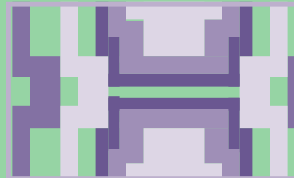


The POLICY Project

John Stover

Alan Johnston

**THE ART OF POLICY FORMULATION:  
EXPERIENCES FROM AFRICA IN  
DEVELOPING NATIONAL HIV/AIDS POLICIES**

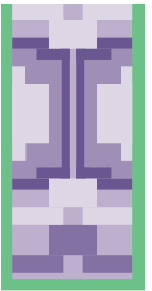


August 1999



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## Preface

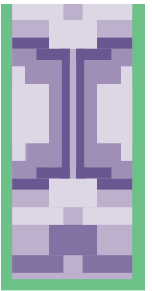
The goal of the POLICY Project is to create supportive policy environments for family planning and reproductive health programs, including HIV/AIDS, through the promotion of a participatory policy process and population policy that responds to client needs. The project has four components—policy dialogue and formulation, participation, planning and finance, and research—and is concerned with crosscutting issues such as reproductive health, HIV/AIDS, gender, and intersectoral linkages.

The POLICY Project is implemented by The Futures Group International in collaboration with Research Triangle Institute and The Centre for Development and Population Activities. The U.S. Agency for International Development (USAID) funds the project under Contract No. CCP-C-00-95-00023-04.

*POLICY Occasional Papers* are intended to promote policy dialogue on family planning and reproductive health issues and to present timely analysis of issues that will inform policy decision making. The papers are disseminated to a variety of policy audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations.

An up-to-date listing of POLICY publications is available on the FUTURES website. Copies of POLICY publications are available at no charge. For more information about the project and its publications, please contact:

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## Acknowledgments

Much of the information in this report is derived from presentations and papers delivered at a workshop held in Geneva on June 27, 1998, immediately before the 12<sup>th</sup> World AIDS Conference. The workshop, entitled “The Art of Policy Formulation: Experiences from Africa,” provided participants with an opportunity to share their experiences in the policy process and in confronting specific policy issues. Participants from nine Anglophone African countries attended the workshop, representing national AIDS control programs, universities, research organizations, and nongovernmental organizations (NGOs).

In preparation for the workshop, consultants wrote case studies detailing the policy process in five of the nine countries. For each country, the reports were based on interviews with 20 to 30 individuals closely involved in the development of national policy. Since the focus of the reports was on the policy process, some key implementation issues, such as resources and funding, did not receive full treatment. The country case studies noted below are summarized in this report, together with information about the policy process obtained during the workshop from the other four countries.

- ✓ *AIDS Policy Environment and Formulation Process in Ethiopia* by Dr. Fisseha Haile Meskal and Negussie Y. Ayele, Addis Ababa, June 1998.
- ✓ *Report on the Policy Process Involved in the Development and Adoption of the National AIDS Policy Paper (Sessional Paper No. 4 of 1997 on AIDS in Kenya)* by Ambrose Rachier, Advocate, High Court of Kenya, Nairobi, June 1998.
- ✓ *The AIDS Policy Process in South Africa* by Helen Schneider, Center for Health Policy, University of Witwatersrand, Johannesburg, June 1998.
- ✓ *The Formulation of the National AIDS Policy in Tanzania (Mainland)* by E.P.Y. Muhondwa and D.B. Gasarasi, Institute of Public Health, Muhimbili University College of Health Sciences, Dar es Salaam, June 1998.
- ✓ *The HIV/AIDS Policy Development Process in Zambia* by James Kayanda Sulwe, JKS and Associates, Lusaka, June 1998.

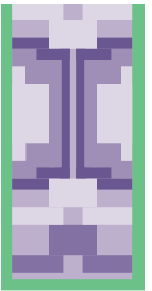
The authors wish to express their appreciation for the information provided by the following country teams during the workshop:



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- ✓ Malawi — Ms. Rosemary Chinyama, National AIDS Control Program; Dr. Owen Kalua, National AIDS Secretariat
- ✓ South Africa — Dr. Helen Schneider, Center for Health Policy, University of Witwatersrand; Ms. Rose Smart, Department of Health; Ms. Ann Strode, Lawyers for Human Rights
- ✓ Tanzania — Dr. Ronald Swai, National AIDS Control Program
- ✓ Uganda — Dr. Nathan Bakyaite, Dr. Elizabeth Madraa, and Ms. Vasta Kibirige, STD/AIDS Control Program
- ✓ Zambia — Ms. Elizabeth Mataka, Family Health Trust
- ✓ Zimbabwe — Ms. Ruth Gumbie, Mr. Kambarami, and Mr. Sunday Manyenya, National AIDS Control Program; Prof. Norman Nyazema, University Medical School

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## Executive Summary

AIDS has presented a major challenge to African societies during the last two decades. Governments throughout the region have struggled to develop effective policies and programs to address the epidemic. Each country has employed a unique approach to policy development; the results are equally diverse. The purpose of this report is to describe some of the country experiences and to highlight areas of similarity and difference as well as major problems addressed by Anglophone African countries. We hope that the experiences detailed here will prove useful in future policy development efforts.

This report presents case studies of the policy process in nine Anglophone African countries. There are many differences and similarities in the approaches used and the results achieved. The information has been distilled into a framework that captures key elements of the policymaking process. The major components of the framework are as follows:

- ✓ **Problem identification and need recognition.** Countries have passed through several stages in their response to the AIDS epidemic, including medical response, public health response, multisectoral response, and focused prevention and treatment. During the early phases, countries saw little need for a comprehensive AIDS policy. However, the need for a policy response grew as countries adopted multisectoral approaches to the epidemic and the broad impacts of AIDS on human rights, economic growth, society, and families emerged.
- ✓ **Information collection.** Once a decision to develop a policy is made, the next step usually is to obtain expert opinion—through consultant reports, interviews, or workshops.
- ✓ **Drafting.** Drafting is usually the task of small working committees. Some countries drafted policies quickly with a minimum of outside participation while others relied on a number of drafting committees that sought input and consensus from a range of interests.
- ✓ **Review.** In some cases, draft policies were debated widely and reviewed by thousands of people as a result of special regional meetings and dissemination efforts. In other cases, little outside review took place. As a consequence, policies often languished, with no champions pushing for review and approval.
- ✓ **Approval.** National AIDS policies have been approved at one of three levels: the minister of health, the cabinet, or Parliament.
- ✓ **Implementation.** Some policies have been implemented through operational or strategic plans or through the establishment of committees to develop operational guidelines. In

many cases, elements of the policy can be implemented even before the full policy is adopted. Interest groups may be encouraged to take the lead in disseminating and implementing parts of the policy that are of particular interest to them. Most policies contain some components that can be implemented immediately through administrative actions; other components require efforts to develop specific legislation and to obtain funding.

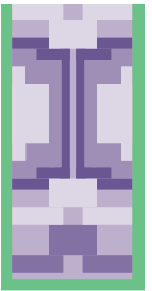
Each country policy addresses a large number of specific issues. Despite several cultural, social, and legal differences among the countries studied, the issues surrounding key policy topics show many similarities. The following are among the topics that were most difficult to resolve:

- ✓ **HIV counseling and testing.** Should the government subsidize voluntary counseling and testing programs within its national AIDS program?
- ✓ **Pre-employment testing.** Should employers be allowed to conduct pre-employment testing to protect their human resource investments? Such tests generally violate rights to gain livelihood without discrimination.
- ✓ **Orphans.** Should special programs be targeted to AIDS orphans to help them stay in school and receive proper food, clothing, and care, or will such programs increase stigmatization? Should AIDS orphans receive benefits not available to other orphans?
- ✓ **AIDS education in schools.** To what extent should the formal education system teach children about HIV and ways to protect themselves?
- ✓ **Condom advertising.** Should advertising of condoms be permitted on radio and television and in newspapers?
- ✓ **Mandatory condom use in brothels.** Can the government require the use of condoms in commercial sex when commercial sex is illegal?
- ✓ **Condom distribution in prisons.** Should the government distribute condoms in prisons if homosexual behavior is deemed illegal?
- ✓ **Willful transmission of HIV.** Should willful transmission be criminalized, or would criminalization discourage people from seeking testing?
- ✓ **HIV and abortion.** Should HIV infection be considered a sufficient cause for abortion?

In some instances when it was difficult to achieve consensus, policymakers simply eliminated issues from policy consideration. For example, most policies do not address willful transmission of HIV. In other cases, vague wording requires the issue to be addressed in national policy, with the exact meaning left to interpretation through implementation guidelines.

The key lessons that have emerged from the case studies are summarized below.

- ✓ Identifying AIDS as a problem does not translate into recognition of the need for a comprehensive AIDS policy. The need for a comprehensive policy may become apparent only when the epidemic becomes so severe that a large portion of the population is affected or when the advocacy efforts of specific groups convince decision makers of the importance of a policy response.



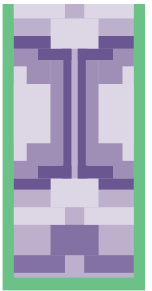
- ✓ There are many approaches to drafting and review. Some countries rely on a high level of participation. Although greater participation lengthens the time required for drafting and review, it builds momentum for the policy and often shortens the time required for approval. As a result, highly participatory approaches may actually require less time for policy development than policies drafted rapidly by a small group of experts who then struggle for years to gain approval. The most participatory processes have produced the broadest policies covering a wide range of key issues. Such policies, it is expected, will prove to be the most effective, but the outcome remains to be demonstrated.
- ✓ Once approved, policies can be implemented in many ways. Some aspects of a policy (such as approval of condom advertising) may be implemented directly, in some cases even before the policy is formally approved. Other policy issues can be implemented only through enabling legislation, with the development of guidelines, or as part of a strategic plan. Countries may lack the resources to implement all facets of a policy at once. Interest groups may need to take the lead in advocating for the implementation of specific portions of the policy that most interest them.



## Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	African National Congress
AZT	Zidovudine
DANIDA	Danish International Development Agency
DFID	Department for International Development
FPP	Focal point person
GNP	Gross national product
HIV	Human immuno-deficiency virus
KANCO	Kenya AIDS NGO Consortium
MOH	Ministry of Health
NA	Not applicable
NACP	National AIDS Control Program
NACOSA	National AIDS Convention of South Africa
NASTLP	National AIDS/STD/TB and Leprosy Program
NGO	Nongovernmental organization
PLWHA	Persons living with HIV and AIDS
SIDA	Swedish International AIDS Organization
TASO	The AIDS Support Organization (Uganda)
UN	United Nations
UNAIDS	United Nations AIDS Organization
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization





# The Art of Policy Formulation: Experiences from Africa in Developing National HIV/AIDS Policies

## Introduction

The AIDS epidemic has quickly become one of the most serious health and development problems facing the world today. In most countries, efforts to combat AIDS have so far been too little too late. Over 30 million people are currently infected with HIV, the virus that causes AIDS. More than 80 percent of AIDS deaths have occurred in Africa. In 1998, AIDS was responsible for about 2 million deaths.

A supportive policy environment is crucial to the implementation of successful programs that prevent the spread of HIV, deliver care to those infected, and mitigate the impacts of the epidemic. An appropriate policy environment is essential in supporting efforts to ensure that human rights are respected and eliminating stigmatization and discrimination associated with HIV/AIDS.

National and subnational policies, guidelines, and plans are needed to guide the effective implementation of HIV prevention and care initiatives. At the same time, financial and other resources must be mobilized to build capability to respond to the epidemic. Several countries in Africa have recently developed comprehensive national HIV/AIDS policies; others are in the process of developing such policies. Some rely on a series of discrete policy statements rather than on a single comprehensive policy to guide their program.

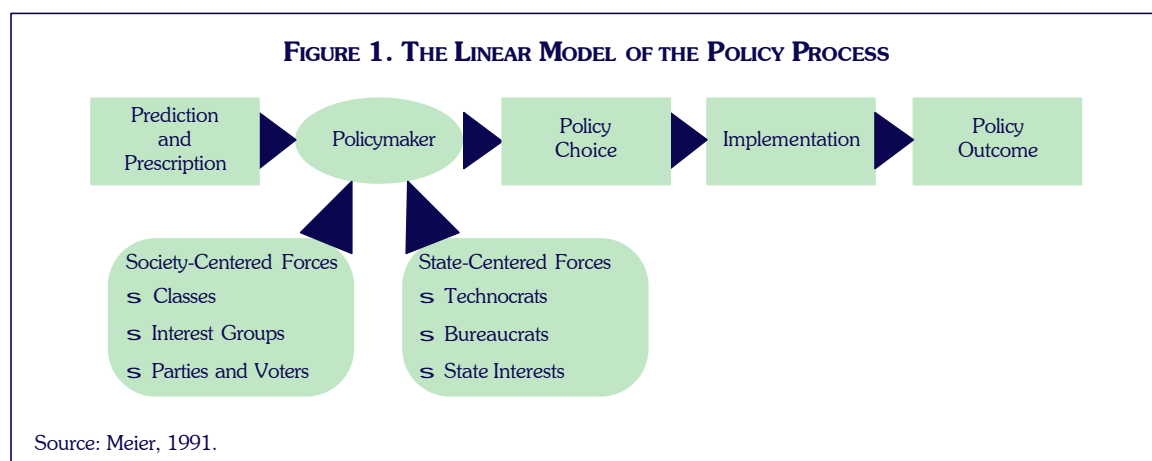
This paper describes the experience of nine African countries in policy formulation and discusses both the content and process of HIV/AIDS policy formulation. The country experiences should be useful in understanding and promoting further policy reform in these and other countries in Africa and elsewhere.



## The Policy Process Theoretical Frameworks

The process of developing, approving, and implementing HIV/AIDS policies differs in each country and for each issue. However, some underlying processes are common to most efforts. A better understanding of these processes can improve efforts to facilitate policy development and achieve better outcomes.

Lasswell (1951) pioneered work on the stages of the policy process. In turn, Meier (1991) built on these stages by elaborating a framework that describes the major steps in the policy development process and some of the forces acting on decision makers. Figure 1 presents this framework.

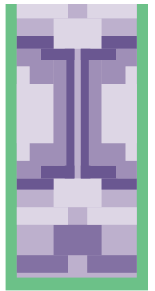


This section briefly reviews the literature that describes the general process of policy development. The appendix presents a bibliography of resources on the policy process.

The literature proposes several different theoretical frameworks to describe the policy process. Although no single framework claims to describe the process completely in all cases, most frameworks try to provide useful descriptions of certain aspects of the process.

Meier's framework describes five major steps in policy development as follows:

- ✓ **Prediction and prescription.** The process starts when a problem is recognized, predictions are made that the problem will not be solved naturally, and one or more solutions are proposed.
- ✓ **Policymaker.** The focus shifts to the policymaker, who is responsible for formulating policies in response to potential problems. The policymaker is often influenced by interest groups both within and outside government.



- ✓ **Policy choice.** After considering the alternatives, the policymaker decides on the appropriate policy.
- ✓ **Implementation.** Once a policy decision is made, it is implemented.
- ✓ **Policy outcome.** In the final step, the desired outcome is achieved.

The framework shows that the policy process starts with the recognition of a problem that needs to be solved. It also shows that various interest groups attempt to influence the policy decision. The framework is useful in clearly separating policy choice from policy implementation and policy outcome. The linear nature of the framework makes the different steps appear straightforward. In the real world, however, the process rarely proceeds in such a prescribed fashion. At a minimum, the framework is lacking the evaluation phase that can start the process all over again if the desired policy outcome is not achieved. In addition, the influence of interest groups is shown only during the stage of considering alternative policy choices. In reality, interest groups are usually important in other stages as well, particularly during implementation.

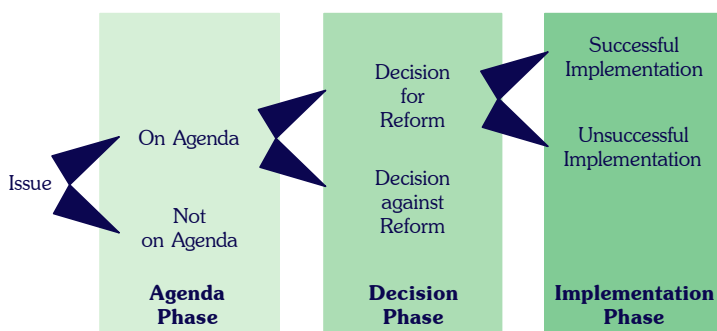
Grindle and Thomas (1991) developed a different framework (see Figure 2) that includes two particularly useful features. First, they show an agenda phase when a particular issue is considered for inclusion on the policy agenda. The process of

developing policy does not begin until policymakers are convinced that the issue is important enough for them to spend time considering it. Second, Grindle and Thomas show that the process can halt at any stage and does not inevitably lead to implementation. The issue may never make it onto the policy agenda. Furthermore, once the issue is on the agenda, policymakers may decide not to do anything about it. And once a policy is formulated, it may or may not be implemented. The framework indicates that continuous efforts may be required to see that the process advances to its desired conclusion.

Porter (1995), building on the work of Kingdon (1984), developed a completely different view of the policy process that focuses on the need for many elements to come together simultaneously if policy action is to take place. This framework describes three different processes occurring almost independently of each other: problems are identified and described; solutions that may or may not address existing problems are proposed; and political openings to address the problems appear and disappear. Action is achieved only when all three processes come together at the same time. Porter's framework shows that problems and solutions need to be linked. Most important, it points out that continuous effort to bring the issue to the attention of

policymakers may be required in order to keep the issue alive until a political opening appears. Keeping the issue alive is often the role of the policy "champion," a member of the policy elite who engages in continuous advocacy among peers and then shepherds the issue through the process once the political opening appears.

**FIGURE 2. PHASES OF THE POLICY PROCESS**



Source: Grindle and Thomas, 1991.

Walt and Gilson (1994) and others have considered the many actors involved in the policy process and the different roles that they play. Table 1 shows five of the key groups.

TABLE 1. ACTORS AND THEIR ROLES	
ACTORS	ROLE
Technocrats Bureaucrats Interest Groups Politicians Donors	Knowledge Institutions Representation Power Influence
Source: Walt and Gilson, 1994.	

- ✓ Technocrats include scientists, academicians, public health professionals, and other experts who provide information to identify the extent and nature of the problem as well as technical analysis of its causes and solutions. Technocrats are interested in pursuing solutions to society's problems and generating interest and funding to support further research.
- ✓ Bureaucrats bring knowledge of government institutions, including how institutions can address the issue at hand. Bureaucrats are interested in using the government structure in the manner best suited to addressing issues and often seek to maintain or expand the current bureaucracy.
- ✓ Interest groups are generally formed to represent the concerns of particular groups of people (e.g., people living with HIV/AIDS, religious groups, physicians, and parents). They seek to make sure that the group's interests are heard and considered in policy decisions.
- ✓ Politicians are usually the ultimate decision makers. Some seek power in order to help solve society's problems while others may be interested in obtaining or retaining power.
- ✓ Donors often play an important role in policy formulation and implementation. They may support the process with funds

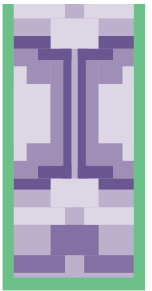
and technical assistance, provide international recommendations and guidelines, and have significant influence on implementation through their funding decisions.

Policy experts have also described several other features of the policy process that can influence policymaking. The appendix contains an extensive bibliography of publications on the policy process and efforts to stimulate policy reform. Among the other concepts in the literature that relate to the case studies presented in this report are

- ✓ **History/precedents.** Experience and precedents often govern the approach to policy development and, to some extent, likely outcomes.
- ✓ **Institutional structures.** Existing institutional structures can have a powerful influence on the policy process, affecting which institutions take the lead on particular issues, the level of involvement and communication between policymakers and technical experts, the role of interest groups and community groups, the balance of power between national and regional interests, and the role of the bureaucracy.
- ✓ **Culture.** The culture can determine which policies and programs are feasible as well as the nature of the process (e.g., confrontational, consensus seeking).
- ✓ **Timing.** If the issue is seen as a crisis requiring immediate action, policymakers may be able to develop new structures and experiment with novel approaches. If the issue is treated as "business as usual," then the bureaucracy is more likely to deal with it in traditional ways.

Each of these views explains part of the policy process and can aid in interpreting actions and results while providing guidance to those who wish to facilitate the process or direct it in certain ways.





## The HIV/AIDS Policy Process Case Studies

This section reviews the experience of nine African countries in the development of national HIV/AIDS policies. It provides details of the approaches used by the countries and discusses some major policy hurdles and solutions to them.

### Ethiopia

PROFILE OF ETHIOPIA (1997)	
INDICATOR	VALUE
Population size	60.1 million
GNP per capita	\$110
Life expectancy	50 years
Infant mortality rate	109
Under-five mortality rate	177
Population below the poverty line	NA
Adult HIV prevalence (15-49)	9.3%
Number infected with HIV (all ages)	2.6 million

Sources: World Bank, 1999; UNAIDS, 1998.

In 1985, one year before diagnosis of the first AIDS case in that country, the government of Ethiopia responded to a potential AIDS epidemic by forming a national task force for the prevention and control of HIV infection and AIDS. The task force issued the first AIDS control strategy by the end of 1985. In 1987, Ethiopia developed short- and medium-term plans in accordance with guidelines from the Global Program on AIDS. In September 1987, the government established an HIV/AIDS department within the Ministry of Health (MOH). The department developed the Second Medium Term Plan in 1991.

An important feature of Ethiopia's approach to combating the AIDS epidemic has been its emphasis on international, regional, and intersectoral collaboration as well as close collaboration with the World Health Organization (WHO), the United Nations Development Program (UNDP), the United Nations Children's Fund (UNICEF), and other international agencies. Intersectoral collaboration with key government ministries, community organizations, and NGOs marked the early stages of policy development.

In August 1989, the MOH drafted a four-point policy statement on AIDS prevention. As mounting epidemiological evidence indicated a worsening of the epidemic, the need for a strong and clear national policy backed by legal measures became apparent. It was in this context that the minister of health convened a 13-member Policy Drafting Committee on HIV/AIDS. The minister directed the committee to draft a comprehensive national policy for approval. The committee in turn commissioned a consultant to prepare a background document summarizing the literature and existing Ethiopian policy documents.

The Policy Drafting Committee produced the first draft of the national policy in 1991 and forwarded it to the Policy Committee of the MOH (a standing committee that reviews all health policies).

The Policy Committee thoroughly discussed the draft document and returned suggestions and comments for improvements. Between 1992 and 1993, the Technical Advisory Committee (composed of vice ministers of all the sectoral ministries) subjected the draft policy to several rounds of intersectoral review. The Technical Advisory Committee was to prepare a final version for presentation to the Council of Ministers.

Between 1993 and 1996, there was little progress on the policy largely because the Ethiopian government was engaged in significant decentralization of many of its activities, including health. The AIDS Control Program employed 70 people at the national office in Addis Ababa before decentralization, but only three remained by 1996 as most functions of the central department were shifted to regional health bureaus. In mid-1996, the MOH revived the effort to prepare the national policy. A workshop held in Addis Ababa in March 1997 to review and revise the draft policy brought together experts from the relevant government ministries as well as some NGO and UN agency representatives. In April 1997, regional representatives discussed the new draft and revised it accordingly.

In June 1997, the Policy Drafting Committee discussed the new draft, and then forwarded it to the vice minister. In late 1997, the policy was sent to the Office of the Prime Minister for endorsement by the Council of Ministers. The Legal Committee of the Council of Ministers reviewed the draft and worked with the MOH to resolve legal issues. The Council of Ministers gave final approval to the policy on August 14, 1998.

Several unique features distinguish the AIDS policy development process in Ethiopia. The first policy statements and plans were developed before diagnosis of Ethiopia's first AIDS case. The early response was probably a function of the efforts of the Global Program on AIDS and recognition by Ethiopian scientists, public health officials, and government officials that AIDS was a potentially major problem. Ethiopia also started earlier (1989) than most other countries to develop a comprehensive national policy. Ultimately, the process took much longer to complete than in other countries because of the disruption caused by decentralization. The Ethiopian process was characterized by many rounds of internal government review involving relatively few people and almost no participation by interests outside government.

## Ghana

PROFILE OF GHANA (1997)	
INDICATOR	VALUE
Population size	18 million
GNP per capita	\$370
Life expectancy	59 years
Infant mortality rate	71
Under-five mortality rate	110
Population below the poverty line (1992)	31%
Adult HIV prevalence (15-49)	2.4%
Number infected with HIV (all ages)	210,000

Sources: World Bank, 1999; UNAIDS, 1998.

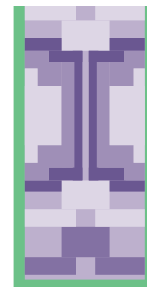
Ghana established medical guidelines for treating and preventing AIDS in 1987. In 1994, participants at a national workshop identified the need for a comprehensive national AIDS policy. At the same time, a review of the accomplishments of the Medium Term Plan for AIDS pointed to the need for a comprehensive policy to support prevention and care efforts. By 1996, public health specialists and government officials agreed that enough was known about the epidemic to develop a comprehensive policy. Two consultants were commissioned to develop the first draft of the policy. They conducted key informant interviews with health officials, people living with HIV and AIDS (PLWHA), NGO representatives, legal experts, and others. They also reviewed policy documents from other countries and the recommendations of various UN organizations and international conferences. The consultants identified the following eight topics as key sections of the policy:

- ✓ testing;
- ✓ care;
- ✓ information, education, and communication;

- ✓ condoms;
- ✓ youth;
- ✓ women;
- ✓ funding; and
- ✓ research.

The MOH and other government and nongovernmental officials reviewed the first draft of the policy prepared by the consultants. The government decided that the policy was not sufficiently comprehensive and did not call for adequate participation from those outside the health sector. As a result, the AIDS Control Program launched a new effort that started with a workshop in June 1999 to review the content of the draft policy and compare it to policies prepared by other countries and recommended by international conferences. Workshop participants identified several new issues and established drafting committees to prepare a new draft of the policy. The completed draft will be reviewed by members of civil society at several regional meetings later in 1999. The revised policy will be submitted to the cabinet for review and approval and then to Parliament for final approval.

The policy process in Ghana originally included little participation outside the MOH. A review of the draft policy and discussions with other countries about their policy development processes convinced the AIDS Control Program that the draft policy could be strengthened by expanding participation in the drafting and review process. The new effort will require more time for developing the draft policy, but it is likely to make the approval process proceed more smoothly and rapidly.



## Kenya

PROFILE OF KENYA (1997)	
INDICATOR	VALUE
Population size	28 million
GNP per capita	\$330
Life expectancy	59 years
Infant mortality rate	57
Under-five mortality rate	90
Population below the poverty line (1992)	42%
Adult HIV prevalence (15-49)	11.6%
Number infected with HIV (all ages)	1.6 million

Sources: World Bank, 1999; UNAIDS, 1998.

The first AIDS case in Kenya was diagnosed in 1984. In 1985, the government established the National AIDS Committee to advise the MOH on matters related to HIV/AIDS control. In 1986, the MOH formulated policy statements and guidelines on safe blood supply. The First Medium Term Plan was developed in 1987. Because the government viewed AIDS primarily as a health issue, it did not see the need for a comprehensive policy.

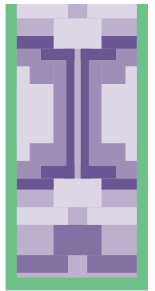
A 1991 government-led review of the accomplishments of the First Medium Term Plan found government officials and donors seriously concerned about the lack of a national policy and clear guidelines on HIV/AIDS. The National AIDS Control Program and the Kenya AIDS NGO Consortium (KANCO) made efforts to increase senior officials' understanding of the seriousness of the epidemic and its multisectoral nature. The Ministry of Planning and National Development initiated efforts to integrate HIV/AIDS into national planning efforts. The first major policy document to address AIDS was the 7<sup>th</sup> National Development Plan, issued in 1994. The chapter on AIDS pointed out that HIV prevalence was increasing at a rapid rate, that HIV/AIDS was consuming an ever-growing portion of recurrent health expenditures, and that gains in infant and child survival were being reversed. On the basis of these observations, the government found it necessary to address the issue of a national HIV/AIDS

policy. In 1994, the cabinet issued a memorandum to the MOH calling for formulation of an AIDS policy. The policy was to be developed in the form of a sessional paper on AIDS.

The MOH established a Working Committee with representation from the MOH, the Office of the President, and the Ministry of Planning and National Development, and charged it with initiating policy development. In 1995, the Working Committee established a Steering Committee to guide the policy process under the chairmanship of the permanent secretary of the MOH. Membership of the Steering Committee was broad and included representatives from the following organizations:

- ✓ Ministry of Health;
- ✓ Office of the President;
- ✓ Department of Defense;
- ✓ Ministry of Information and Broadcasting;
- ✓ Ministry of Labor and Manpower Development;
- ✓ Ministry of Culture and Social Services;
- ✓ Ministry of Education;
- ✓ Ministry of Finance;
- ✓ Ministry of Tourism and Wildlife;
- ✓ Ministry of Research, Science, and Technology;
- ✓ Attorney General's Chambers;
- ✓ Ministry of Local Government;
- ✓ Ministry of Planning and National Development;
- ✓ Central Bureau of Statistics;
- ✓ National AIDS Committee;
- ✓ Kenya Medical Research Institute;
- ✓ Population Studies and Research Institute; and
- ✓ University of Nairobi.

The MOH vested the Steering Committee with responsibility for providing overall guidance for policy development, approving the budget, reviewing draft documents, and



obtaining feedback from the public. It established a six-person secretariat to provide support to the Steering Committee.

In 1995, the Steering Committee set up nine technical subcommittees covering the following areas:

- ✓ epidemiology and health care;
- ✓ establishment of a National AIDS Council;
- ✓ economic impact;
- ✓ psycho-sociocultural dimensions;
- ✓ legal and ethical concerns;
- ✓ women and children;
- ✓ youth;
- ✓ strategies and interventions; and
- ✓ policies.

The technical subcommittees were charged with seeking inputs from experts and drafting sections of the sessional paper. The subcommittees worked intensively during May and June 1995 to develop an initial draft of their sections for presentation to the Steering Committee. July to September 1995 was a period of public dissemination and debate. Technical workshops and public forums were held in each of Kenya's eight provinces and in many districts as well. Donors, NGOs, employers, trade unions, insurance organizations, lawyers, ethicists, physicians, researchers, sociologists, population experts, epidemiologists, anthropologists, economists, journalists, educators, religious leaders, civil servants, politicians, public health officials, and gender experts all provided input. The Steering Committee revised the draft on the basis of the information collected from July to September. It then established an editorial committee to consolidate the various pieces into a final draft and discussed and approved the final draft in early 1996.

The cabinet approved the Sessional Paper in December 1996. Parliament tabled the paper in June 1997 and subsequently adopted it in September as *Sessional Paper No. 4 of 1997 on AIDS in Kenya*.

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### *Key Issues in the Policy Debate on AIDS in Kenya*

- I *In the absence of a cure for AIDS, there was a need to focus on prevention.*
  - I *Measures were needed to mitigate the impact of AIDS on individuals, communities, and the nation.*
  - I *Counseling and care for people living with HIV/AIDS needed to be enhanced.*
  - I *Human rights and ethical issues were viewed as important to prevention efforts and to ensure the dignity of PLWHA.*
  - I *Poverty was seen as a key factor in the spread of HIV.*
  - I *Cultural practices were identified as major constraints to prevention.*
  - I *A tug-of-war appeared to be raging between public health needs and individual rights.*
- 

The adoption of the policy has clearly benefited AIDS program planning and implementation. Those involved in the AIDS program cite the following benefits:

- ✓ The Sessional Paper provides an avenue for serious planning and coordination of interventions.
- ✓ Resources for AIDS have increased. Ministries other than the MOH—including the Ministries of Education, Culture and Social Services, and the Department of Defense—have developed HIV/AIDS programs with budgets.
- ✓ The Sessional Paper has enabled the development of a strategic plan for HIV/AIDS.

The Kenyan process was characterized by substantial technical input from experts and a high degree of multisectoral participation in the review of the draft policy. Although it took some time to get the process organized, policy development moved along quickly and smoothly once the technical subcommittees were established. By the time the Sessional Paper reached Parliament, it had undergone a thorough review. As a result, Parliament approved the paper quickly and with little dissent.

## Malawi

PROFILE OF MALAWI (1997)	
INDICATOR	VALUE
Population size	10.3 million
GNP per capita	\$220
Life expectancy	43 years
Infant mortality rate	133
Under-five mortality rate	217
Population below the poverty line (1990-91)	54%
Adult HIV prevalence (15-49)	14.9%
Number infected with HIV (all ages)	710,000

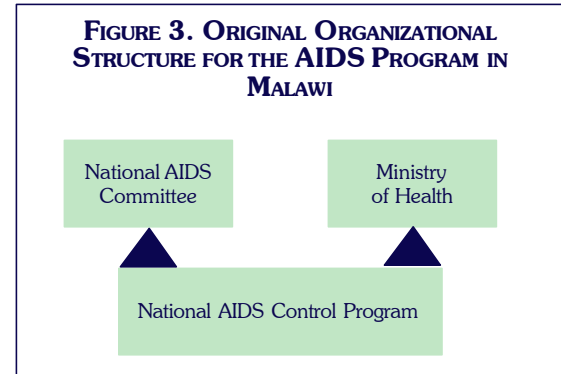
Sources: World Bank, 1999; UNAIDS, 1998.

The first AIDS case in Malawi was diagnosed in 1985. In 1986, the government established a Technical Committee within the MOH to set guidelines for blood screening and other medical issues. The MOH developed a Short Term Plan in 1987 and a Medium Term Plan in 1988. In 1989, the government established the National AIDS Committee to organize the response to the epidemic. The Second Medium Term Plan was implemented in 1993.

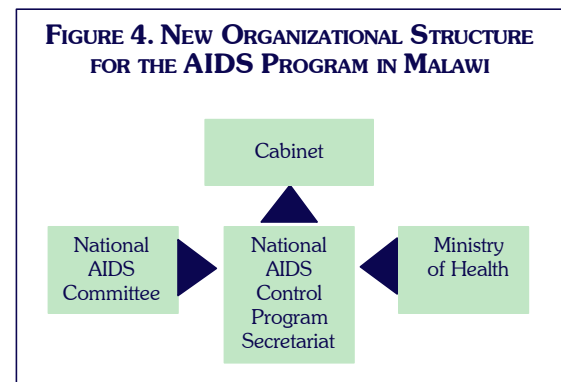
Malawi has yet to develop a comprehensive national AIDS policy. Early in the epidemic, there seemed to be no need for a comprehensive national policy. Instead, planning documents addressed key policy issues. Recently, however, the government recognized the need for greater participation in policy dialogue. As a result, Malawi embarked on a three-phase process to develop a strategic plan for its HIV/AIDS program. The first phase focused on stimulating community discussion. Trained facilitators ensured the maximum possible opportunities for community input. The second phase involved modification to and analysis of key operational and policy issues based on the community discussions and expert reports. The third phase called

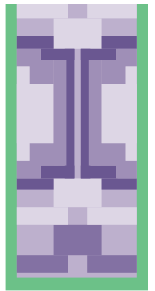
for preparation of a draft strategy document that was circulated for comments and suggestions. The plan will be presented at a national forum in October 1999.

A main issue for Malawi has been organization of the multisectoral effort. Initially, the government established a National AIDS Committee parallel to the MOH, as shown in Figure 3 below.



The difficulty with the parallel approach was that it lacked an easy mechanism for the National AIDS Committee to present recommendations to Parliament. Recommendations needed to go through the National AIDS Control Program to the MOH before the minister could present them to Parliament. The new structure, shown in Figure 4, attempts to provide a more direct route to the cabinet and, from there, to Parliament.





## South Africa

PROFILE OF SOUTH AFRICA (1997)	
INDICATOR	VALUE
Population size	38 million
GNP per capita	\$3400
Life expectancy	65.2 years
Infant mortality rate	49
Under-five mortality rate	66
Population below the poverty line	NA
Adult HIV prevalence (15-49)	12-14%
Number infected with HIV (all ages)	3.2 million

Sources: World Bank, 1999; UNAIDS, 1998.

AIDS was first recognized in South Africa in 1982. The epidemic proceeded at a relatively slow pace until the 1990s, when it entered an explosive phase. Recent efforts to develop national policies and plans began with the African National Congress (ANC) while it was still banned. At a conference in Mozambique in early 1990, the ANC drafted the Maputo Statement on HIV and AIDS, which acknowledged the urgent need to make HIV prevention a priority. The ANC decided to work with the existing government through the MOH well before elections for the new government were set. The AIDS Unit of the MOH and the ANC worked together to establish a Steering Committee that included representatives of business (three national Chambers of Commerce), trade unions (two national union federations), churches (South African Council of Churches), civic organizations (South African National Civic Organization), political parties (ANC), and the government (MOH).

The Steering Committee decided on the need for a National AIDS Strategy. The effort began with a major conference in October 1992 entitled "South Africa United against AIDS." The conference called for a National AIDS Strategy with the following components:

- ✓ education;
- ✓ counseling;

- ✓ prevention;
- ✓ health care;
- ✓ welfare;
- ✓ research;
- ✓ human rights;
- ✓ law reform; and
- ✓ socioeconomic improvement.

The conference also established the National AIDS Convention of South Africa (NACOSA). NACOSA created its own Steering Committee and eventually expanded it to include representatives of NGOs working in HIV/AIDS. The Steering Committee set up task groups to develop different parts of an AIDS strategy. The draft strategy was circulated for comments and finalized at a meeting in September 1993. In early 1994, the committee developed an implementation plan to put the strategy into operation.

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### **Information for Advocacy in South Africa**

*South Africa benefited from local modeling efforts that demonstrated the consequences of the epidemic if it were permitted to spread unchecked. The Doyle model (developed by Metropolitan Life) was seen as a scientifically sound model that could generate useful information about the epidemic. It was used to counter wild claims about the impact of AIDS in South Africa and to demonstrate the costs and benefits of prevention efforts.*

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The committee presented the combined document, referred to as the Strategy and Plan, to South Africa's two deputy presidents soon after the Government of National Unity assumed power in May 1994. The minister of health formally adopted the Strategy and Plan in July 1994.

The policy development process in South Africa is notable for many unique features. First, the Strategy and Plan was developed not by a government department but rather by a coalition of forces outside government. These forces, led by the ANC, had the advantage of a

strong moral position. Between 1990 and 1994, the policy terrain took the form of two general positions—those in favor of apartheid and those opposed to it. Few people wanted to be associated with a negative past. For many, support of ANC positions was equivalent to opposition to apartheid. Thus, from 1990 to 1994, it was easier to achieve consensus for ANC-led efforts than before or since.

In addition, the groups leading the policy process were unconstrained by previous government experience. It was a time of “dreaming and grand visions.” The Strategy and Plan reflects an “ideal” policy in its values and comprehensiveness.

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***The South African AIDS Strategy and Plan generated tremendous optimism but failed to prevent rising HIV prevalence.***

*Mandela spoke at the 1992 conference that led to the drafting of the AIDS strategy, and it was widely believed that he would ensure that it was put into action. This confidence was rooted in Mandela's immense stature as a progressive leader, the country's postapartheid optimism, and its leading role in the economics of the continent. With its comparatively advanced infrastructure, health and education systems, and greater technology, hopes were high that South Africa would escape the devastation of AIDS that countries to the north were facing. The new cabinet members had pledged to fight AIDS, and HIV campaigns were touted as an essential part of the new democracy. A better life for all was an ANC election promise, and people with AIDS had reason to believe they were included. What went wrong?*

Mary Crewe, *South Africa's Moment of Truth*,  
*POZ*, July 1999.

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The Strategy and Plan also raised the profile of AIDS within government and became a symbol and rallying point for the broader AIDS community. In the years since 1994, however, it has become apparent that the Strategy and Plan has many weaknesses and suffers from delays in implementation due at least in part to the lack of government experience among many new members of the government. A major review of the Strategy and Plan in 1997 led to a reformulation of policy priorities at the national level. Top priorities now include strengthening support among public and private leaders, capacity building, intersectoral action, and reducing the stigma associated with HIV. In late 1998, the government launched a major new effort to encourage participation of all sectors of society in the fight against AIDS. In addition, President Mandela and Vice President Mbeki began to speak out about AIDS.

In recent years, treatment issues have moved to the top of the policy agenda. In 1998, the government stopped trials of the use of zidovudine (AZT) to prevent maternal-to-child transmission of HIV on the grounds that the money for treatment would be better spent on prevention efforts. It also drafted a bill that would provide for compulsory licensing of antiretrovirals and parallel importing of drugs produced by firms other than the patent holders as a way to reduce the costs of treatment. Both decisions stimulated vigorous debate both within and outside South Africa. The government that took power in June 1999 is carefully reviewing both these issues.

## Tanzania

PROFILE OF TANZANIA	
INDICATOR	VALUE
Population size	31.3 million
GNP per capita	\$210
Life expectancy	51 years
Infant mortality rate	86
Under-five mortality rate	144
Population below the poverty line (1991)	51%
Adult HIV prevalence (15-49)	9.4%
Number infected with HIV (all ages)	1.4 million

Sources: World Bank, 1999; UNAIDS, 1998.

The first AIDS case in Tanzania was identified in 1983. Since then, the national response to AIDS has developed through four phases as follows:

- ✓ 1985–1986. The Short Term Plan developed by the MOH governed early activities to control the epidemic.
- ✓ 1987–1991. The First Medium Term Plan was implemented. It included a more complete set of interventions and the first steps to decentralize the program.
- ✓ 1992–1996. The Second Medium Term Plan was implemented. It adopted a multisectoral approach and focused on reducing transmission of HIV and mitigating the personal and social consequences of the epidemic.
- ✓ 1996–1998. The Third Medium Term Plan was developed.

In 1991, a review of the National AIDS Control Program (NACP) called for the development of a national policy that would provide guidelines for dealing with AIDS. The review identified the following major issues:

- ✓ care of people with AIDS;
- ✓ pretest of HIV counseling;
- ✓ AIDS orphans; and
- ✓ AIDS education in the schools.

The Second Medium Term Plan reiterated the need for a national policy and added several additional policy issues that

needed to be addressed, including the following:

- ✓ support for family members of people who have died from AIDS;
- ✓ loss of productivity;
- ✓ protection of the legal rights of AIDS patients and people living with HIV and AIDS; and
- ✓ use of condoms.

With the absence of a supportive legal framework for many AIDS programs, the need for a national policy became evident. It was difficult to change laws and regulations to create a supportive legal framework without a government policy requiring those changes. Therefore, the government designated the NACP to develop a national policy. The NACP commissioned experts to write lead papers on 11 key components. The experts then presented the papers at a national policy formulation workshop in 1995. The workshop lasted for seven days and included 28 people, most of whom were government officials; only two represented NGOs. The NACP made efforts to solicit input from other sectors of society, including PLWHA and commercial sex workers, but received few responses. As of mid-1999, the policy had still not been approved. The lack of widespread participation in the development of the policy may have contributed to a lack of momentum for approval.

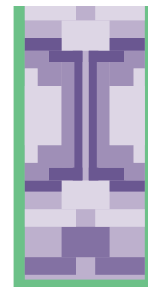
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### **Lack of conducive political conditions led to a delay in approving the AIDS policy in Tanzania.**

*The draft policy was prepared in 1995; however, it still has not been approved. The draft was prepared when the country was at the peak of the transition to a multiparty democracy. Government efforts were directed at ensuring a smooth transition. Little attention was devoted to advancing the AIDS policy through the approval channels.*

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In 1998, the NACP prepared a new five-year strategy for 1998–2002, developed with broad participation. It has been approved and is now being implemented.



## Uganda

PROFILE OF UGANDA	
INDICATOR	VALUE
Population size	20.3 million
GNP per capita	\$330
Life expectancy	43 years
Infant mortality rate	99
Under-five mortality rate	141
Population below the poverty line (1993)	55%
Adult HIV prevalence (15-49)	9.5%
Number infected with HIV (all ages)	930,000

Sources: World Bank, 1999; UNAIDS, 1998.

Uganda was one of the first countries to experience an AIDS epidemic. HIV prevalence reached extremely high levels in some parts of the country in the mid- to late-1980s. Uganda's response to the epidemic was early and relatively well organized. The first policies dealt with blood transfusion and testing. Uganda developed one of the first multisectoral programs when it established the Uganda AIDS Commission within the Office of the President in 1991. Other countries are copying the multisectoral approach developed by Uganda in an effort to expand participation in the fight against AIDS. Uganda's approach has been effective in involving all sectors of government and demonstrating a strong commitment; however, the approach has not been entirely successful. At times, the extra layer of bureaucracy has proven to be inefficient. Recently, the government

began moving some of the functions of the commission back to the AIDS Control Program in the MOH.

Efforts to develop a comprehensive national policy did not begin until the mid-1990s. The Uganda AIDS Commission is managing the process, which has called for the following steps:

- ✓ input collected from various sectors;
- ✓ preparation of an initial draft policy;
- ✓ review and revision of the draft by the Technical Committee of the Uganda AIDS Commission;
- ✓ distribution of the draft to the full commission for review;
- ✓ submission of the draft report by the MOH to the line ministries for review;
- ✓ submission of a memorandum on the draft policy to the cabinet;
- ✓ submission of a draft bill to the Health Committee of Parliament; and
- ✓ submission of the bill to Parliament for approval.

As of early 1999, Parliament had not yet approved the policy, but approval is expected later in the year. Nonetheless, many of the administrative policies contained in the comprehensive document have already been implemented. Parliamentary approval is necessary for those policies that require legislative action.

## Zimbabwe

PROFILE OF ZIMBABWE	
INDICATOR	VALUE
Population size	11.5 million
GNP per capita	\$750
Life expectancy	56 years
Infant mortality rate	56
Under-five mortality rate	86
Population below the poverty line (1990-91)	25%
Adult HIV prevalence (15-49)	26%
Number infected with HIV (all ages)	1.5 million

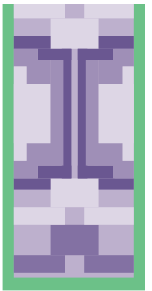
Sources: World Bank, 1999; UNAIDS, 1998.

Zimbabwe has experienced an extremely severe HIV/AIDS epidemic during the last 10 years. In response, the country has implemented several short- and medium-term plans and established the National AIDS Coordination Program. The effort to develop a comprehensive national policy began in 1994 with the establishment of a Steering Committee to plan the process and provide leadership. The committee consists of three members from the National AIDS Control Program, two from NGOs, two from universities, one from the Attorney General's Office, and one from an organization of PLWHA.

The Steering Committee solicited inputs and opinions from experts through a series of consultations and brainstorming sessions. The inputs formed the basis of the first draft of the policy, which the committee then circulated widely (200,000 copies printed and distributed). The draft policy was also used as the focus of discussions with several national, provincial, and district groups. More than 4,500 people participated in discussion forums held in conjunction with seven provincial workshops. The draft policy was even serialized in the national newspaper to make it accessible to a larger portion of the general population.

The Steering Committee prepared the second draft based on the public's inputs and sent it to the Attorney General's Office for legal review. Final approval is expected later in 1999.

Although the final policy has not been officially approved, many of its administrative policies have already been implemented. In addition, the extensive participation has created widespread awareness of the policy, and many of the advocacy and support-building objectives have already been achieved (Vera, 1997).



## Zambia

PROFILE OF ZAMBIA	
INDICATOR	VALUE
Population size	9.4 million
GNP per capita	\$380
Life expectancy	44 years
Infant mortality rate	112
Under-five mortality rate	202
Population below the poverty line (1991)	68%
Adult HIV prevalence (15-49)	19%
Number infected with HIV (all ages)	770,000

Sources: World Bank, 1999; UNAIDS, 1998.

The first AIDS case in Zambia was identified in 1984. Early government responses to the epidemic focused on the prevention of HIV transmission through the protection of blood supplies and the dissemination of information to the public on how to prevent HIV infection. A broader multisectoral approach later replaced the initial biomedical response.

The National AIDS/STD/TB and Leprosy Program (NASTLP) began broad-based and extensive consultations with the government and other stakeholders in 1993 to build consensus and collaboration on the future of the multisectoral program. In May 1993, the National Consensus Workshop of stakeholders brought together donors, government ministries, local and international NGOs, church organizations, traditional practitioners, trade unions, private business organizations, and students.

The National Consensus Workshop was followed by other specific and well-targeted workshops involving, among others, permanent secretaries, focal point persons (designated AIDS officers) from various ministries, church organizations, and NGOs. The workshops had the task of developing sectoral strategies.

The process of developing HIV/AIDS sectoral policies is complementary to the national health reforms, which emphasize decentralization of the health care system

and the building of partnership, collaboration, and consultation with organizations outside the health sector.

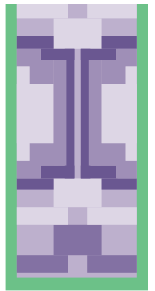
Zambia has a major AIDS policy component in its Second Medium Term Plan and relies on a number of discrete policies, regulations, and guidelines; however, the government has not developed a comprehensive national AIDS policy.

### **National Consensus Workshop in Zambia, May 1993**

*The National Consensus Workshop marked a watershed in the prevention and control of HIV/AIDS in Zambia. First and foremost, the Ministry of Health and the National AIDS/STD/TB and Leprosy Program realized that HIV/AIDS had affected all the sectors of the economy, hence it needed more than a medical or health response to combat it more effectively and efficiently. Secondly, their role changed from that of sole implementer and planner to one that was going to advocate, facilitate, and coordinate the development of a multisectoral response. Thirdly, it was also realized that for the major stakeholders to wholly commit themselves to participate in the fight against the epidemic, they had to be a part and parcel of the planning process in which the outcome would not be viewed as being imposed on them. The National Consensus Workshop was therefore an important step in building consensus, fostering collaboration, consultation, and partnership among the major stakeholders.*

NGO Representative

The nation has stimulated a multisectoral response through a variety of mechanisms, of which one is the generation of information on the impact of AIDS on nonhealth sectors. Studies conducted on the impact of AIDS on agriculture, community development and social welfare, education, employment, health, and the media illustrate the multidimensional nature of the epidemic and the need for a multisectoral response. During the initial implementation of the multisectoral approach, each ministry duplicated the functions of the MOH. Later, however, the ministries were urged to develop unique programs that used their



comparative advantage. Accordingly, the government convened a conference of permanent secretaries in March 1994 to establish the concept of the focal point person (FPP) in each ministry and to firmly signal the government's commitment to the multisectoral approach.

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***A meeting of the permanent secretaries firmly established the multisectoral approach in Zambia.***

*The first meeting of the permanent secretaries was a turning point in sensitizing us on the issues of HIV/AIDS and the need to institute HIV/AIDS policies within our line ministries. We were able to hold extensive deliberations on the way forward specifically on the concept of comparative advantage, which encourages us to conduct HIV/AIDS education programs utilizing existing opportunities and institutional structures of our organizations or institutions to influence activities within our mandated areas of operation.*

Permanent Secretary,  
Ministry of Labor and Social Security

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In many countries, the focal point person has been a key component of the multisectoral approach. At first, the Zambian ministries greeted the approach with great enthusiasm. However, the creation of new official posts ran counter to the Public Sector Reform Program that attempted to reduce the number of government employees. Nonetheless, a study of AIDS-related absenteeism concluded that the FPP program was essential to achieving the goals of civil service reform.

Zambia has also tried to involve nongovernmental sectors in the fight against AIDS. The government has supported special private sector efforts to motivate individual firms to implement policies and programs. Efforts included a meeting in July 1996 with the chief executive of the Zambian Federation of Employers. The meeting highlighted the role of the private sector and how it can be integrated into the national HIV/AIDS program. Special efforts have also

involved religious organizations. For example, NASTLP has worked with the Council of Churches to conduct interdenominational workshops on the church's role in the battle against AIDS.

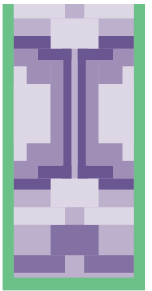
Thus, Zambia does not have a comprehensive HIV/AIDS policy but has actively pursued the development of specific policies and programs through a multisectoral approach. Those in the program view the lack of a comprehensive HIV/AIDS policy as both an advantage and a disadvantage. The existing policy frameworks developed before AIDS emerged as a serious problem are often incomplete and full of loopholes that allow the continuation of discriminatory practices. On the positive side, given that new policies and programs need to be grafted onto existing regulatory frameworks, more recent efforts are tightly integrated with existing approaches.

The review of the policy development process in Zambia highlighted the following major lessons:

- ✓ A two-pronged strategy has been helpful in combining sensitization to the general issues and problems of HIV/AIDS with efforts to develop policies on specific issues needing urgent attention.
- ✓ The FPP approach has worked well in some ministries and poorly in others. Where the focal point person is ineffective, it is necessary to intervene directly with the leadership of the ministry to develop effective policies.
- ✓ The multisectoral approach is long and cumbersome and can achieve success only when permanent secretaries and other senior officials are fully committed to the effort.
- ✓ The most effective way to implement the multisectoral approach is to integrate activities into existing structures rather than to set up parallel structures.

- ✓ The process of developing sector-level HIV/AIDS policies should not be left entirely to the focal point persons but should involve all key players within a ministry.
- ✓ To enhance sustainability, it is critical to implement a continuous process of consultation, collaboration, and consensus building. The role of NASTLP in sustaining the response is critical.

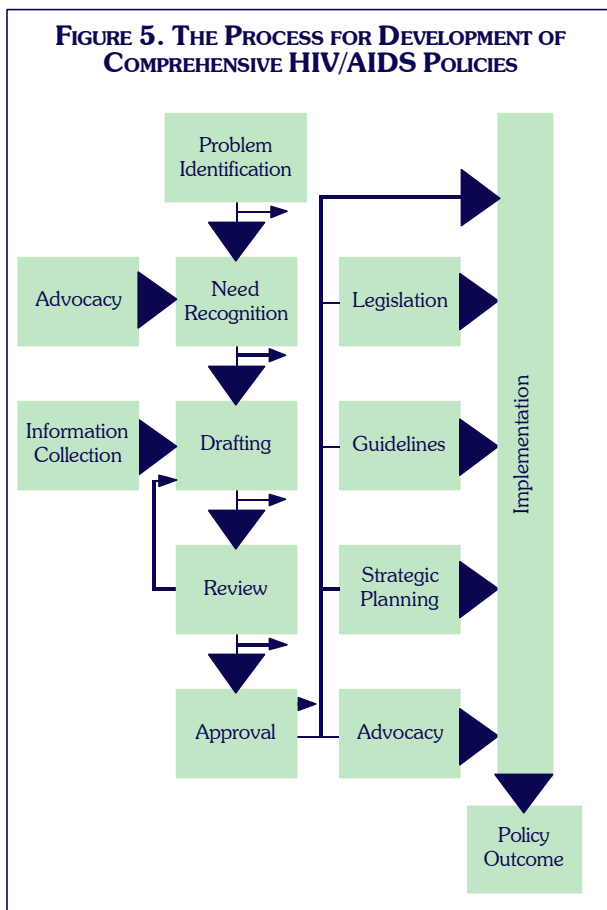




## Comparative Analysis of the Policy Process

The country case studies suggest that the theoretical frameworks outlined earlier capture much of the policymaking process. Nonetheless, the frameworks need elaboration to provide a better description of the process as it has unfolded in Africa. Figure 5 presents a revised framework for the policy process that more accurately reflects the reported experiences.


The revised framework follows the major steps outlined by Lasswell (1951) and Meier (1991) but makes more explicit some of the key steps identified in the case studies, particularly the drafting and review steps and the multiple pathways by which policies can be implemented. The right-pointing arrows that do not connect to boxes indicate that the process can stop at each step. Progress from the first step to the last is not inevitable.



### Problem Identification and Need Recognition

As the case studies illustrate, there is a clear distinction between recognizing AIDS as a problem and determining that formal policies are needed to address the disease. In most countries, the first AIDS cases were reported in the mid-1980s; however, the development of comprehensive policies did not begin until the 1990s. Governments responded to the emerging problem with a variety of incremental steps before recognizing the need for a comprehensive policy. These responses can be summarized in four phases of policy development as described below.

- ✓ **Medical response.** The first response to AIDS in most countries was to treat the disease as a medical problem. Activities focused on screening donated blood, ensuring safe medical practices, and conducting surveillance and research. In most countries, the medical response coincided with the development of the



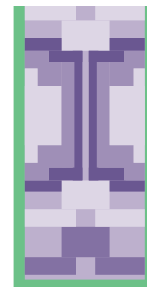
first medium-term plan under the guidance of the Global Program on AIDS. The first cases of AIDS were identified, and while research showed that infection levels were increasing in some population groups, the number of AIDS deaths remained low. At this stage, medical and research guidelines were needed, but there was little recognized need for comprehensive national policies.

- ✓ **Public health response.** As the epidemic progressed, governments and international organizations began to realize that a medical approach to HIV prevention and care was insufficient. Intervention research showed that progress toward prevention could be achieved with a combination of programs such as condom promotion, peer counseling, and mass media campaigns. In this phase, the response to AIDS broadened considerably and, as a result, difficult policy issues began to arise, such as condom advertising in the mass media. Governments generally dealt with these issues on an ad hoc basis through specific regulations or laws.
- ✓ **Multisectoral response.** Later in the epidemic, the number of AIDS deaths began to rise. International organizations began to stress the broad social and economic impacts of AIDS, thus spurring multisectoral responses. All sectors of government were encouraged to get involved in HIV prevention. The role of the private sector, NGOs, and communities took on greater importance. By this time, the full range of difficult policy issues had become apparent, forcing governments to consider, for example, the situation of orphans, AIDS education in the schools, human rights, treatment and care, and research ethics. At this point, the need for a comprehensive national policy to address all of these issues became apparent in most countries.

- ✓ **Focused treatment and prevention.** In many countries, the latest phase is distinguished by a focus on proven approaches. This may mean less emphasis on the multisectoral approach and greater emphasis on the most promising prevention interventions. The latest phase also includes a sharper focus on the ethical and resource issues associated with new treatment and prevention options, such as antiretroviral therapy and prevention of maternal-to-child transmission.


Table 2 shows the timing of the development of comprehensive national policies for nine countries. Ethiopia was the first country to respond (1989). Most of the other efforts started between 1992 and 1994. Of the nine countries, three have received final approval for their policies (Ethiopia, Kenya, and South Africa) while four countries are still awaiting final approval (Ghana, Tanzania, Uganda, and Zimbabwe). In Ethiopia, the entire process took nine years; South Africa started much later but completed policy development in only two years. Table 2 refers only to the development of comprehensive national HIV/AIDS policies. It does not indicate other policy activities that may have preceded the AIDS policy effort. For example, Tanzania issued medical guidelines on testing, care, and prevention in 1989 but did not start developing a comprehensive national policy until 1995.

Although most countries see AIDS as a national crisis, the amount of time required to develop and approve comprehensive AIDS policies clearly shows that governments did not treat the epidemic as a crisis demanding an immediate policy solution. Instead, governments relied on normal mechanisms of policy development rather than on more rapid crisis-intervention mechanisms. On the positive side, the traditional approach had the benefit of providing the opportunity for widespread participation in the policy debate.



**TABLE 2. TIMELINE FOR THE DEVELOPMENT OF COMPREHENSIVE HIV/AIDS POLICIES, 1982 1999**

Country	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
Ethiopia					A												H	
Ghana					A													m
Kenya			A													H		
Malawi				A														
South Africa	A												H					
Tanzania		A																m
Uganda		A																m
Zambia			A															
Zimbabwe					A													m

A = First AIDS case reported.  
 = Development of comprehensive national policy.  
 H = Comprehensive national policy approved.  
 m = Policies pending final approval.

Accordingly, the two-year process in South Africa and the four-year process in Kenya were a natural consequence of the decision to develop comprehensive policies with broad participation. On the negative side, the failure to recognize the urgency of the situation has contributed to periods of little activity that span a nine-year gap between initial activities and final approval in Ethiopia. In addition, policies are not yet approved after four years of development in Ghana and after five years in Tanzania.

### Advocacy

In most countries, advocacy by various interest groups to stimulate a government response has been a chief aspect of problem identification and need recognition. International organizations such as UNAIDS, WHO, and, more recently, the World Bank are responsible for some of the AIDS advocacy efforts. International donors, including USAID and Britain's Department for International Development (DFID), often include AIDS in their policy dialogue with host governments and support projects, such as the POLICY Project, as part of their efforts to provide technical assistance and training in advocacy. National AIDS Control Programs have conducted some advocacy, too. The

programs in Ethiopia, Ghana, Kenya, South Africa, Uganda, Zambia, and Zimbabwe have all developed advocacy presentations and booklets for use in creating awareness of the AIDS epidemic and building support for effective policies and programs. In some countries, local NGOs and interest groups have been instrumental in making the case for government action. In Uganda, The AIDS Support Organization (TASO) increased awareness of the AIDS problem by establishing a network of people to provide support to persons with HIV and their families. In Kenya, the Kenya AIDS NGO Consortium (KANCO) supports AIDS NGOs, disseminates AIDS information, and supports efforts to engage parliamentarians in discussions about AIDS. In South Africa, the National Association of People Living with HIV and AIDS has been a leading voice for an expanded response to AIDS.

### Information Collection

Most countries established drafting committees or steering committees charged with overseeing the development of the first draft of an AIDS policy. The drafting committees typically sought expert advice through interviews (Ghana), commissioned papers on key topics (Tanzania), or inclusion of experts on technical

subcommittees (Kenya). Some countries conducted national workshops during which the commissioned papers or consultant views were discussed and an initial draft produced (Ethiopia, Tanzania).

### Drafting

In Ethiopia, Ghana, South Africa, Tanzania, and Uganda, the major work of drafting an AIDS policy was completed before or during a national workshop. Most opportunities for participation came during the predrafting or drafting stage. The level of participation depended on the amount of diversity represented by those involved in the drafting process. In South Africa, both the diverse makeup of NACOSA and the unique political situation contributed to a substantial level of participation in policy dialogue. In Ethiopia and Tanzania, reliance on a single national workshop provided fewer opportunities for participation for those outside the public health field. However, Tanzania did send its draft policy to organizations representing PLWHA and commercial sex workers but received little feedback. (In both Ethiopia and Tanzania, more opportunities for participation are being created as part of the strategic planning process that is now underway.) Malawi addressed the problem of limited community feedback by training facilitators to organize and run meetings specifically designed to elicit a greater level of response from the community.

Zambia lacks a comprehensive national policy, but it fosters participation in discussion of specific policies in several ways. For example, it conducts an annual national AIDS conference for debate of recommendations to be sent to Parliament.

### Review

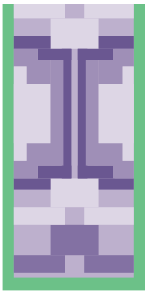
In Kenya and Zimbabwe, the draft policies were widely debated. Zimbabwe printed 200,000 copies of the first draft for distribution. Both countries held provincial and district workshops that provided

extensive opportunities for participation and reaction to the first draft. While such an approach is time-consuming, it does provide opportunities for focused input from interested individuals and organizations.

**Dispute resolution.** Many aspects of AIDS policy are controversial. The various disputes that invariably arose during the discussion of each policy were handled in a different manner according to the issue and its context. In some cases, it was possible to bring additional scientific information to the debate to produce consensus on the best approach. For example, the issue of quarantine for infected individuals is easy to reject once all participants understand that the infection is extremely widespread. In other cases, expert opinion on medical ethics was persuasive in convincing participants of a correct approach (e.g., the need for confidentiality). For some issues, however, it was impossible to achieve consensus. Many such issues were simply dropped from the policy. Examples include criminalization of willful transmission of HIV and distribution of condoms in prisons. For other issues, participants reached compromise by making the issue less specific. For example, "sex education in the schools" might be controversial, whereas "family life education" or "AIDS information for young people" might be less inflammatory in that the statements can be interpreted in many different ways. Zimbabwe was able to refer to willful transmission in its policy by including a statement on "sexual assault."

**Lead institution.** The National AIDS Control Program within the MOH took the lead in policy development in all countries except South Africa and Uganda. During discussions surrounding the transition to the new government, South Africa's ANC initiated discussions with the government on the need for an AIDS policy. The result





was the establishment of NACOSA, a broad-based coalition that spearheaded preparation of the Strategy and Plan for AIDS in South Africa. In Uganda, responsibility for policy development rests with the Uganda AIDS Commission, a multisectoral body that includes representation from all parts of the government involved in AIDS activities. In most other countries, the multisectoral coordinating bodies, such as national AIDS councils, have not been established, are not functioning, or are established as part of the comprehensive policy. In Uganda, however, the AIDS Commission was established in the early 1990s. It provides a broader base within the government structure for policy development than the AIDS Control Program under the MOH.

### Approval

National AIDS policies have been approved at one of three levels: the minister of health, the cabinet, or Parliament. The minister of health approved most of the early guidelines or specific policies. The South Africa National Plan was presented to the deputy presidents, but final approval came from the minister of health. Final approval came or will come from the cabinet in Ethiopia, Tanzania, and Zimbabwe. Ghana, Kenya, and Uganda are seeking or sought final approval from Parliament. It would seem that final approval by Parliament would signal that greater debate had taken place and that the final policy would receive stronger support and lead to greater understanding of the magnitude of the AIDS challenge. It is not yet clear whether such is the case. Presumably, the legitimacy of the government and the degree of participation by opposition parties in Parliament would be important factors in determining the depth of support and awareness.

### Implementation

Once policies are adopted, they need to be implemented. Countries have adopted many different approaches to implementation. Several countries implemented policies through operational or strategic plans that may reflect substantial participation. In some countries, committees need to be established to develop the guidelines required to implement the policies. The process of developing the guidelines can be every bit as time consuming as the process of developing the policy. Often, difficult decisions that were avoided when policies were drafted need to be resolved as plans and guidelines are developed. In many cases, elements of a policy can be implemented even before the full policy is adopted. Interest groups may be encouraged to take the lead in disseminating and implementing parts of the policy that are of particular interest to them. Most policies contain some elements that can be implemented immediately through administrative actions; other items require efforts to develop specific legislation and to obtain funding.

**Value of multisectoral approach.** Most countries and international organizations have tried or recommended multisectoral approaches to AIDS because of the diverse impacts of the disease and the need for many sectors to confront the epidemic. The experience to date has been mixed. Malawi set up a National AIDS Committee that was multisectoral in nature and shared control of the National AIDS Control Program with the MOH. The structure created problems in that the National AIDS Committee had no direct path for bringing important issues to the cabinet. Malawi later revised the structure; it maintained the multisectoral aspects but created a secretariat for the National AIDS Control Program. Line ministers are secretariat members with a direct route to the cabinet. The MOH and the National AIDS Control Program both report to the secretariat.

Uganda was one of the first countries to implement the multisectoral approach. First, it established the Uganda AIDS Commission within the Office of the President. In addition to the MOH, many ministries established AIDS control programs. Eventually, the commission later moved to the MOH (although it has a separate budget) where it is likely to receive more attention.

Several countries have experimented with AIDS focal point persons to lead the multisectoral effort within the various ministries. In cases where the focal point persons perform satisfactorily, the approach can lead to the active participation of many ministries. For many countries, however, the experience has been disappointing. The focal point persons rarely have AIDS written into their job description, which means that they need to fold AIDS activities into all their other responsibilities and can be transferred to another job or ministry without specific plans for handing over the AIDS function to another person within the ministry. With many governments undergoing civil service reform aimed at reducing the number of government employees, effective implementation of the FPP concept may be difficult.

Although everyone recognizes the need to involve all sectors of government and society in AIDS programs, the best mechanisms for achieving widespread involvement are not apparent. Most efforts to develop multisectoral approaches have focused on engaging all government departments in AIDS programs. By contrast, some countries have made special efforts to involve nongovernmental sectors as well. These efforts try to enlist the private sector, NGOs, religious groups, trade unions, community organizations, associations of PLWHA, and others. Although the participation of these different segments of society can sometimes lead to conflict, the experience has generally been positive.

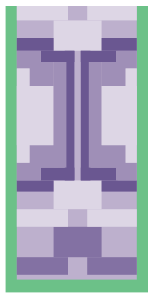
AIDS is not solely a medical problem; therefore, all sectors of society affected by AIDS need to be involved in the effort to confront the disease.

**National versus provincial/district roles.** The division of responsibility between national and provincial or district departments is another important consideration for policy development. Setting national policies is clearly the role of the national government, but implementation is often the responsibility of local administrations. The recent trend toward decentralization of all government functions, including health, has sharpened the division between national and local government. In Ethiopia and Zambia, the functions of the National AIDS Control Program are limited to policy, advocacy, research, interaction with international donors, and some other functions while most responsibility for implementation rests with the districts or the provinces. The division of responsibility for developing guidelines may not be clear, and some uncertainty surrounds the degree to which districts or provinces are bound by policy decisions or guidelines established at the national level. The need for broad participation in developing and implementing national policies cannot be overstated—whether through continuous advocacy, planning, or training.

### Actors

The various actors in the policy process play different roles, and their degree of participation varies according to the stage of the process. Although all actors may be involved to some extent in all stages, they make their key contributions in only a few stages. Table 3 summarizes the experiences from the case studies. This discussion categorizes actors according to the key groups identified by the literature on the policy process. In the case of HIV/AIDS, the groups include





- ✓ Technocrats—epidemiologists, physicians, scientists, public health specialists, policy analysts, and economists within the MOH, from national research institutions, and from international organizations;
- ✓ Bureaucrats—primarily from the MOH, the Ministry of Planning, and the president’s or prime minister’s office;
- ✓ Interest groups—NGOs providing HIV/AIDS prevention and care services, organizations of PLWHA, community organizations, and organizations representing populations at special risk (e.g., commercial sex workers, truckers);
- ✓ Politicians—ministers and deputy ministers, members of Parliament, members of the cabinet, the president, and the prime minister; and
- ✓ Donors—representatives of UNAIDS and its member organizations (WHO, UNICEF, UNDP, UNFPA, and the World Bank) and key bilateral donors such as USAID, DFID, and the Danish and Swedish development agencies (DANIDA and SIDA).

out by epidemiologists within the MOH and university research groups. They were typically supported by international specialists provided by WHO, USAID, and other donor organizations.

**Need recognition** comes from politicians who place AIDS on the policy agenda. Therefore, advocacy efforts focused on convincing key politicians of the need for a comprehensive response.

**Advocacy** for action can come from any group. Typically, it is carried out by interest groups and donors. Advocates may forge alliances with technocrats and bureaucrats who see the need for accelerated policy action to advance their case through normal government channels. In some cases, far-seeing politicians recognize the need for more action and become champions of the effort to develop a comprehensive and effective response. In South Africa, for example, the ANC recognized AIDS as an issue early on and placed it on the policy agenda. In Ethiopia, donors helped support a large technical staff in the country’s AIDS Control Program;

**TABLE 3. ACTORS IN THE POLICY PROCESS BY STAGE**

STAGE	TECHNOCRATS	BUREAUCRATS	INTEREST GROUPS	POLITICIANS	DONORS
Problem identification	4				4
Need recognition				4	
Advocacy	4	4	4	4	4
Information collection	4				
Drafting	4	4	4		
Review			4	4	
Approval				4	
Implementation	4	4	4	4	4

**Problem identification** is led by technocrats who collect and analyze data and present it in various forms to illustrate current and future problems. The key pieces of information are reported AIDS cases and surveillance studies for HIV infection. Donors played a role by presenting information from other countries that corroborated the national experience. In all the countries examined for this report, data collection and analysis were carried

that staff effectively made the case for more action. However, when Ethiopia’s decentralization program caused the drastic reduction of the technical staff, the pressure for action diminished and the process was delayed by several years.

**Information collection** is conducted by technocrats. In the case studies presented here, expert information was collected through special papers prepared by technical consultants (Kenya, Tanzania),

workshops with technocrats (Ethiopia, Tanzania), or interviews (Ghana).

**Drafting** policy documents is usually carried out by bureaucrats with the participation of other groups. In several of the case studies (Kenya, South Africa, Zimbabwe), interest groups had many opportunities to participate in the drafting process. In others (Ethiopia, Tanzania), opportunities were few.

**Approval** is usually a political process. In the case of South Africa, the minister of health formally approved the AIDS strategy, although the deputy presidents provided tacit approval. In all other countries, the cabinet or Parliament approved the policy.

**Implementation** can and should involve everyone. Technocrats need to provide information and remain involved in program planning. Bureaucrats create and run the formal structures that implement programs. Interest groups advocate for action on specific portions of the policy and work

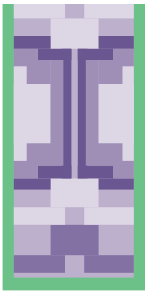
through NGOs and other types of organizations representing civil society to implement some policy components. Politicians need to be involved in developing the enabling legislation that may be required to implement some portions of the policy; they also allocate the funding for implementation. Donors often play a major role in funding and setting program priorities.

### Information Needs

Information needs differ at each stage of the policy process (see Table 4). National and international research and evaluation efforts are essential to providing the information that supports appropriate decisions at each stage. Local capability to generate, evaluate, and disseminate needed information is an important ingredient in a successful policy process. Without such information, the process may not proceed, or ineffective or harmful policies may result.

**TABLE 4. INFORMATION NEEDS BY STAGE OF THE POLICY PROCESS**

STAGE	ILLUSTRATIVE INFORMATION NEEDS
Problem identification	<ul style="list-style-type: none"> <li>  Number of reported AIDS cases by age, sex, and region</li> <li>  Surveillance information on HIV prevalence by risk group</li> <li>  Estimates of the number infected</li> </ul>
Need recognition	<ul style="list-style-type: none"> <li>  Projections of the future number of infections and AIDS cases and deaths</li> <li>  Estimates of the social and economic impacts of AIDS</li> <li>  Personal stories of the hardships caused by AIDS illustrating impacts on individuals, families, communities, human rights, etc.</li> </ul>
Advocacy	<ul style="list-style-type: none"> <li>  Information showing impact of AIDS on special groups and effectiveness of interventions</li> </ul>
Drafting and review	<ul style="list-style-type: none"> <li>  Status and extent of epidemic</li> <li>  Policy inventory of existing laws and regulations</li> <li>  Model policies recommended by international organizations and conferences</li> <li>  Examples of policies adopted by other countries</li> </ul>
Approval	<ul style="list-style-type: none"> <li>  Views of interest groups on draft policies</li> <li>  Estimates of the impact of policies on controlling epidemic</li> <li>  Estimates of the costs of policies</li> </ul>
Legislation	<ul style="list-style-type: none"> <li>  Inventory of existing legislation</li> <li>  Drafts of legislation required to address key policy issues</li> </ul>
Guidelines	<ul style="list-style-type: none"> <li>  Scientific information concerning approaches that work and do not work</li> </ul>
Strategic planning	<ul style="list-style-type: none"> <li>  Effectiveness of proposed interventions</li> <li>  Cost-effectiveness and cost-benefit analyses</li> <li>  Projections of resources required</li> </ul>



## Key Policy Issues

National HIV/AIDS policies and operational policy guidelines have addressed a broad array of policy issues. Specific issues range from medical and care guidelines to policies affecting access to services to human rights and antidiscrimination. For many of the topics covered in the national policies and guidelines, policymakers and other stakeholders have been able to reach a clear consensus as to the appropriate policy recommendation. In other cases, the adoption of specific policies has faced serious obstacles, in terms of either vocal opposition to the policy or the lack of consensus on the feasibility, effectiveness, cost-effectiveness, or cultural/social appropriateness of a policy or program recommendation.

### General Policy Topics Addressed in Most National HIV/AIDS Policies

Most national HIV/AIDS policies include statements and guidelines on the following general topics:

- ✓ public health issues such as HIV testing and counseling, blood safety, and surveillance;
- ✓ clinical management and infection control;
- ✓ home-based care;
- ✓ counseling in the areas of breastfeeding, adolescent health, and reproductive health;
- ✓ gender issues;
- ✓ information and education;
- ✓ research;
- ✓ ethical, legal, and human rights issues such as privacy, confidentiality, notification, cultural factors, discrimination, access to health care and social services, education, employment, housing, insurance, travel, migration, refugees, prisons, intravenous drug users, commercial sex workers; and
- ✓ multisectoral approach, collaboration, role of NGOs, decentralization, and resource mobilization.

The HIV/AIDS Policy Compendium developed by the POLICY Project provides many specific examples of the policy statements and guidelines for each of the above topics. The compendium is a database of policy statements compiled from national policies and statements of international conferences and documents. The database is available on the Internet at [www.tfgi.com/areas/hiv aids.htm](http://www.tfgi.com/areas/hiv aids.htm) or on a CD-ROM available from the POLICY Project.

One of the more complex and difficult areas in HIV/AIDS policy formulation is coverage of human rights. The key issues involving human rights and HIV/AIDS are summarized below.

- ✓ **Stigma.** Social ostracism leading to deterioration of civil, economic, or political rights.

- ✓ **Education.** Government restrictions on the dissemination and free exchange of HIV/AIDS prevention and treatment information; restrictions on access to education.
- ✓ **Legal system.** Unequal legal system application of substantive and procedural criminal and civil law leading to a reduction in protection for those infected with HIV.
- ✓ **Health services.** Unequal management of services (access, testing, reporting, coverage).
- ✓ **Social welfare and insurance.** Unequal application of social welfare or social security services, benefits, and administration systems otherwise universally entitled; restrictions on indemnity or life insurance coverage.
- ✓ **Housing.** Unequal public and private accommodations (access, services, quality).
- ✓ **Family life.** Mandatory HIV testing (e.g., to receive marriage license); withdrawal or modification of family and interpersonal rights.
- ✓ **Employment.** Unequal employment requirements and procedures (testing, confidentiality, workplace, benefits, dismissal).
- ✓ **Prisons.** Denial of equal conditions in detention (segregation, benefits, release).
- ✓ **Migration.** Restrictions on movement or stay (mandatory declaration, testing, exclusion).

On some policy issues, there is general agreement on approaches and language. Other issues have presented difficulties either in understanding what policies are most appropriate or developing a consensus on specific language. Some of the difficult issues are described below along with a discussion of strategies that have been used to address them.

## HIV Counseling and Testing

The provision of services for voluntary HIV counseling and testing (VCT) is now seen as a core element of many national AIDS programs. Even though substantial research has documented the positive impact of VCT programs on changing behaviors, controversy continues to rage over policies that support publicly subsidized VCT programs, particularly with respect to the cost-effectiveness of VCT and resource allocation priorities within the national programs. In Ghana, the possibility that the 1992 constitution can be interpreted as prohibiting HIV testing raises specific legal concerns.

### Pre-Employment Testing

Pre-employment testing can be a contentious issue. Many employers want to conduct pre-employment tests to protect their investment in employee training. In several countries, the armed forces routinely test all new recruits. Such testing can, however, violate the rights of individuals to work if the test results lead to the denial of employment on the basis of HIV status. Botswana, South Africa, and Tanzania have included specific language in their policies to prohibit pre-employment testing and the use of HIV status as the sole criterion for dismissal. Botswana's policy follows:

#### 6.2 HIV Testing

*The following principles should be observed with regard to all testing for HIV:*

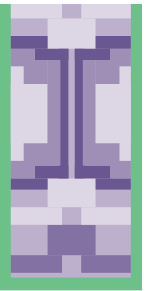
*Pre-employment HIV testing as part of the assessment of fitness to work is unnecessary, and should not be carried out .*

*Botswana National Policy on HIV/AIDS, approved and adopted through Presidential Directive CAB:35/93*

## Orphans

In many countries, the number of AIDS orphans has increased to alarming levels. Yet, attempts to mitigate the impact of AIDS on children and families can generate





conflict. For example, some people have called for school-fee waivers for AIDS orphans; however, such actions could lead to stigmatization as well as undermine the efforts of school boards mandated to raise their own funds. Other suggested services targeted to AIDS orphans included feeding programs and clothing allowances. However, it is difficult to justify special programs for AIDS orphans if other orphans are not also included.

As part of the effort to reduce the cost of attending school in Zambia, the requirement for school uniforms and black shoes has been lifted to assist the growing number of AIDS orphans. The Kenya AIDS policy calls for free education and social support for orphans.

*The economic impact of AIDS calls for mobilization of resources from various sources which include individuals, communities, the exchequer and donor agencies. The Government will therefore:*

*Within the framework of Universal Primary Education, offer free educational and social support to orphans .*

*Sessional Paper No. 4 of 1997 on AIDS in Kenya*

## AIDS Education in Schools

The issue of AIDS education in schools is generally contentious. Although general education about AIDS may not be controversial, the specifics of an AIDS curriculum can be the most controversial policy issue of all those discussed here. Major elements in the debate are whether parents or schools should be teaching young children about sex and whether prevention messages should be limited to abstinence or should address the use of condoms. One approach is to use extracurricular activities such as forums (anti-AIDS clubs) that could provide more specific guidance and advice. In any event, the most contentious controversies generally surround the development and review of curricula rather than the more general statements of principle that are

usually embodied in national policy statements. For example, the Kenya Sessional Paper on AIDS sets a broad goal for the role of the education system without specifying details of the specific messages.

*Young people comprise the majority of AIDS cases as reported from various hospitals. The youth become infected through environmental, social, cultural, psychological, and biological factors. To protect young people against HIV/STD infections, the Government will:*

*Provide direction in designing culturally, morally and scientifically acceptable AIDS education programmes for youth in and out of school .*

*Sessional Paper No. 4 of 1997 on AIDS in Kenya*

## Condom Advertising

The promotion of condoms is a key aspect of most HIV prevention programs. Some countries, however, have banned condom advertisements on radio or television in response to opposition from religious and other interest groups. The MOH in Uganda initially approved condom advertising by the social marketing program. Shortly after the advertising campaign started, the Ministry of Information banned it, although it permitted some advertising to begin again later.

Condom advertising may be most often considered a regulatory rather than a policy issue that is best addressed in a comprehensive policy, even though the regulatory approach may mean that implementation is subject to different interpretations. Nonetheless, several comprehensive policies state that the mass media should play a major role in the effort to prevent AIDS. For example, the preamble to the second draft of the Zimbabwe policy states:

*The mass media is an important force for influencing public opinion and stimulating debate. It should be fully utilized to promote HIV prevention and encourage supportive attitudes.*

*National HIV/AIDS Policy (second draft), Zimbabwe*

## Mandatory Condom Use in Brothels

The success of Thailand's program requiring 100 percent condom use in brothels has suggested to many that other countries should try a similar approach, although the Thai strategy may not be equally successful in countries where commercial sex is not well organized. In any case, such policies can be extremely difficult to develop when commercial sex is illegal. In most settings, it is impossible to pass policies or laws that regulate illegal behavior.

## Condom Distribution in Prisons

With the high level of HIV transmission in prisons, several countries have considered the distribution of condoms in prisons as a way to reduce HIV transmission. In some instances, such programs may be undertaken without official sanction, although official policies encouraging such programs are rare. One major problem is that homosexuality is illegal in some countries. As a result, programs that distribute condoms to prisoners usually cannot be encouraged in official policy statements.

Nevertheless, some African countries have dealt with the issue of HIV transmission in prisons in their national policies and plans. The Zimbabwe draft policy recognizes that HIV transmission in prisons is a problem in other countries and suggests that actions be taken to reduce potential problems in Zimbabwe.

*The AIDS & HIV Charter* of the South African AIDS Consortium calls for prisoners to have the same access to information and means of prevention as the rest of the population.

*T10.3 Prisoners should have the same access to education, information and preventive measures as the general population.*

*AIDS & HIV Charter, South Africa*

Uganda's draft policy calls for education for prisoners and protection of their human rights but does not specifically mention prevention programs in prisons.

- a. *Appropriate and specific HIV education programmes for all inmates and staff shall be instituted.*
- b. *Legislation affecting the welfare of inmates and staff shall be reviewed and enforced.*
- c. *Compulsory HIV testing for all inmates and staff shall be done on conviction.*

*National AIDS Control Policy Proposals (revision 3), Uganda*

## Willful Transmission of HIV

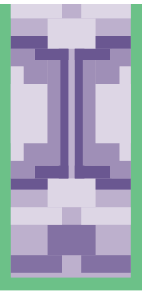
Many countries have considered the inclusion of specific language in their policies to make willful transmission of HIV a crime. Despite agreement that willful transmission should be halted, it may be difficult to define such instances. Is it necessary to demonstrate intent or is any unsafe sex act involving a person known to be HIV-infected considered willful

### **Preamble**

*Overcrowding in Zimbabwe's prisons is acknowledged as a problem by the Ministry of Justice, Legal and Parliamentary Affairs. HIV/AIDS among prisoners is high. Homosexuality and sodomy are known to occur in prisons worldwide. In addition, rape of prisoners (both male and female) by prison staff is a problem that has been reported in many countries but about which little data exists in Zimbabwe. Some prisoners with HIV/AIDS may attempt to spread it through sexual attacks, biting, and other aggressive action. Improved surveillance and supervision is not sufficient to prevent consensual and forced sexual activity in crowded prisons. Prisoners have the right to information on, protection from, and treatment for HIV related illnesses. It is in the interests of both prisoners themselves and the wider community into which prisoners will be released that the risk of HIV/AIDS in prisons be reduced.*

*Guiding Principle 38: Prisoners have basic human rights that must be respected including the right to information and treatment.*

*National HIV/AIDS Policy (second draft), Zimbabwe*



transmission? Would people be discouraged from seeking HIV testing if they thought that a positive result would mean that any future sex would be defined as a crime? What about sex within marriage? The concept of marital rape is not well defined in Africa.

In most countries, the issue of willful transmission has proven too difficult to handle. As a result, few countries have formulated policies on this matter; however, demands to develop such policies are increasing. Zimbabwe partially addressed willful transmission by defining it as sexual assault. Some legal experts have argued that such cases can be handled under existing laws relating to murder and assault.

In Malawi, the Commission on Criminal Justice Systems is considering a recommendation to revise the country's penal code to allow for the possible prosecution of people who recklessly spread HIV. The commission plans to hold a series of workshops to gather opinion about criminalizing the transmission of HIV.

## HIV and Abortion

Abortion is illegal in most African countries except under special circumstances. Some people believe that HIV infection should be grounds for abortion to prevent the birth of HIV-infected children or the creation of more AIDS orphans. Others believe that HIV infection is not sufficient to justify abortion. The only existing AIDS policy in Africa that addresses the issue is the *National AIDS Plan for South Africa, 1994–1995*, which states:

*The rights of women to elect to have an abortion on the grounds of being infected with HIV must be respected. Ultimately this must be the decision of the mother. HIV-related conditions specific to women have not been comprehensively researched, but special attention will have to be paid to the care and treatment needs of women.*

*National AIDS Plan for South Africa 1994 1995*



## Conclusion

At the beginning of the epidemic, AIDS was addressed primarily as a medical problem. Relatively few people seemed to be affected, and issues of surveillance, safe blood, and safe medical practices were paramount. As the epidemic progressed, countries began to recognize that most of the population would be affected in one way or another. Nations also started to acknowledge that the potential socioeconomic impacts of AIDS necessitated a multisectoral response. As the number of infected people grew, human rights emerged even more dramatically as one of the most important and difficult issues requiring a response. At this stage of the epidemic, many countries have recognized the need for a comprehensive national policy covering all aspects of HIV/AIDS, including access to information and services, multisectoral responsibilities, and human rights.

The following are among key lessons synthesized from the AIDS policy development experience:

- ✓ Identifying AIDS as a problem is not the same as recognizing the need for a comprehensive policy. The need for a comprehensive policy may be acknowledged only when the epidemic becomes so severe that a large portion of the population is affected or the advocacy efforts of specific groups begin to convince decision makers of the appropriateness of a policy response.
- ✓ There are many approaches to drafting and review. Some countries have incorporated a high level of participation while others have turned to supposedly more rapid approaches that involve relatively few experts. Although greater participation lengthens the time required for drafting and review, it builds momentum for the policy and often shortens the time required for approval. As a result, highly participatory approaches may actually take less time than those that rely on a small group of experts who then struggle for years to gain policy approval. The most highly participatory processes have produced the broadest policies that cover the widest range of key issues. Such policies, it is believed, will prove to be the most effective, but the outcome remains to be demonstrated. However, the experience of the nine countries clearly shows that the policy process improves significantly when many people and organizations have the opportunity to participate. Given that AIDS affects all parts of society, only the most highly participatory processes can give a voice to all concerned.
- ✓ Once approved, policies can be implemented in many ways. Some aspects of a policy (such as approval of condom advertising) may be implemented directly, in some cases even before the policy is formally

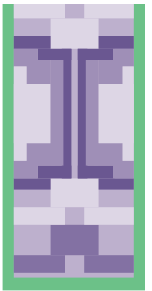
approved. Other policy issues can be implemented only through enabling legislation, the development of guidelines, or as part of a strategic plan. Countries may not have the resources to implement all components of the policy at once. Interest groups may need to take the lead in advocating for the implementation of those specific portions of the policy that most interest them.

In the early phases of the epidemic, most countries saw little need for a comprehensive HIV/AIDS policy. Instead, they turned to guidelines, standards of care, and specific regulations and legislation to address medical and public health issues. The need for a comprehensive policy grew more pressing when the spreading epidemic required governments to address issues of human rights, ethics, religion, individual versus community rights, and so forth. Of the nine countries included in this study, seven developed comprehensive national HIV/AIDS policies. Two countries (Malawi and Zambia) developed policies on specific issues, such as orphans or condom advertising, but have not seen the need to develop a comprehensive policy addressing all key issues.

In some cases, plans such as the series of medium-term plans or strategic plans undergoing development in many countries today have addressed policy issues. The adoption of these plans effectively approves the policy statements they contain. Reliance on plans can be an expeditious way to address key policy issues and to link them closely with prevention and care activities. However, the level of participation in the discussion of such plans falls far short of that for a national policy. Furthermore, any policy statement contained in a plan may be seen as valid only for the life of the plan, which is usually three to five years.

Since most of the comprehensive national policies have been developed only recently, it is not possible to say whether they will make a significant contribution to the fight against AIDS. While it may be harder to address new policy issues if those issues were not considered in the initial formulation of the comprehensive policy, the process of developing a comprehensive national policy forces the simultaneous consideration of a wide range of policy issues. Comprehensive policies also are likely to offer broad protection to groups engaged in prevention and care activities. In addition, the development of a comprehensive policy may have the benefit of focusing later efforts on implementation of an effective program. It will be important to continue to observe closely the progress made in addressing HIV/AIDS in those countries with comprehensive policies in place compared to those that have followed a different path.

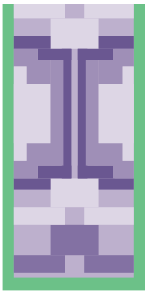
This report, based on an analysis of African country experiences and discussion with the participants in the various policy development processes, has helped develop a new framework for describing the policy process. The framework identifies elements of the process that are critical—especially for practitioners—but that are not often separately featured in frameworks in the more theoretical literature on policy formulation. Elements include information collection, policy drafting and review, and steps toward implementation such as development of guidelines and strategic plans. By focusing attention on these additional elements and the challenges associated with each, the framework may not only provide practical guidance to future policy development efforts but also point to theoretical gaps and areas for further research in studies of policy formulation.





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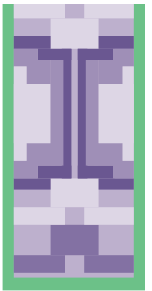
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