region varies with three countries having HIV prevalence rates for adults aged 15-49 exceeding 30%, while three countries have prevalence rates below 6%.



Source: UNAIDS(2004). 2004 Report on the Global AIDS Epidemic

- It is estimated that over 14.260 (11.167-18 820) million adults and children are living with HIV and AIDS in the SADC region.
- Almost 10 million people are estimated to have died of AIDS-related illnesses since the epidemic began and in 2003 alone over 1.27 (826 000-1 771) million people died of AIDS-related illnesses. The number of AIDS-related deaths are expected to increase in the coming years owing to the timelag between initial infection with HIV and the onset of AIDS-related illnesses.
- As the number of deaths increase amongst young adults, so too are the number of children orphaned by the epidemic increasing. UNAIDS estimates that over 5.5 (3.718-7.921) million children aged 0-17 are orphaned in the SADC region as a result of the epidemic.
- Reasons why the epidemic has spread so fast in the SADC region include: poverty, population mobility, and stigma and discrimination.
- The majority of people living with HIV in the SADC region are women. UNAIDS estimates that by the end of 2003 over 7.5 (6.14-9.61) million women were living with HIV and AIDS in the region. In most Southern African countries more than one in five pregnant women are living with HIV and AIDS. The majority of women living with HIV are between the ages of 15 and 24 years.
- HIV prevalence rates amongst pregnant women in the rural areas of Southern Africa are lower than amongst their urban counterparts, but more than 40% of the population in the region lives within urban areas.
- Approximately 7% of all HIV transmissions in the region are as a result of mother to child transmission. HIV and AIDS is a significant factor underlying infant and child mortality in the region.
- Most SADC Member States have developed National Strategic Plans and policies and programmes aimed at preventing the spread of HIV, mitigating its impact and providing care and support to those living with and affected by HIV and AIDS. In some Member States policies and legal frameworks have been amended to address issues relating to stigma and discrimination.
- There are signs of progress being made in preventing HIV infection amongst youth, with some Member States reporting that HIV prevalence rates amongst young people appear to have stabilised. Behavioural studies undertaken in some Member States indicate increased condom usage. However, the provision of condoms for the prevention of HIV remains below that required.
- The availability of HIV and AIDS voluntary counselling and testing and ARV treatment is being scaled-up throughout the region, but still remains far below that required to meet the needs of the population.

1 WHO estimates for Southern Africa relate only to the ten countries and do not include the Democratic Republic of the Congo, Mauritius and the United Republic of Tanzania.

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Fact Sheet

HIV and AIDS and the Agricultural Sector

Agriculture is one of the most important sectors in SADC and contributes 35% to the regional GDP and 13% of total export earnings. Between 60-80% of people in SADC depend on the agriculture sector for their livelihoods and 70% of agricultural workers are women. There is a strong correlation between agricultural growth and economic growth and the general improvement in the standard of living of the SADC population. Agricultural growth and development leads to poverty reduction, equitable economic growth, employment creation and food security.

Securing Agricultural Production - The Dar Es Salaam Declaration on Agriculture and Food Security, 15 May 2004

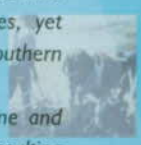
- The commitment of SADC to accelerating agricultural development and food security was underlined during the Summit of SADC Heads of State and Government held in Dar es Salaam, Tanzania, on 15 May 2004. This summit resulted in the adoption of the Dar es Salaam Declaration on Agriculture and Food Security.
- This summit outlined the priorities for SADC over the following two years and medium to long term to achieve sustainable agricultural production and food security, including:
  - Providing support to vulnerable farmers with key inputs such as improved seed varieties, fertilisers, agrochemicals, tillage services and farm implements in order to increase agricultural production.
  - Embarking on water management programmes such as flood control, supporting programmes on water havesting, inter-basin water transfers and construction of water storage facilities, and to accelerate and scale up the adoption and use of irrigation technologies.
  - Increasing progressively within the next five years investment in agriculture to at least 10% of national budgets in line with the African Maputo Declaration on Agriculture and Food Security of July 2003.
  - Mobilising resources and scaling up intermediaries such as savings and credit schemes and rural mobile banks, and to consider establishing financing mechanisms such as a rural Agricultural Development Banks/Facilities.
  - Improving the region's disaster preparedness capacity by establishing a Regional Food Reserve Facility and reviewing the SADC Food Security Early Warning and Monitoring System to respond to food emergencies, improve risk management and support safety-net strategies.
  - Enhancing gender mainstreaming by enacting non-discriminatory laws on finance,credit and land and to promote gender sensitive technologies, particularly on agro-processing.
- To ensure food security through mainstreaming HIV and AIDs and other chronic disease control in agriculture and natural resources policies and programmes.

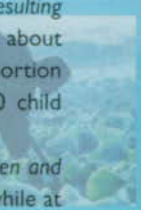
The linkages between food security and the prevention, management and treatment of HIV and AIDS

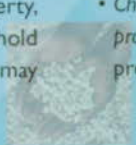
- ***Prevention of HIV:*** Not having enough to eat owing to poverty, climatic conditions or the impact of HIV and AIDS on household income increases vulnerability to HIV infection as people may engage in risky sexual behaviours such as transactional, intergenerational sex and sex work in order to survive.
- ***Management of HIV***: A healthy and nutritious diet can help the immune system of people living with HIV to fight off illness, shorten the recovery time from ill-health, keep people productive and active, and slow the progression of HIV to AIDS. A secure and clean water supply can delay the onset of opportunistic infections associated with waterborne germs.
- ***Treatment of AIDS***: Antiretroviral treatment is more effective when combined with a good diet rich in energy, protein and micro-nutrients, and access to safe drinking water.

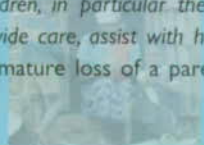
The challenges of HIV and AIDS to Agricultural production at the household and community level

- *FAO estimates that by 2001 AIDS had claimed the lives of 7 million agricultural workers and 16 million more may die of AIDS by 2020.* In the nine Southern African countries most affected by HIV and AIDS between 13-26% of the agricultural labour force will be lost due to the epidemic in the period 1985 - 2020.
- *HIV and AIDS negatively impacts on the production of food* as the majority of people who die as a result of AIDS are young people aged 15-49. These are the main producers of food resulting in a loss of labour, income and food reserves. It is estimated that the time spent consoling bereaved family, friends and neighbours and attendance at funerals results in more than 25% of lost productivity in critical time periods for activities such as sowing, weeding and attending to crops and livestock.
- *Women account for 70% of food production in sub-Saharan Africa and carry out most of the labour intensive farming activities, yet approximately 60% of all those living with HIV and AIDS in Southern Africa are women.*
- *HIV and AIDS combined with natural disasters such as famine and drought undermines the ability of households to produce food resulting in malnutrition.* In the SADC region malnutrition is high with about one third of children being underweight and a higher proportion being stunted. It is estimated that in 2001 over 700 000 child deaths were related to malnutrition.
- *Households affected by HIV/AIDS, in particular the youth, women and the elderly are burdened to provide care for those that are ill,* while at the same time needing to compensate for the loss of labour.
- *Household income and productive assets, including livestock and crops are sold off* to meet the rising medical costs associated with HIV compromising future household incomes and food security.
- *Children, in particular the girl child, are withdrawn from school to provide care, assist with household chores and food production.* The premature loss of a parent, coupled with the lack of education,









compromises the transfer of knowledge of indigenous farming practises undermining the food security of future generations.

- *Decreased productivity and reduced incomes result in families working smaller fields or switching to less labour intensive subsistence crops* which have lower nutritional and or market value.
- *In the event of death, women and children may be deprived of their right to inheritance* resulting in them being unable to sustain themselves and increasing their vulnerability to HIV infection and food insecurity.

What can be done to protect Agricultural workers and communities?

- Provide vulnerable farmers with key inputs such as improved seed varieties, fertilisers, agrochemicals, tillage services and farm implements.
- Provide food assistance to all persons in need as a preventative measure. Relieve children and the elderly of their responsibilities as care givers and breadwinners, and prolong the lives of those living with HIV and AIDS.
- Expand and integrate HIV and AIDS prevention within school feeding programmes.
- Review legislation relating to access to finance, credit, property and inheritance rights, and ensure that the rights of children and women are protected.
- Integrate HIV prevention and management into the work of agricultural extension workers including making available information and educational materials, condom distribution and information on healthy living.
- Develop nutritional policies and protocols to inform the implementation of nutrition programmes for the general population, including people living with HIV and AIDS, and integrate these within national health systems.
- Establish regional centres of excellence to study crops that can withstand poor weather and water shortages and encourage their use in agricultural production.
- Integrate information on healthy and balanced nutrition within counselling, care and treatment programmes and routinely monitor the nutritional problems and concerns of people living with HIV and AIDS.

The impact of HIV and AIDS on the capacity of the Agricultural Sector:

- *Agricultural workers are at risk of HIV infection* owing to the need for extension workers to travel frequently into the field to conduct their work. Senior staff may travel to attend conferences, seminars and training programmes resulting in separation from their spouses for prolonged periods of time which may result in unsafe sexual behaviours and an increased risk of HIV infection.
- *Knowledge and awareness* amongst staff of HIV and AIDS may be high but may not translate into behaviour change as their perceived risk of HIV infection may be low.
- *Staff living with HIV and AIDS may be unwilling to disclose their status owing to the perceived or real stigma and discrimination* associated with HIV and AIDS including fear of loss of employment, intolerance and negative attitudes from colleagues owing to ignorance.
- *HIV and AIDS may hamper service delivery* as extension workers fall ill and are unable to provide advice and access to improved agricultural practices, new technologies, seeds etc at a time when increasing illness and loss of life amongst farmers require such services to be delivered to those left to fill the production gaps.
- *AIDS may result in capacity shortages* amongst senior managers, veterinarians and experienced technical workers in whom resources, such as training, has been invested that may be difficult to replace
- *As AIDS takes its toll it may result in reduced staff productivity* owing to a loss of human resources, increased absenteeism owing to illness, the need to care for family members and to attend funerals, and a decline in staff productivity and morale owing to increasing workloads.
- *AIDS may lead to increased expenditure* by MoA's owing to rising medical, burial and recruitment costs, and the implementation of workplace-based policies and programmes.

What can be done to protect Agricultural workers?

- Facilitate understanding of HIV and AIDS in key Ministries of Member States and integrate HIV and AIDS into core activities.
- Develop and/or review HIV and AIDS workplace based and human resource policies and procedures and implement on a continuous basis workplace programmes based on the SADC and ILO Code of Good Practice and review existing human resources policies and procedures.
- Review human resources needs and assess the impact of HIV on staff and develop national and regional plans to address the human resources needs for sustainable rural development.
- Strengthen the capacity of agricultural extension workers to integrate HIV prevention and wellness management in their interaction with clients.

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Fact Sheet

HIV and AIDS and Education

Education and training are the cornerstones for achieving lasting and sustainable development as it provides skills and builds human capital vital for economic and social development. Education promotes social well being and reduces poverty by improving gender equality and reducing infant, child and maternal mortality. As such education plays an important part in determining living standards and the ability of countries to compete in the global economy.

Education is the most cost effective and effective means of HIV prevention as it plays a key role in providing knowledge that engenders appropriate values and attitudes providing learners with the necessary tools to maintain or adopt behaviours that will minimise or eliminate the risk of HIV infection. It reduces the vulnerability of girls to HIV infection providing them with the means to be economically independent, to delay marriage and the power to make decisions regarding their reproductive health. The school system brings together students, teachers, parents and the community and can be a powerful vehicle for HIV prevention.

Promoting education and Training - the SADC Protocol on Education and Training and the SADC Strategic Framework for Regional Cooperation in Combating HIV and AIDS in the Educational Sector

- The *1997 SADC Protocol on Education and Training* recognises that the development of human resources is essential for addressing the socio-economic development challenges confronting the region and for achieving sustainable development.
- In June 1999 the SADC Human Resources Development (HRD) Ministers directed the Sector to develop a multisectoral regional strategy that complements the efforts of Member States to address the impact of HIV and AIDS on human resources. This strategy was finalised in 2001, when the *SADC Strategic Framework for Regional Cooperation* in combating the HIV and AIDS epidemic in the educational sector was finalised.
- This strategy acknowledged that the HIV and AIDS epidemic could undermine the vision of the 1997 SADC Protocol on Education and Training as HIV and AIDS affects those aged 15-29 who are going to school, involved in tertiary education and career training, and are at the most productive stage of their lives.
- The Strategy highlights that HIV and AIDS impacts the education system in terms of the demand for education (students and school enrolments), the supply of education (the provision of education) and the quality of education (impact on learners and education providers).

The impact of HIV and AIDS on the demand for education - learners and school enrolments

- *HIV and AIDS reduces the demand for education* as fewer children enter school as the number of children born declines owing to reduced fertility and AIDS-related deaths amongst young adults. Children born with HIV die of AIDS-related illnesses before they enter school. In some of the most affected Member States of SADC there is evidence to suggest a reduced intake of Grade 1 learners.
- *Increasing numbers of children, and in particular young girls, are withdrawn, drop out of school or have lower attendance rates as a result of HIV and AIDS.* This is partly owing to the inability of AIDS-affected households to pay for school fees and uniforms or the need to provide care to their sick parents or look after their siblings. The trauma related illness and death, and the discrimination and stigma experienced by children affected, may result in fewer children being able to compete their education.
- *Children orphaned or made vulnerable by HIV and AIDS may not attend school, which may hamper their ability to complete their schooling, enter the labour market, and their quality of life.* UNAIDS estimates that the number of orphans in the **SADC region** is 5 587 000 (3 718 000 - 7 921 000).
- *The education of girls and young women may be undermined owing to poverty, cultural factors, sexual violence and sex with older male partners, which in turn may increase their risk of HIV.* There is a strong correlation between education and the vulnerability of girls to HIV infection. The higher the education the greater the awareness and knowledge of HIV prevention, testing, condom use and communication with sexual partners. However poverty, whether through the impact of AIDS or not, may result in relationships between young girls and older sexual partners. In Southern Africa the majority of young women have partners who are 5-7 years older than them and already living with HIV. Most young girls will be infected with HIV within the first year of them becoming sexually active.
- *Girls are vulnerable to HIV infection even in the school setting.* Studies in Southern Africa show that girls experience high levels of sexual violence and harassment from male students and teachers in schools.

What can be done to protect learners?

- Develop and implement school-based life skills and peer education based prevention programmes with the aim of reaching students before they become sexually active or drop out of school.
- Link school-based programmes with other community-based youth-friendly services especially those tied to health.
- Provide guidance to educators and learning institutions on the basic facts of HIV and AIDS, universal safety precautions, condom availability and issues relating to stigma and discrimination. Ensure that HIV and AIDS is integrated into the pre-service and in-service training programmes of universities and colleges.
- Explore approaches that keep down the cost of education by subsidising or abolishing school fees and keeping the cost of text books and uniforms to a minimum so as to ensure that children affected by HIV and AIDS, or who are orphaned as a result of HIV, can complete their education.
- Put in place, and apply rigorously, codes of conduct for teachers and learners so as to protect the rights of girls in the school setting and to eliminate stigma and discrimination against students living with, or affected by, HIV and AIDS.

The impact of HIV and AIDS on the quality and supply of Education and training

- *Educators are at increased risk of HIV infection* owing to their relative affluence, mobility and status in the community, separation from their families for employment purposes and their expectations of 'sexual bonuses'.
- *Teacher absenteeism* owing to illness related to HIV, caring for family members living with HIV and AIDS, or to attend funerals of colleagues and family, reduces the quality and quantity of education. According to the World Bank a teacher or education officer living with HIV is likely to lose 6 months of professional time before developing AIDS, and a further 12 months after developing illnesses associated with AIDS.
- *The costs to the education system may increase owing to HIV and AIDS.* This includes costs relating to employee benefits, hiring of temporary staff, costs of recruitment and training.
- *HIV and AIDS negatively affects the supply of skilled personnel providing educational services.* In some of the most affected Member States it is estimated that between 12-30% of teachers are living with HIV and AIDS, and that an increasing number of teachers are being lost to AIDS, which may place an increasing strain on the availability of educationalists in specialised areas such as maths and science.

- *The supply of teachers to the rural areas may be adversely affected* by HIV and AIDS as teachers living with HIV and AIDS may be more inclined to stay in the urban areas so as to be closer to medical services.

- HIV and AIDS may place a strain on the emotional status of educators and young people. This may result in low teacher morale combined with teacher and student trauma.
- Owing to increasing levels of HIV and AIDS related illness and death amongst experienced teachers, educational systems may have to increasingly rely on less experienced teachers to provide education.

What can be done to protect the quality and supply of Education?

- Undertake an impact assessment of the epidemic on the education sector that provides predictions on the future demands for education and the supply of teachers and trainers needed to meet this demand.
- Apply a dual approach to counteract the impact of the epidemic through developing policies and programmes that prevent the further spread of the epidemic and that reduces the anticipated impact of the epidemic on the education sector.
- Advocate for a commitment to action by political leaders, senior officials, unions, the teaching service and school governing bodies in support of the dual approach.
- Develop HIV and AIDS strategic plans to cover all levels of the education sector.
- Allocate adequate resources to ensure the successful implementation of plans and strategies to counteract the impact of the epidemic on the education sector.

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Fact Sheet

HIV and AIDS and Mining

The SADC Region is rich in mineral resources such as gold, platinum, diamonds and other precious metals. In several Member States of the SADC Region, mining is one of the most important sectors, employing large numbers of people, particularly men. Mining is also one of the largest sources of foreign exchange for Member States.

Promoting Mining in the SADC Region - the SADC Protocol on Mining

- The SADC Protocol on Mining was adopted in 1997 to promote the interdependence and integration of mining policies for the accelerated development and growth of the Mining Sector in the SADC Region.
- The Protocol outlines a number of key areas in which the Member States of SADC agree to collaborate. These include information sharing, enhancing technological capacity, the promotion of private sector and small scale mining, environmental protection and occupational health and safety.
- One of the key principles underlying the SADC Protocol on Mining is the recognition that a thriving Mining Sector can contribute to economic development, alleviation of poverty, and the improvement of the standard and quality of living throughout the region.
- To achieve this the Protocol encourages private sector participation and the promotion of economic empowerment for the historically disadvantaged through the mining sector.
- Investments in training and capacity building, including in the area of occupational health, are seen as an important cornerstone in attaining the objectives of the SADC protocol on Mining.

The linkages between Mining and HIV vulnerability

HIV and AIDS may undermine the objectives of the SADC Protocol on Mining. According to UNAIDS the estimated number of people living with HIV and AIDS in sub-Saharan Africa increased from between 5-6 million in 1990 to approximately 23.1-27.9 million by the end of 2003. Studies have shown that HIV prevalence amongst women attending antenatal clinics is particularly high in areas surrounding mines that use migrant labour, and in those areas from which mineworkers are traditionally recruited. The following are factors that increase the risk of miners and the surrounding communities to HIV.

- The majority of people employed by the Mining Sector are males aged between 18-49 years, who are in the prime of their sexual and reproductive lives.
- A large proportion of mine workers are migrants who have sought employment in the mines as a means to support their families who usually remain in the villages.
- Miners work in an environment that is dangerous and risky and may therefore have a different perspective of risk to HIV infection. This may be ascribed to lack of knowledge owing to lower levels of education, complex forms of denial, feelings of powerlessness in the context of high levels of disease and injury, and the stigma associated with being identified as HIV-infected.
- Within the SADC region there are various forms of living arrangements for miners, this ranging from family units located at the mines to single sex hostel dwellings.
- Men living in single sex hostels, or who move to mining areas in search of employment to support their families, are removed from their families for lengthy periods of time and may engage in unsafe sexual behaviour with persons from the communities in which they reside. This poses a risk to their sexual partners in their areas of origin. Likewise sexual partners in the areas of origin may also engage in unsafe sexual behaviour while their partners are away increasing their risk and that of their partner to HIV infection.
- Around a mine site informal businesses such as shebeens, brothels and gambling dens may emerge to cater for the needs of the large mine workforce. These create conditions that are conducive to risky sexual behaviour.
- Mineworkers have a higher income in relation to the communities in which they may reside. This may result in transactional sex between mineworkers and the local population which increases the risk of HIV spreading.
- Most mineworkers are the main breadwinners and heads of households. Mineworkers who become sick with HIV and AIDS related illnesses may have their contracts terminated leading to a loss of income for the affected family.
- Families, especially women and young girls, and communities are burdened with the increased costs of care, the cost of funerals and increasing numbers of children orphaned by the pandemic. This will result in deepening household poverty, and therefore increased vulnerability to HIV, by those affected.

The impact of HIV and AIDS on the Mining Sector

HIV and AIDS may undermine the profitability of the Mining Sector, particularly small scale mines, owing to HIV and AIDS related increased costs.

- The costs incurred by the Mining Sector in dealing with HIV and AIDS include both direct and indirect costs. The direct costs includes increased contributions to medical, death and disability benefits, and pension schemes.
- The indirect costs are those related to increased absenteeism, sick leave, a reduction in staff morale owing to a loss of colleagues, increased workloads, training and the need to replace labour that has been lost owing to HIV and AIDS, perceived and actual stigma and discrimination, all of which may contribute to reduced productivity.

What can be done to protect mineworkers and the Mining Sector:

- *Recruitment:* Mining companies can alter their recruitment policies to give greater employment opportunities to people from surrounding communities.
- *Accommodation:* Where migrant labour is used, family units can be promoted as opposed to single sex hostels, which could substantially reduce HIV transmission amongst mineworkers and their partners.
- *Policies, laws and regulations relating to visa and residence permits* should be reviewed and harmonised to allow workers to move with their family members.
- *Workplace based policies and programmes:* Together with unions, government and civil society workplace based policies and programmes should be developed based on the ILO, SADC and national laws and guidelines for workplace HIV interventions. This includes undertaking HIV prevention programmes, putting in place policies that combat stigma and discrimination in the workplace, and providing care and support including counselling and treatment for workers and their partners.
- *Community outreach programmes:* Undertake community outreach programmes in partnership with civil society and governments targeting vulnerable populations in Mining areas such as young people, particularly young women, and commercial sex workers, while also working with informal traders such as shebeens, brothels and gambling dens to protect their clients from HIV infection.
- *Develop community capacity for prevention, care and support:* Create skills in communities from which mineworkers are recruited to undertake awareness and education and provide care and support for mineworkers and other community members with HIV and AIDS related illnesses.
- *Promote income generating activities and services* to assist needy families in establishing micro-enterprises and together with stakeholders support community development in areas from which Miners are recruited.

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Fact Sheet

HIV and AIDS and Tourism

The World Tourism Organisation (WTO) defines tourism as the "activities of persons travelling to, and staying in, places outside their usual environment for not more than one consecutive year for leisure, business, and other purposes". Since 1990 the number of international tourist arrivals globally increased from 445.9 million to 694 million. In sub-Saharan Africa the number of international tourist arrivals increased from 6.6 million in 1990 to 19.8 million representing 2.4% of the total global tourism market.

Tourism is a major source of income and employment for many countries in the SADC region. In some SADC Member States tourism is the second or third largest sector after agriculture and mining. The majority of tourists in the SADC region are between the ages of 18-44 and residents of other Member States. The most common reasons why tourists travelled within the SADC region was to visit friends and family, holiday and leisure, and in the case of South Africa for shopping and nightlife. A significant proportion of tourists are also from outside the SADC region. Tourists arriving by air tend to stay longer than those who travel by land.

Promoting Tourism in the SADC Region - The SADC Protocol on Tourism

- The SADC Protocol on Tourism guides the work of the SADC Secretariat in relation to promoting sustainable tourism.
- It recognises that the tourism potential of the region, through its diverse natural features, history and culture, is underdeveloped and not contributing sufficiently to the economic wellbeing of the people of the region.
- The protocol recognises that the tourism potential of the SADC region can be enhanced through the collective and concerted efforts of all Member States and can contribute to the overall economic development of the region.
- The objectives of the SADC Protocol aim to:
  - Promote tourism as a vehicle for sustainable social and economic development.
  - Ensure the development of the tourism industry in the region.
  - Increase the competitive advantage of the region through collective efforts and cooperation.
  - Ensure the involvement of small and micro-enterprises, local communities, women and youth in the development of tourism in the region.
  - Contribute to human resource development through job creation and the development of skills at all levels in the tourism industry.
  - Create a favourable investment climate for private and public sectors and small and medium scale tourism establishments.
  - Improve the quality, competitiveness and standards of service of the tourism industry in the region.
  - Improve standards of safety and security of tourists visiting the region and make provision for disabled, handicapped and senior citizens in Member States.
  - Promote the region as a single but multifaceted tourism destination capitalising on common strengths and highlighting individual Member States unique tourists attractions.
  - Facilitate intra-regional travel for the development of tourism through easing or removing travel and visa restrictions and harmonisation of immigration procedures.
  - Improve tourism service and infrastructure in order to foster a vibrant industry.

The linkage between Tourism and HIV and AIDS

HIV and AIDS may undermine the objectives of the SADC Protocol on Tourism. According to UNAIDS the estimated number of people living with HIV in sub-Saharan Africa increased from between 5-6 million in 1990 to approximately 23.1-27.9 million by the end of 2003. HIV Prevalence rates in the SADC region vary with Mauritius and the Seychelles having HIV prevalence rates below 1%, while countries such as Botswana and Swaziland have HIV prevalence rates in the region of 35-41%.

- Tourism may facilitate the spread of HIV both in countries of destination as well as countries of origin.
- Unaccompanied travellers, young people on holiday and employees of tourism establishments may engage in unsafe sex with fellow tourists and the local population. This may be owing to the fact that they perceive their risk of HIV infection as low, the lack of availability of condoms, the use of alcohol and drugs, which may impair judgement, and the time spent away from families and partners. For those travelling by land, border delays and the duration of time spent travelling may also increase the chances of them engaging in risky sexual behaviours.
- Some tourists may travel with the specific intention of soliciting sex, so called "sex tourists", who may use their wealth to buy sex from younger girls and women. Poverty may result in younger girls and women engaging in transactional and intergenerational sex with tourists in order to survive, while some may engage in sex work in areas frequented by tourists such as nightclubs and bars.
- Female travellers may be at risk of rape, and local women may also be at risk of sexual violence, abuse and rape from tourists with whom they engage.

- In all these instances the risk of HIV infection is not only to the tourist and their sexual partners in their country of origin, but also to the persons with whom they have sexual activities while travelling and their partners.

The impact of HIV and AIDS on tourism workers and the tourism industry

- High levels of HIV and AIDS coupled with a perception of a lack of health care facilities may undermine the attractiveness of the SADC region to tourists.
- Employees in the tourism sector are highly skilled and difficult to replace.
- Reduced productivity owing to increasing levels of illness, absenteeism owing to the need to care for family members, and high staff turnovers due to premature loss of staff.
- Rising costs of employee benefits such as medical care, early retirement, premature payouts from pension schemes and increased costs of insurance premiums.
- Reduced staff morale owing to stigma and discrimination as a result of ignorance.

What can be done to protect tourists, local communities and the tourism sector?

- In partnership with government and NGOs information on HIV and AIDS and condoms can be made available to all tourists, local communities and employees in the tourism industry. This includes airlines, bus and taxi operators, at border controls, in hotels, guesthouses and other hospitality establishments, and at nightclubs.
- Tourists should be reassured of the availability of health care facilities in the SADC region.
- Integrate tourism into HIV prevention activities to promote community-based tourism.
- Tourism establishments should provide information to travellers and employees on the risk of rape as well as train staff members in the counselling of rape survivors, including legal procedures and services providing post-exposure prophylaxis.
- Research should be undertaken on the behaviours of tourists that may increase their risk and the risk of HIV transmission to the local population.
- National and regional protocols should be developed with the local industry on IEC, behaviour change and care and treatment services for the tourism sector.
- Review existing policies relating to Tourism and ensure the integration of national protocols into these policies and frameworks.

- Establishments engaged in the hospitality industry should develop and implement workplace-based policies and programmes providing ongoing education and training to educate their staff and families of the risk of HIV infection and make available condoms within the workplace.

- Staff at risk of occupational exposure to HIV and AIDS should be educated on the use of universal precautions when administering first aid and tending to cuts and wounds.
- Undertake an assessment of the impact of HIV and AIDS on the tourism sector so as to facilitate planning for labour shortages and potential impact on the profitablity of the sector.

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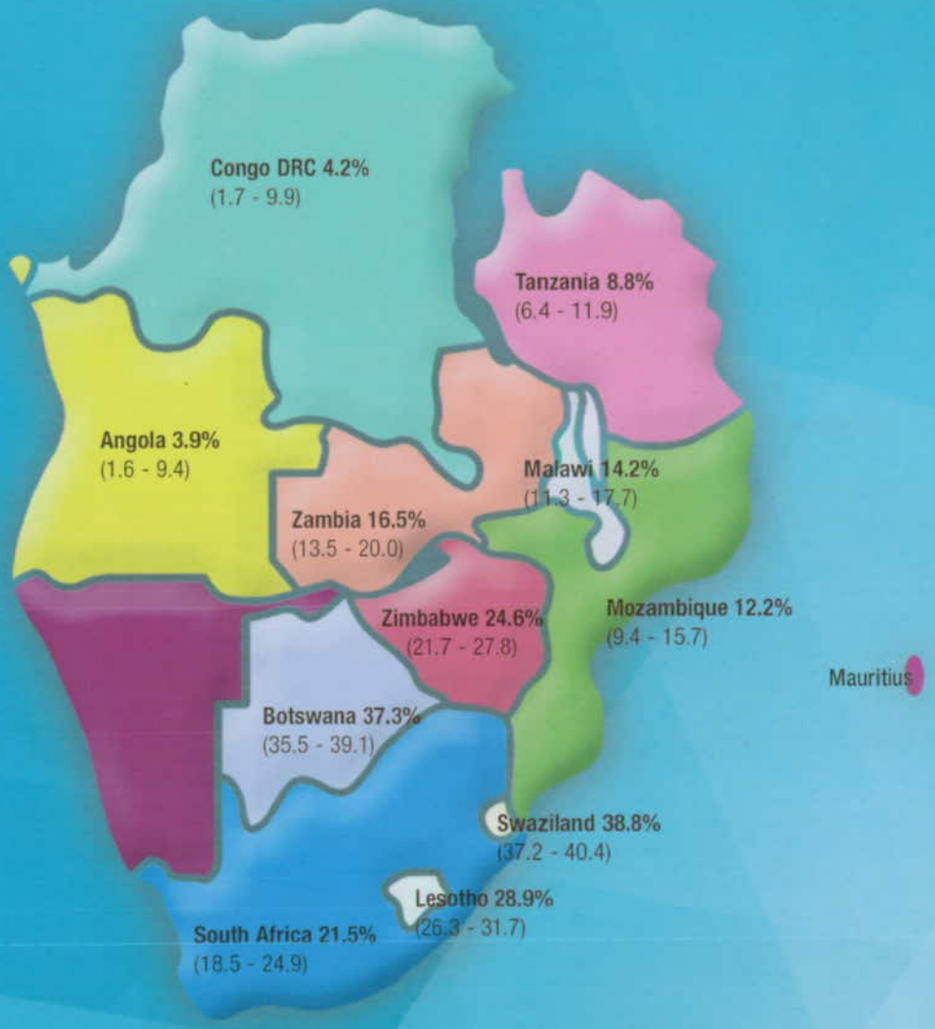
HIV Prevalence amongst adults aged 15 - 49 in the SADC Region, end 2003



Source: UNAIDS(2004). 2004 Report on the Global AIDS Epidemic

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Making a Difference

This component of the SADC/EU Project on HIV and AIDS comprises nine innovative projects and studies that address:

Care for the psychological and physical needs of children affected by the epidemic.

Reduce the effects of HIV infection among nurses and midwives, to improve health service delivery.

Address stigma and discrimination by creating a supportive environment for people living with HIV and AIDS.

Protect the health of transport workers to curb the spread of HIV and minimise the impact of AIDS on this sector.

Secure a clean water supply by reducing the impact of the epidemic on water resource management

Strengthen support to migrants and mobile populations through a coordinated response.

Develop strategies to secure food supplies and agricultural production

Improve surveillance of the epidemic and including understanding behavioural factors driving HIV.

Ensure better regional coordination of the response through using information and communication technology.

The response of the Southern African Development Community (SADC) to HIV and AIDS

The Southern African Development Community (SADC) consists of 14 Member States.

HIV and AIDS is a priority area for the work of SADC and is a standing item on the SADC Summit of Heads of State.

The SADC HIV and AIDS Unit is responsible for overseeing the SADC response to the epidemic guided by the SADC Strategic Framework on HIV and AIDS.