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Assessing the Impact of Free Trade Agreement (FTA) on the Spread of HIV and vice versa in the SADC Region

Nyasha Madzingira
Tendayi Kureya

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
BOCCIM	Botswana Confederation of Commerce, Industry and Manpower
COMESA	Common Market for Eastern and Southern Africa
CSWs	Commercial Sex Workers
CZI	Confederation of Zimbabwe Industries
DRC	Democratic Republic of Congo
EAC	East African Community
EMCOZ	Employers Confederation of Zimbabwe
FTA	Free Trade Area
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
IOM	International Organisation on Migration
MARPs	Most at Risk Populations
MBCA	Malawi Business Coalition Against AIDS
MS	Member State
NABCOA	Namibia Business Coalition on AIDS
OECD	Organisation of Economic Cooperation and Development
SACU	Southern Africa Customs Union
SADC	Southern Africa Development Community
SMEs	Small and Medium Scale enterprises
TACAIDS	Tanzania Commission on AIDS
TB	Tuberculosis
TIFI	Trade, Industry, Finance and Investment
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation
ZBCA	Zimbabwe Business Coalition on AIDS
ZIMRA	Zimbabwe Revenue Authority
ZNCC	Zimbabwe National Chamber of Commerce

Executive Summary

Implementation of the SADC Free Trade Agreement (FTA) began in 2000, and was launched in August 2008 fulfilling one of the objectives set under the Protocol on Trade signed in 1996. The FTA is a step along the path towards deeper regional economic integration – which is central to the strategy and objectives of SADC. The FTA is being implemented in a region highly decimated by the HIV and AIDS epidemic. HIV prevalence rates amongst adults in SADC is 11.4% but varies significantly from country to country, ranging from 26.1% in Swaziland (the highest in the world) to 2.1% in Angola.

It is against this background that SADC commissioned a study to assess the impact of the SADC FTA on the spread of HIV infection and vice versa in the region and to carry out an institutional capacity assessment on how well positioned the Trade, Industry, Finance and Investment directorate is to provide guidance on mainstreaming HIV and AIDS to this very important cluster.

The methodology utilised for data collection was a desk review, focus group discussions and in-depth interviews with key informants from Botswana, Malawi, Mozambique, Namibia, Tanzania and Zimbabwe. Triangulation of complementary data was done to ensure that the findings are reliable, valid, comprehensive and informative.

This study reveals that the SADC FTA has reduced the cost of doing business through the elimination of tariffs. In the long term, economic benefits brought about by the FTA will lead to poverty reduction, creation of job opportunities and new business ventures, increased access to a variety of cheaper goods and larger markets. The FTA is creating markets for producers. If its tenets are well implemented, the FTA will lead to economic activity and development of the SADC Member States and the generality of their populations. Member States reported an increased use of transport corridors, creating an environment of competition between the corridors, pushing prices of transportation down and increasing trade. However, sentiments were expressed on the need to construct and resuscitate railway lines to complement the corridors.

The economic, technological and labour changes taking place because of the SADC FTA indicate that people move in much the same way as materials and goods. Migrant workers are responding to unprecedented economic growth, increased trade and tourism, liberal economic policies and the relaxation of travel restrictions. Indications from Members States are that there is generally an increase in return movement and interaction of people due to the introduction of the FTA, as people move from one country to another for trade.

Introduction of small businesses, enhanced economic empowerment that brings a sense of 'being' to individuals enabling them to respond to family needs. Economic benefits have a positive effect on the social status of households and communities. Through the accrued economic and social benefits,

capacity building of human capital is strengthened, increasing the labour market base to respond to the creation of employment opportunities in the market. The FTA has the possibility of improving health of communities through pooled standards of living.

Despite these positive socio-economic benefits of the FTA, negative implications have been noted. Member States are signatory to a number of economic groupings including COMESA, SACU EAC, SADC and bilateral trade agreements. The respondents to the study noted that participation of MS in the SADC FTA may be affected by the differences in the rules and regulations of the economic groupings. Examples cited were that COMESA's rules of origin are less stringent compared to those of the SADC FTA. The choice on which FTA or agreement to participate in may disadvantage the SADC FTA if rules of origin are not addressed.

The other negative factors cited are that local businesses are facing stiff competition and are out-competed by big companies to the extent that some may collapse as they lose market share. Some MS are introducing discriminatory fees, designed to discourage or reduce economic benefits of traders. Thirdly, governments in SADC are losing revenue through the smuggling of goods, use of illegal routes across borders, and under-declaring of goods. The SADC FTA seems to focus more on removing economic barriers to facilitate movement of trade i.e border posts facilitate trade and that goods are not delayed at border posts without a focus on other socio-economic, cultural and health related factors linked to trade.

Member States are of the view that some of the negative impacts of the FTA could be pressure on the health systems of countries where there are better medical facilities. This may also result in poor quality health care system and depletion of resources due to increased burden from foreigners. At family level, cross border trade leads to separation of spouses and their families which may lead to extra marital relationship which can increase the spread of HIV if prevention measures are not adhered to. Time spend at the border posts can create opportunities for people to interact, which may lead to engagement in transactional sexual acts.

Even though the FTA does not encompass movement of persons, the increased trade between member countries has triggered a general increase in movement of people leading to congestion at border posts. Under the SADC FTA, one stop border posts have been established, reducing drastically the time spend at the posts for clearance. The introduction of one stop border posts coupled with removal of non-tariff barriers led to decrease in time spend at borders.

Border posts need to increase capacity to facilitate passage and to accommodate the traffic. There is need to encourage dialogue between Customs and the private sector to be responsive to the needs of customers. These partnerships enable stakeholders to appreciate one another's roles and responsibilities and how they can complement each other in serving a mutual customer. Such partnering and dialogue

help bring to the fore health related issues such as transmission of HIV, spread of communicable diseases and unhygienic conditions associated with crowding.

As is the case with many mobile populations, labour migrants are susceptible to health problems including HIV infection and other communicable diseases. Widespread risk and vulnerability factors include substandard living environments, high rates of alcohol use, and sex with multiple partners or commercial sex workers. Prevalence rates among those who travel for employment reasons demonstrate the extent of this vulnerability. In southern African mining companies where 95% of the work force are migrant workers, the average HIV infection rates are close to 18% (Interagency Coalition on AIDS and Development, 2008).

According to WHO (2009), cross-border movements of people can lead to the spread of communicable diseases such as HIV, malaria, TB and influenza. This is as a result of overcrowding at border points and the volumes of people that travel at any given time. The delays encountered at the border posts do not help matters either. Sanitation facilities at border posts are small and unhygienic. The situation is worsened by the increase in numbers of people using them. This is an environmental hazard that can easily result in disease outbreaks and their transmission to neighbouring countries.

Other health issues related to the FTA that were noted by MS include the fact that patient retention on HIV treatment is compromised and patients might encounter problems in drug adherence and responding effectively to treatment while in other countries. Another factor noted was the movement of livestock and crops across borders may also create a health challenge, particularly in instances where the goods/products are smuggled in.

There is need to provide correct and adequate information for travellers on HIV, TB, yellow fever, influenza and malaria. This can be printed on travel documents, or on cards such as those used for yellow fever. Information centres can be established at border posts to distribute materials with medical specifications on HIV prevention and treatment, communicable diseases and yellow fever to reduce possible spread.

Adherence to HIV treatment is at risk as some traders are importing fake drugs that are used in place of ARVs such as tiens, herbs, moringa and other structure enhancing drugs that find their way on to the market. SADC member states need to put in place full proof systems and enforce regulatory mechanisms to avoid importation of fake medicines and other commodities such as condoms to reduce the possibility of HIV related deaths from non adherence of drugs and possible drug resistance for those on treatment.

Member States visited pointed out the need for SADC to facilitate better coordination in management of treatment regimens. There is need to harmonise initiatives and policies (ART regimens) across countries as was the case with the SADC campaign on Multiple Concurrent Partnerships that

culminated from the Maseru declaration. Initiatives taken at SADC level have an intrinsic collective drive for the flow and continuity of messages across the region. The East Africa Community has harmonised six treatment protocols under the Great Lakes Initiative to address HIV treatment issues in the region. At national level, countries need to be better coordinated, making ART programmes sensitive to the regional nature of the epidemic. Suggestions have been proffered to introduce an electronic medical card with client's medical history and treatment regimen under the harmonisation of policies and initiatives to facilitate access to treatment from any Member State. Currently, there is no antiretroviral production that can sustain the region, hence the need to develop a regional strategy on how to produce ARVs within the region or to establish a regional approach to bulky procurement of ARVs.

SADC Member States have put in place mechanisms intended to address HIV and AIDS issues at national and regional levels. National HIV and AIDS Strategic Plans are the guiding frameworks to the national HIV and AIDS response which are based on the SADC 2005 framework. Member States are mainstreaming HIV and AIDS in the public sector, and in the private sector through Business Coalitions who work together with the Ministries of Trade, Health and Industry and Commerce. The HIV and AIDS mainstreaming seeks to enable development actors to address the causes and effects of AIDS in an effective and sustainable manner both through their work and within their workplaces.

The main focus of activities in the region that address HIV and AIDS issues related to trade are more on the transport sector targeting truckers, bus drivers, commercial sex workers and communities along the Corridors. A number of programmes to address HIV and AIDS issues along the corridors and main highways were initiated under the Corridors of Hope, the North Star Foundation, the Sub Saharan Africa Transport Programme, the Walvis Bay Corridor and two main corridors in Tanzania targeting the Most at Risk Population groups. The SADC Secretariat, with financial support from the Global Fund is currently supporting a 5 year regional programme that reaches 32 key border crossing points.

An important observation coming out from the study is the need to re-define the workplace especially for truckers. The transport corridors that they ply day and night is their workplace and not the company headquarters. Re-defining the workplace will help focus on the programmes to address health challenges at places where they spent most of their time. There is need for a coordinated approach and sustained partnerships between government and the private sector in addressing HIV and AIDS in the workplace. MS governments should be responsible for implementation and monitoring of HIV and AIDS mainstreaming activities in the private sector.

One of the objectives of this study was to assess the capacity of TIFI to mainstream HIV and AIDS in the SADC FTA. At SADC Secretariat, HIV and AIDS mainstreaming is currently under the Directorate of Social and Human Development and Special Programmes (SHDSP). Mainstreaming at

MS level is through the National AIDS Councils, where SADC Secretariat has a focal person to ensure that priority issues are addressed through National Strategic Frameworks. The proposed approach to mainstreaming is to utilise it as a management tool for organisations to increase institutional focus on cross-cutting issues and better promote adaptability and change. For this to be applicable, we propose the creation of a stand alone "Simultaneous Mainstreaming Unit' at SADC Secretariat where all the core cross cutting issues (HIV and AIDS, gender, human trafficking, and human rights) are addressed in a coordinated manner. The Unit may be located either in the office of the Deputy Executive Secretary - Regional Integration or the higher office of the Executive Director. Mainstreaming and capacity development can easily be effected from this office to units of the Secretariat with a trickledown effect to the different sectors.

From the study and the ensuing discussion, the following recommendations are proposed:

a) Harmonisation of Guidelines, Regulations and Policies

- Harmonise customs procedures systems and simplification of procedures in the region to facilitate movement of people and reducing queues at border posts.
- Harmonise HIV treatment at regional level. Mechanisms should be put in place to allow universal access to prevention, treatment and care in the region
- SADC to establish a 'pulled pharmaceutical programme' for procurement of drugs for the region
- Expeditious review of the stringent rules of origin for the FTA.
- Free movement of persons is still a constraint that needs to be addressed

b) Regional approach to HIV and AIDS Programming

- Strengthen mainstreaming at SADC Secretariat and at MS level through simultaneous mainstreaming of core cross cutting issues such as HIV and AIDS, gender, human trafficking, and human rights for an integrated approach that improves and sustains people's standard of living.
- Ensure that mainstreaming is utilised as a practical management strategy that will increase institutional focus on cross-cutting issues and promote adaptability and change.
- SADC should be an entry point for HIV and AIDS mitigation strategies and funding for the region instead of MS approaching funders individually.
- Establish private public sector partnerships at all levels to increase interaction and dialogue that help bring to the fore health related issues such as transmission of HIV, spread of communicable diseases and unhygienic conditions associated with crowding.
- Support and strengthen existing networks of People Living with HIV to promote and improve positive living in the region.

c) Strengthen Monitoring and Evaluation Systems

- One regional HIV and AIDS M&E system.

- Strengthen M&E systems in the private sector and ensure that companies are committed to HIV and AIDS issues and not just focus on profits.

d) Track progress on SADC agenda at MS level

- Establish a mechanism to enforce protocols and track progress and commitment of MS to set goals and objectives.
- Increased resource mobilisation efforts for the secretariat to carry out activities effectively.
- Ensure political commitment of all MS on the FTA and make sure it is operational on the ground.

e) SADC Secretariat to Document and Share Best Practices at regional platforms

f) Develop and Maintain Infrastructure to facilitate Trade

- SADC is encouraged to develop and maintain infrastructure in line with increased trade between countries
- Provide quality yet affordable accommodation for cross border traders in the border towns
- Expand the One stop Border Post concept to all busy border posts to address delays.

I. Background to the Study

Approximately 40% (13.1 million people) of the global total of people living with HIV and AIDS (and 60% of the sub-Saharan Africa total) live in the Southern African Development Community (SADC) region. The SADC is a grouping of 15 Member States (Angola, Botswana, Democratic Republic of Congo (DRC), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe). The HIV prevalence rate amongst adults in SADC is 11.4% but varies significantly from country to country, ranging from 26.1% in Swaziland (the highest in the world) to 2.1% in Angola. UNAIDS estimates that 1.9 million people were newly infected with HIV and that more than 14 million children had lost one or both parents to AIDS in Sub Saharan Africa in 2008. The same UNAIDS report acknowledges that most country epidemics appear to have stabilised though 9 of the SADC countries have adult prevalence rates above 10%. However, there is some evidence of decreasing prevalence in Tanzania and Zimbabwe and amongst women in Zambia.

SADC notes that the HIV and AIDS pandemic is reversing the developmental gains made in the past decades and posing the greatest threat to sustainable development of the region. Morbidity and mortality from HIV and AIDS leads to loss of the most productive individuals in all sectors, decline in productivity, and diversion of scarce resources from production to the care and support of the HIV infected and affected persons.

With the SADC FTA fairly an infant in comparison to other regional trade agreements, there is a need to assess its potential as well as related challenges of such in particular the spread of HIV and AIDS. This report presents the findings of the study.

II. Purpose and Objectives of the Study

The purpose of the study is to assess the impact of SADC Free Trade Area on the spread of HIV infection and vice versa in the region.

The set objectives of the study are to:

- Establish whether HIV and AIDS have an impact on FTA in the SADC Region through the review of studies in countries where trade liberalisation has been in place for the last few years.
- Carry out a cross impact analysis of FTA on other clusters under SADC, based on the study findings

III. Methodology

A desk review and in-depth interviews with key informants were employed for data collection. Key informant interviews were carried out in seven Member States namely Botswana, Malawi, Mozambique, Namibia, Tanzania and Zimbabwe. Triangulation of complementary methods of data collection was done in order to ensure that the findings are reliable, valid, comprehensive and informative.

A comprehensive review of literature on the SADC FTA in general, its impact on HIV and AIDS in the region and impact of FTAs in other regions of the world was undertaken. Key informant interviews were carried out with staff from the SADC Secretariat. Members from government ministries, mainly from ministries of Trade, Commerce and Industry, Health, National AIDS Councils in Members States, Trader's Associations, National Chambers of Commerce and Industry, Immigration and Customs Authorities, and stakeholders such as the International Labour Organisation, and the International Organisation for Migration.

South Africa, set up a focus group discussion with key stakeholders from health, industry, public service, transport, and other sectors relevant to trade and regional integration. The focus of the discussions was guided by the tools of the assessments. This approach was useful as it provided an opportunity to stakeholders to start mapping a way to respond to the issues under discussion.

A SWOT analysis was conducted to provide a synthesis of major success areas, gaps, challenges and opportunities of existing strategies, programs, systems and processes for responding to the HIV

and AIDS response of the Trade and Industry Sector and other sectors associated with the FTA. Responses from key informant interviews were computed and analysed by themes and content.

IV. Review of Literature

This section on literature review describes and analyses the recent economic, human development and social trends in SADC based on selected socio-economic indicators. It brings out key issues and main economic and human development challenges facing the region. Reference has been made to the political environment underlying the socio-economic situation in the last decade as all this has direct and indirect impacts on the FTA and in particular FTA and HIV in the region.

4.1 The SADC FTA

Since its inception, SADC has formulated, ratified and signed a number of protocols. Several of these (tourism, trade, transport, education and training) recognise the desirability of increased economic co-operation and specifically, for the increased movement of capital and goods between member states. In this context of regional economic development and integration it has been accepted that regional cross-border migration is a key issue, but that it cannot be adequately managed and regulated on the basis of the domestic legislation of individual member states. Therefore, countries in the region saw the need to co-operate to develop appropriate policies, legislation and mechanisms to establish a regional migration regime (Williams, 2000). This gave birth to the SADC Protocol on Trade which was implemented in 1996 and subsequently led to the establishment of the SADC FTA.

Implementation of the SADC FTA began in 2000 following the signing of the SADC Trade Protocol in 1996. The SADC FTA was launched in August 2008 under the theme "SADC FTA for Growth, Development and Wealth Creation" fulfilling one of the objective set under the Protocol on Trade signed in 1996. The Protocol on Trade provides a legal basis for the establishment of the FTA. The Free Trade Area agreement is a step along the path towards deeper regional economic integration – which is central to the strategy and objectives of SADC.

One of the objectives under the protocol was that of establishing a Free Trade Area in the SADC region. The SADC FTA creates a regional market worth US$360 billion with a total population of 170 million and includes economies growing by up to 7% a year (www.sadc.int). The liberalisation of tariffs has taken place at different rates. South Africa, Botswana and Namibia removed most tariffs in 2000. Middle income countries such as Mauritius have gradually reduced their tariffs each year between 2000 and 2008. Tariff reductions have generally been introduced during 2007-2008 for Mozambique and Zambia.

According to Orble (2008), various forms of economic integration follow on from an FTA, it is envisaged that the SADC FTA is the precursor to a customs union that was planned by 2010 but now postponed, a common market by 2015, a monetary union by 2016 and a single currency by 2018. The FTA also aims at establishing "one stop" border posts which will cut the time spent at the border in half. Currently there are three pilot posts at the borders of Mozambique and Zimbabwe (Forbes - Machipanda), South Africa and Mozambique (Lebombo Ressano Garcia) and Zimbabwe and Zambia (Chirundu).

Foreign trade plays an important role in the economies of SADC Member States. Trade data on SADC countries reveal a number of features. Firstly, trade is relatively a more important component of GDP in small countries like Lesotho and Swaziland than in large countries such as South Africa. Total merchandise trade of the SADC increased between 1991 and 1998. The export trade for Angola, Botswana, DRC, Namibia, South Africa and Zambia is dominated by oil or mineral exports. The oil and mining industry plays a significant role as major foreign exchange earners and are a source of inputs to industrial development. While oil and mining ventures are capital intensive, they still generate substantial employment opportunities directly and indirectly through linkages with other supply and input sectors. In other countries, agriculture commodities dominate export trade. The bulk of imports of SADC countries are intermediate and capital goods. Only South Africa and Zimbabwe have significant capacity to produce such goods.

Available data on the terms of trade show that most SADC member countries alongside with the majority of other African States have been experiencing a long-term decline in their terms of trade. This trend has been particularly persistent between 1980 and 2000. Within Southern Africa, South Africa's intra-regional trade is concentrated in the SACU countries due to the existence of a customs union and a common monetary area. Of South Africa's exports to the Southern African region, which amount to 19 percent of total exports, 13 percent go to other SACU member countries. Five out of 7 percent of South Africa's imports from Southern Africa come from other SACU member countries.

Among other Southern African countries, Lesotho is overwhelmingly dependent on South Africa for its export market. A significant proportion of Zimbabwe's and to some extent Malawi's exports also find markets, mainly in South Africa. Otherwise, for the majority of the countries in Southern Africa, the Organisation for Economic Cooperation and Development (OECD) is the major export market. Asian export destinations are significant for Angola, Mauritius, Mozambique, South Africa, Tanzania and Zambia. The bulk of imports of SADC Member States originate in the OECD. For the DRC, Mauritius, Seychelles and Tanzania, Asian sources account for significant proportions of their imports; while for Angola and South Africa North American Free Trade Agreement (NAFTA) is a significant source of their imports.

Intra-regional trade in SADC is influenced by both the SADC Trade Protocol and bilateral trade agreements, which Member States have negotiated prior to entry into force of the Trade Protocol. The Trade protocol provides for the continuation of existing bilateral arrangements as long as they do not contradict the protocol. Intra-SADC trade is estimated at 24%, which means that the major share of trade is with the rest of the world.

4.2 HIV and AIDS in the SADC region

The AIDS epidemic in sub-Saharan Africa continues to devastate communities, rolling back decades of development progress. Sub-Saharan Africa faces a triple challenge: providing health care, antiretroviral treatment, and support to a growing population of people with HIV-related illnesses; reducing the annual toll of new HIV infections by enabling individuals to protect themselves and others; and coping with the impact of millions of AIDS related deaths on orphans and other survivors, communities, and national development. HIV and AIDS has had the following impacts on SADC and other developing nations in the world: reduced life expectancy from over 60 years to less than 40; reducing households capacity to earn money for their families; increased orphanhood; putting a strain on the health sector; reduced school attendance; reduced labour availability which in turn slows down economic activity and social progress; and significantly affects Africa's economic development.

In 2001 there were more than 20 million people (based on current estimates) living with AIDS in sub-Saharan Africa, but only 8,000 people were accessing drug treatment (UNAIDS, 2010). In 2009 1.3 million people in sub-Saharan Africa died of AIDS. Botswana was the first country in Africa to roll out a national antiretroviral treatment programme in 2002. Botswana's successful treatment programme allayed doubts that antiretroviral treatment for poor African countries was unfeasible. Its programme has been by far the most successful in Africa, although Namibia (treating 71% of those in need in 2006), Malawi (43%) Swaziland (42%), have also been regarded as reasonably successful at rolling out treatment (ibid).

The levels of infection in the individual countries have placed SADC on the top list of the most affected region in the world. Even though the 14 countries are at different levels of the maturity of the epidemic, all indicators point towards a severe state of the epidemic. Estimates of the severity of the epidemic using adult prevalence rates show that about 20 percent of the entire adult population aged 15-49 currently infected resides in Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. Several factors have been noted to be contributing to the spread of the epidemic. These include poverty, gender inequality, intergenerational sex, illiteracy, stigma and discrimination, alcohol abuse and limited communication about HIV and AIDS due to cultural barriers (UNAIDS, 2008).

Demographic impact of HIV and AIDS in Southern Africa

Country	Total population		People living with HIV and AIDS (1000s)		Adult (15-49) HIV prevalence		Estimated AIDS deaths		Life expectancy at birth 1998 (in years)	Life expectancy 2010 (in years)
	'99	'10	'99	'10	'99	'10	'99	'10		
Botswana	1,592	2,029	290	320	35,8	24,8	24,000	5,800	40.1	58.05
Lesotho	2,108	1,925	240	290	23,6	23,6	16,000	14,000	54.0	51.63
Malawi	10,674	15,879	800	920	16,0	11,0	70,000	51,000	36.6	51.7
Mozambique	19,222	22,949	1,200	1,400	13,2	11,5	98,000	74,000	-	51.78
Namibia	1,689	2,148	160	180	19,5	13,1	18,000	6,700	41.5	52.19
South Africa	39,796	49,990	4,200	5,600	19,9	17.8	250,000	310,000	55.7	49.2
Swaziland	981	1,370	130	180	25,3	25.9	7,100	7,000	38.5	48.66
Zambia	8,974	13,881	870	980	20,0	13.5	99,0000	45,000	37.1	52.36
Zimbabwe	11,509	12,084	1,500	1,200	25,1	14.3	160,000	83,000	39.2	49.64
Southern Africa	96,545	226,085	9,390	22,500	19,1	5.0	742.100	1.300	-	-

Source: UNAIDS 2010, avert 2010

UNAIDS reported in 2010 that there had been a behavioural change in some parts of Africa in the new millennium. This was believed to be partly due to increased condom use since the early 1990s, as well as young people delaying first sex and reducing the number of casual sex partners. This trend may have accounted for the reported decline in HIV prevalence in some parts of Africa, notably Kenya, Zimbabwe and urban areas of Burkina Faso. However, the decline was also likely to be a result of high-mortality rates. In 2010, it was revealed that HIV infections had reduced by more than a quarter between 2001 and 2009 in 22 countries in Africa, including among young people and women. Elsewhere in southern Africa HIV prevalence levels appeared to have levelled off by 2006 (i.e. the number of new infections roughly matched the number of people dying of AIDS) although the stabilization was at very high levels. This trend continued as the end of the first decade came to a close.

Some of the negative impact of the HIV and AIDS pandemic noted in many countries are:

- A decrease in the productive capacity of all sectors due to the loss of key personnel.
- A decline in the productive capacity of the economy, leading to a decline in savings and investment rates and eventually the GDP growth rate.

- A reduction in the productive capacity of agriculture, especially the subsistence agriculture sub-sector due to the loss of the economically active population.
- Lower rates of educational attainment and falling enrolment of children affected by HIV and AIDS, coupled with losses of education personnel.
- Health care systems are overwhelmed with HIV and AIDS patients with the result that health workers are overburdened, health care costs are escalating and acute conditions are being "crowded out".
- Conditions such as tuberculosis, which were almost being brought under control in the 1970s, have re-emerged as a result of the HIV and AIDS epidemic, further straining the overstretched health care systems.
- An increase in the number of orphans, street children and child-headed households.

In recognition of the serious threat that HIV and AIDS continues to pose to sustainable development of the region and its integration agenda, SADC developed two Multi-sectoral HIV and AIDS Strategic Frameworks and Programme of Action 2003-2007 and current 2010-2015. It is aimed at intensifying measures and actions to address the devastating and pervasive impact of the HIV and AIDS pandemic in a comprehensive and complementary way. The guiding principle to SADC's Mandate is the Regional Indicative Strategic Development Plan, for all its programs and sectors. The focus of the response is both on the prevention of HIV and AIDS and on the mitigation of its impact in order to ensure sustainable human development of Member States (SADC, 2008). The Framework takes into account and reflects the priorities of the new organisational arrangements of the restructured SADC, which clusters related issues into core areas of regional cooperation and integration. It also builds on the experience of the previous Plan for HIV and AIDS, the SADC HIV and AIDS Strategic Framework and Programme of Action, 2000-2004.

In addition, a Special Summit on HIV and AIDS was held in Maseru Lesotho in 2003 for Heads of State and Government in SADC to map out a common vision for the region and also to prioritise areas of urgent attention. SADC member states committed to the Abuja (2001), the UNGASS (2001) Declarations and the Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010 (2006) to respond to HIV and AIDS in the region and at international level.

The Maseru Summit reviewed the past responses at both the regional and national levels. Furthermore, special attention was given to the issues of resource allocation, best practices and scaling up of programmes. The Summit made four critical conclusions that will guide and support the regional and national responses in SADC.

- The Summit adopted the Framework as a working document.
- It was agreed that the HIV and AIDS Unit be established within the Department of Strategic Planning, Gender and Policy Harmonization to ensure an effective institutional framework at regional level.

- It was agreed that the SADC Secretariat establish a Regional Fund to Combat HIV and AIDS for both regional activities and national needs.
- The Summit mapped out a common vision and prioritised areas of HIV and AIDS response.

The Maseru Declaration prioritised 5 areas that need urgent attention at both regional and national levels, which are: prevention and social mobilization; improving care access to testing and counselling services, treatment and support; accelerating development and mitigation the impact of HIV and AIDS; intensifying resource mobilization; and strengthening institutional monitoring and evaluation mechanisms.

Both the revised framework and the Maseru Declaration emphasize the importance of strengthening partnerships with Civil Society Organizations, Faith-based Organizations, Business, Labour, and International Cooperating Partners. The need to mainstream HIV and AIDS at both policy and program levels is also underscored.

4.3 FTAs and trade blocs around the world (Africa, Asia, Europe, America)

According to Kose and Riezman (2000) there has been a global surge in favour of regional integration in recent years. This paradigm shift has seen the formation of the North American Free Trade Agreement (NAFTA), the Southern Cone Common Market (MERCOSUR) in Latin America, the Association of South East Asian Nations (ASEAN), the Southern African Development Community (SADC), the Common Market for Eastern and Southern Africa (COMESA), and the enlargement of the European Union. The establishment of regional integration agreements has been particularly popular in Africa, where more regional integration and cooperation agreements have been signed than on any other continent (Radelet, 1997:1). These have included the East African Community (EAC), the Southern African Customs Union (SACU), SADC, COMESA, the Economic Community of West African States (ECOWAS), and the Union Economique et Monetaire de l'Ouest Afrique (UEMOA). Regional integration agreements have been implemented in various forms between developed countries (as in the EU) and developing countries (such as the EAC and SADC), or involving both, as in the case of NAFTA.

These regional blocs have facilitated the establishment of Free Trade Agreements (FTA) which in essence are a designated group of countries that have agreed to eliminate tariffs, quotas and preferences on most (if not all) goods and services traded between them. These blocs are generally aimed at removing discrimination between foreign and domestic goods, services, and factors of production (Balassa, 1976). Between 55 and 60 percent of world trade occurs within such regional trading blocs (Schiff and Winters, 1998:178).

4.4 East African Community Experience

The EAC, covering an estimated area of 2.1 million square kilometres and a combined population of about 107 million people, is a regional inter-Governmental Organization comprising Tanzania, Uganda, Kenya, Rwanda and Burundi. The region faces significant challenges when it comes to HIV and AIDS. UNAIDS (2006) estimates that by the end of 2005 in three EAC states, 3.7 million were living with HIV and AIDS of whom 3.4 million were adults aged 15-49 years; 1.97 million (53.2%) were females and 370,000 were children.

Over the last three years though, the partner states of the EAC have registered progress in prevention and control of HIV and AIDS through the use of multi-sectoral and multidimensional approaches to planning and management of the disease. The adoption of the 'Three Ones' Approach (One Coordinating Unit; One Multi-sectoral Plan and; One National M&E Framework), have been used to guide the HIV and AIDS national response by East African countries; and has enhanced involvement of all the stakeholders in participatory decision making processes and implementation of interventions. There is still much to do and the Health Section of the EAC secretariat took the leadership in calling for the development of the Multi-sectoral Strategic Plan for HIV and AIDS 2007 – 2011 that defines regional interventions and actions in support of Partner States' national responses to the pandemic.

The HIV and AIDS Strategic Plan is informed by the EAC Development Strategy (2006-2010) that was adopted by partner states to guide implementation of the regional and national goals and objectives of the EAC Treaty signed in 1999. In this regard the vision and mission of the Development Strategy is used as the beacon to guide the multi-sectoral HIV and AIDS strategy and provide the foundation upon which it will operationalise its imperatives. The challenge in executing the plan is putting in place the appropriate institutional arrangements and human resource capacities.

The major negative impacts of HIV and AIDS at country and regional level are well documented, including declining productivity in almost all sectors including agriculture, a decline in savings, especially for poor households, lower education attainment, burdened health care systems, worsening TB and other health conditions, and an increasing problem of orphaned children. These issues are serious challenges to countries attaining desired development targets, and hinder their full participation in opportunities offered by free trade.

Studies in Kenya, Ghana, Uganda, Zimbabwe, Mexico, Jamaica and the Philippines all show that trade liberalisation has had negative impact on women and accentuating gender inequality (Madeley, 2000). In related developments, the FTA agreement between India and Europe currently has the latter pushing for provisions in the agreement for India to impose greater intellectual property protection on medicines, measures which would delay the registration and marketing of generic medicines, and would extend the duration of a patent, blocking competition and maintaining prohibitively high prices

– thus seriously putting at risk the lives of people living with HIV and other diseases in developing countries (Medecins Sans Frontiers, 2010).

Research findings from South America, Asia, South East Asia and Africa clearly show that on the one hand, FTA have increased poverty among the most marginalised and vulnerable populations such as subsistence and rural farmers, women and children. On the other hand, it has made other sections of the populations extremely wealthy, particularly those with capital or easy access to capital. Free Trade Liberalisation also increases both internal and external migration. In internal migration, it is mostly the rural poor and subsistence farmers, with large numbers of women who migrate from poor rural areas to the urban areas and from one country to another in search of jobs.

The same groups of people may also move from country to country looking for a better life. The negative and positive impacts above increase the risk of the spread of HIV:

- Poverty and gender inequality increases susceptibility and vulnerability
- Affluence also increases the risk of infection from HIV
- Migration has been associated with increase in transmission of sexually transmitted diseases including HIV
- Food insecurity is associated with decreased adherence to medication intake; since most regimens require patients to have a full stomach before taking medicine
- The separation of families has been found as another risk for infection.

V. Findings of the Assessment

This section presents the findings of the study. It is worth noting that the study whose findings are presented in this report is not necessarily aiming to stand in the way of trade liberalization and economic integration in the region and beyond, but rather to understand what the potential side effects are and then develop the right sorts of policies to address and mitigate those negative impacts. In some cases, it could mean changing aspects of the proposed trade rules themselves, but these might be quite targeted (e.g., IP rules) rather than 'free trade' in general.

5.1 Reported impacts of the FTA on regional economies

It is noteworthy that outside of the SADC FTA, member countries have signed individual trade agreements within and outside of the region, such as SACU, COMESA and the EAC, coupled with other bilateral agreements, running concurrently with the FTA which may make it difficult to ascribe all socio-economic benefits accrued to communities in the region to the SADC FTA. Most recently,

a tripartite FTA also came into effect pulling together Member States in SADC, COMESA and the EAC.

Economic Benefits

SADC Member States in the FTA benefit from free movement of goods without payment of duty. More people are buying goods from Member States, which do not necessarily share borders with their country. Zimbabwe indicated that probably migration trends have increased with more Zimbabweans crossing the border. However, this may not be a direct result of the FTA but more so as a result of push factors (e.g. economic hardships) that necessitated this movement.

The FTA reduces the cost of doing business through the elimination of tariffs. South Africa which has product diversity and a large industrial base to market and export products, benefits more from duty reduction. Tanzania reported increased trade with exports to Zambia, Malawi, Botswana, Namibia and Mozambique. The country is also importing more from South Africa, Zambia and beer from Namibia.

There is growth in numbers and range of products traded in by informal traders, who are mainly women who are heads of households. There is noticeable increased loads of goods moved by private vehicles, buses and trailers from one to the other. People in the Diaspora have even devised a courier kind of arrangement of sending goods to their countries of origin (popularly known as Malaicha) increasing volumes and value of trade.

Increased trade in SADC Member States brings with it freedom of choice on products and where to buy and what to buy. The FTA has brought about economic empowerment of the people through the economic benefits of trade. There is an increase in economic opportunities as employment opportunities are created through increased productivity. Benefits from employment of individuals trickle down to the household level, improving economic benefits.

Member States reported an increased use of transport corridors, creating an environment of competition between the corridors, pushing prices of transportation down and increasing trade. Over the years, there has been a growth in transportation and supply agencies (large, medium and small scale). However, sentiments were expressed on the need to construct and resuscitate railway lines to complement the corridors. Plans are underway in Botswana to construct a rail line for the transportation of coal. Similar construction projects in Mozambique opened areas that were considered remote and also created employment opportunities for locals.

Other economic benefits cited include:

- The region has become an 'economic village' with widened scope of business through the FTA,
- Market creation and increased business opportunities
- bringing people of different nationalities closer resulting in cross learning on business activities
- Stronger collaboration among government agencies and stakeholders (customs, police, transport agencies).

The respondents were of the view that the economic benefits brought about by the FTA will lead to poverty reduction, creation of job opportunities and new business ventures, increased access to a variety of cheaper goods and larger markets. The FTA is creating markets for producers. If its tenets are well implemented, the FTA will lead to economic activity and development of the SADC Member States and the generality of their populations. However, there are also some unintended consequences emanating from its implementation as discussed below.

Negative Economic Implications

Some Member States in SADC such as Malawi, Zambia, Mauritius and Zimbabwe, are signatory to COMESA which is more established than the SADC FTA, while others are members of SACU. The respondents to the study noted that the rules and regulations for COMESA are less stringent compared to those of the SADC FTA. Examples were cited on rules of origin in the SADC FTA highlighting that they are more user friendly in COMESA and in bilateral trade agreements for example those between Zimbabwe and Namibia with Botswana. The choice on which FTA or agreement to participate in may disadvantage the SADC FTA if rules of origin are not addressed. Tanzanian textiles, for example, cannot be exported to Member States in the SACU due to the rules of origin regulations.

Botswana highlighted that local businesses are facing stiff competition and are out-competed by big companies to the extent that some may collapse as they lose market share. Despite closure of some industries due to this competition, Tanzania noted that these challenges are opportunities in the long term as they lead to product quality improvement locally to maintain market share. The FTA created a regional transport market, with increased competition that brought about rivalry. There were fatalities at the border of Lesotho and South Africa, when cross border passenger drivers fired at each another due to competition. Heads of States for the two countries had to intervene but the rift has not yet been resolved.

Other countries are said to be introducing discriminatory fees, designed to discourage or reduce economic benefits of traders. Tanzania has banned Interlinks, a type of vehicle which carries more pay load than the standard vehicles, despite the fact that it conforms to all requirements and specifications. The Interlinks are from the Democratic Republic of Congo and Zambia into Tanzania. Namibia

gave an example of carbon tax levied to foreign traders by Zambia amounting to USD1000. These sentiments were aired also by Botswana against Zambia. These non tariff barriers restrict movement and trade. It seems the FTA was signed but there is no common consensus on what Member States need from each other, and what they are expected to bring into the equation to facilitate trade.

Mozambique noted that the net flow for unskilled labour was out of the country, and the reverse was true for skilled labour. While the suggestion was to put quotas for skilled labour, there is need to balance this with the need for development for the country, and with the origin of these skilled people. South Africa indicated that they were a net importer of unskilled labour, and were also keen to take strict measures to control influx of these people. Large influx of unskilled labour leads to xenophobia, as observed recently in South Africa.

Governments in SADC are losing revenue through the smuggling of goods, use of illegal routes across borders, and under-declaring of goods by some traders. Other negative economic implications brought out in discussions are that:

- Regulations that impact on prices are not simplified and harmonised
- Member States are at different levels of economic development
- Illegal money trading especially where exchange rates are low
- Interest rates on loans may be affected which can impact on stability of currencies
- There could be polarisation of industries in some MS leading to unemployment.
- The SADC FTA seems to focus more on removing economic barriers to facilitate movement of trade i.e border posts facilitate trade and that goods are not delayed at border posts without a focus on other socio-cultural factors linked to trade

Social Benefits

A key informant in Botswana quipped at the start of our interview "Through improved technology, you can move goods without individuals moving". True as this may be, indications from Members States are that there is generally an increase in return movement and interaction of people due to the introduction of the FTA, as people move from one country to another to buy and sale goods. Introduction of small businesses, enhanced economic empowerment that brings a sense of 'being' to individuals enabling them to respond to family needs. Economic benefits have a positive effect on households and communities.

The social benefits that may arise due to FTA include the transfer of skills and reduction of migration into and out of country. Through the accrued economic and social benefits, capacity building of human capital is strengthened, increasing the labour market base to respond to the creation of employment opportunities in the market. The FTA has the ability to attract scarce skilled people, transfer and sharing of skills within the region. It may also lead to the right skilled people getting the right jobs.

Finally if the FTA is implemented properly it has the possibility of improving health of communities through pooled standards of living. Increased interaction within countries and between Member States enhances cultural exchange and knowledge sharing that can augment these standards.

Negative Social Implications

Migration, and specifically illegal migration, poses a problem to individuals to the receiving countries of these migrants. Illegal migrants often do not seek health services due to legal and administrative barriers. If immigrants do not have IDs then there is need to profile them at health service centres, and this often reduce health seeking behaviour. It was noted that some illegal migrants may have commenced antiretroviral therapy while in their country of origin, may fail to access ARV regimens they are on while in the country they migrated to. The question being posed is 'Is there room to have a standard first line regimen for all SADC member states?' to ensure continuity of treatment and access for people living with HIV when they are in a neighbouring country. These discussions brought out the need for continued civic education to ensure safe movement and access to treatment.

Member States are of the view that some of the negative impacts of the FTA could be pressure on the health systems of countries where there are better medical facilities with high volumes of people in need of health care services and increased demand. This may also result in poor quality health care system and depletion of resources due to increased burden from foreigners. There also could be over population due to influx of foreigners in some countries. Districts servicing both legal and illegal migrants need to plan their health budgets with these people in mind despite the fact that there is no formal agreement between the SADC countries on how this should be tackled. Countries need to rethink access to health services for foreigners.

Cross border trade leads to separation of spouses and their families. In Malawi, most passport and visa applications were by people intending to travel to South Africa, UK, China, and Tanzania to seek employment. Malawi also notices an influx of people from the Great Lakes and the Horn of Africa, although the numbers are not accurately known. At one stage, there was an influx of people seeking Malawian passports which were favourable documents to travel to Europe. Separation of spouses through migration may lead to extra marital relationship which can increase the spread of HIV is prevention measures are not adhered to.

There are problems with procedures to many traders who do not have proper travelling documents. It has been reported that sometimes, people indulge in sex as a way to gain favours and have their custom duty lowered, or to speed up the clearance process. Such activities do not necessarily happen immediately at the port of entry, but could be favours given in advance, or sometime after a successful "deal". Such could be avoided by keeping the borders open for longer hours so that most traders have adequate time to clear their goods and move on (therefore not needing to spend nights on end at the border).

The FTA may create xenophobia as a result of people moving to countries where there are employment opportunities as was experienced in South Africa. The negative impacts of the FTA to all levels of society in the member states include informal families and an increase in criminal activities. Namibians are said to be fearful of moving out of their country and the few that travel, only visit South Africa. While the rest of SADC is looking for opportunities in Namibia, the locals are seen as not pro-active. This can lead to development of a negative attitude towards foreigners leading to xenophobic attacks. During the peak of deportations at Plumtree border post, 3000-5000 Zimbabweans were deported each day from Botswana while in Beitbridge about 9000 were deported from South Africa. Respondents to this study were of the view that the media can play a major role in sensitising and raising awareness of communities, informal and small scale traders on trade opportunities in the region, the benefits of intra-regional trade, economic integration and specific information on the FTA.

Other negative social implications highlighted include:

- Time spend at the border posts can create opportunities for people to interact, which may lead to engagement in sexual acts. Transactional sex may increase as some traders may want to buy their entry using their bodies.
- Uninspected goods that find their way into countries through illegal entry and exit points, may lead to spread of pest diseases that can affect agricultural production.
- Cultural erosion as different practices are shared and exchanged between different states

5.2 Border Post Related Issues

Even though the FTA does not encompass movement of persons, the increased trade between member countries has triggered a general increase in movement of people. This is evident with the congestion being experienced at most border posts in the region especially at Beitbridge (SouthAfrica/Zimbabwe border) and Nyamapanda (Zimbabwe/Mozambique border). Beitbridge is a major route for goods coming into SADC from South Africa and South African ports. Other major ports are Walvis Bay in Namibia and Beira in Mozambique. In Zimbabwe, demand for accommodation (hotels and lodges) has gone up, even though tourism was on a decline between 2005 and 2008. The economic meltdown in some Member States augmented the movement.

It is against this backdrop that the SADC FTA aims to establish “one stop” border posts to reduce time spent at the border in half. Currently there are three pilot posts at the borders of Mozambique and Zimbabwe (Forbes - Machipanda), South Africa and Mozambique (Lebombo Ressano Garcia) and Zimbabwe and Zambia (Chirundu). The table below indicates the time spend at Chirundu border post before the introduction of the one stop post.

Border Post Delays at Chirundu Border Post

Vehicle Type	Travel Direction	Delays (in hours)
Passenger cars, buses, mini buses, light vehicles	North bound	1
	South bound	1
Refrigerated trucks	North bound	28.5
Oil Tankers	South bound	7
Heavy trucks	North bound	40.5
Containerised	South bound	20.5

Source: From Cape to Cairo: Exploring the COMESA-EAC-SADC Tripartite FTA – Proceedings of the Sixth Southern African Forum on Trade (SAFT) held in Pretoria, SA, 3 to 4 August 2009

Zimbabwe and Zambia have established a one stop border post at Chirundu, with infrastructural and systems upgrades and streamlining to reduce waiting times by at least half. It was officially launched on the 5th December 2009. The Chirundu one stop border post is the first to be implemented in Africa and lies between Zimbabwe and Zambia. In African economies poor infrastructure, operational bottlenecks, and slow bureaucratic procedures at internal borders all comprise the global competitiveness of most economies. International organisations like World Customs Organisation are emphasizing on one stop border concept as a facilitation measure through the Revised Kyoto Conventions. Since its establishment, it is taking truckers less than two hours if pre-cleared and not more than four to six hours if not pre-cleared. Under the East Africa Commission, Tanzania and Kenya operate a one stop border post system at their shared border. A Memorandum of Understanding has been signed between Tanzania and Zambia for the same concept. There is therefore a need to increase the number of border posts in the region designated as one border posts, especially those servicing busy corridors.

One Stop Border Posts have social advantages. For instance public health research reveals that there is a close association between high incidences of HIV transmission and delays at border crossings of haulage trucks (Trades Centre, 2010; IOM, 2010). According to the findings from Family Health International, (2010), based on careful observation, enumeration in guesthouses, bars and streets, and interviews with health workers and peer educators, the researchers estimated that Chirundu has approximately 100 permanent sex workers and another 200 transient sex workers who can easily extend their business activities to those stranded at the border as they wait for clearance. A One Stop Border Post cuts the time spent at a border post by half thus minimizing the risk of traders consenting to commercial to sex. Time spent at border posts can further be reduced through E-governance where trucks can be pre-cleared before their arrival at the port of exit.

Other benefits that were indicated from these discussions on one stop border posts include a reduction in supply chain transaction costs; increased/higher trade flows; increased revenue with increased trade; reduction in the prices of consumer goods; reduction in duplication of efforts; enhanced border security and trade chain security; and transparent and reduction of opportunities for corruption.

Botswana indicated that border posts are not open 24 hours despite the increased traffic. There is very little that one country can do to change border hours since there has to be a bilateral agreement between countries sharing a border. The change also comes with costs as staff have to be increased to man the posts, but comes with immense benefits to facilitate trade. However, discussions are underway between Botswana and South Africa for the possibility of a 24 hour border post. Discussions are at a higher level in streamlining activities at the borders of Botswana with Zimbabwe, Zambia and Namibia even though these are not earmarked for 24 hour opening. Tanzania noted different operating hours at border post between her border with Mozambique at Mtwara and these need to be harmonised to facilitate movement of goods and people.

Botswana raised the issues of urgent repairs required on road and bridge over the Zambezi River over Tete. Another concern that was raised, seen as a hindrance to free trade and faster processing at the border, was the size of the ferry at Kazungula which only takes a maximum gross vehicle mass of 45 tons. This causes unnecessary delays.

Removal of non-tariff barriers led to decrease in time at borders. Small-scale traders report finding it simpler to trade across the borders, and now only need to pay value added tax on some goods. There has been an increase in the number of traders. It is now common in Malawi, for example, that rural traders advertise and sell goods brought in from South Africa. Most people are beginning to change their tastes and looking for quality apart from pricing. Middle class and the rich benefit more. The goods that are imported are mainly for the affluent. But there is a trickle-down effect for agricultural products.

Border posts need to increase capacity to facilitate passage and to accommodate the traffic. There is need to encourage dialogue between Customs and the private sector for Customs to be responsive to the needs of customers. SADC has encouraged partnerships in countries, for instance in Zimbabwe a partnership between Zimbabwe Revenue Authority (ZIMRA), Confederation of Zimbabwe Industries (CZI), Zimbabwe National Chamber of Commerce (ZNCC) and Ministry of Health and Child Welfare. These partnerships enable stakeholders to appreciate one another's roles and responsibilities and how they complement each other in serving a mutual customer. Such partnering and dialogue help bring to the fore health related issues such as transmission of HIV, spread of communicable diseases and unhygienic conditions associated with crowding.

Other Issues Identified

A positive noted at political level was the FTA may lead to peace and cohesion in the region. Two negative implications of movement of people that is increasing with trade was the issue of human trafficking, even though there was no evidence recorded from this study. Lastly, the issue of transit visa for South Africa, visa requirements for Angola and the DRC were raised as areas of concern.

5.3 Regional Trade related Health Issues

According to WHO (2009), cross-border movements of people can lead to the spread of communicable diseases such as HIV, malaria, TB and influenza. This is a result of overcrowding at border points and the volumes of people that travel at any given time. The delays encountered at the border posts do not help matters either. Sanitation facilities at border posts are small and unhygienic. The situation is worsened by the increase in numbers of people using them. This is an environmental hazard that can easily result in disease outbreaks and their transmission to neighbouring countries.

HIV prevention efforts are still to continue along transport corridors as most truckers still engage in sexual relationships with more than one partner including commercial sex workers. This affects communities the truckers interact with along the corridors. This becomes a conduit through which HIV finds its way across communities and borders. Member States visited noted that there is no common HIV and AIDS treatment regimen in the region. Each Member State is currently using its own treatment regimen, making it difficult for traders to access treatment from country of destination. Some Member States such as Botswana provide HIV treatment drugs to their own citizens, leaving a yawning gap for foreigners. This points to the need for Member States to harmonise HIV treatment in the region and for a change in policy to cater for foreigners.

An increase in traffic along the transport corridors in the SADC region has led to an increase in traffic accidents. This is the beginning of the UN decade for road safety awareness to be launched in October 2011, and in line with that there is need for joint inspection of vehicles to ensure road worthiness and law enforcement to combat un-roadworthy vehicles.

The major health issue for Mozambique includes care and treatment for mine workers plying their trade in South Africa. Mozambique actively works on cross border issues with miners, through the Mozambique Miners Association. The main challenge to date has been that of different HIV treatment regimens in the two countries. It is certain that there may be a big problem of resistance to some drugs in coming years, unless the region quickly standardised its regimens. Some of these problems can already be seen with TB and Malaria, where resistant strains have emerged. Mozambique attested to contributing to the WHO led roadmap on harmonising treatment for HIV.

Mozambican districts that share borders with other countries will continue to get their citizens served in neighbouring countries. According to the Ministry of Health, they are currently reaching 60% of the population with health services, with 40% not reached. There is a need to take advantage of HIV

funding to strengthen health systems. Mozambique shares borders with 7 countries, and would need support of SADC to ensure that services delivered with neighbouring countries are harmonised.

South Africa, Malawi and Mozambique all pointed out common issues where borderline citizens usually choose to obtain medications in neighbouring countries if the services are deemed cheaper, of a better quality, or if there are other incentive to cross the borders. For example, Mozambicans cross over to Likoma Island to get ARVs; while at some time, up to 60% of bed occupancy in Limpopo Province, South Africa, was by Zimbabweans. Improvements in the transport sector have aided this. It is now common even for the less affluent to board a bus and travel from northern Malawi to South Africa in a single day or two. It can be assumed that easier border controls make it possible to increase frequency of trips, and the range of goods and services taken out and brought in. SADC could facilitate that border districts meet and work together in providing services.

A number of trade and regional integration related issues are more visible in South Africa, and this place a burden on the health system. Although health access, whether for HIV treatment or in general is a just cause, there are instances where the scale of unplanned access becomes problematic. For example, it was reported that 60% of health care at Musina was accessed by non-South Africans. In the Free State on paper health care is planned for 500,000 but there are more than a million who actually access the services.

The discussants at a focus group in South Africa noted that HIV prevalence rates were higher in South Africa than in neighbouring countries, thus there was a chance that immigrants were moving to higher risk areas. Provision of health to illegal migrants had serious challenges:

- Inadequate harmonisation and protocols. Not able to give ART without history.
- Access to health services by immigrants, no legal status.
- Responses eg to cholera took long due to bureaucracy on notification.
- Language: most migrants are unskilled and of low literacy rates, and therefore difficult to communicate with.

Member States reiterated the need to have region-led research. There is need to share best practise and operations research as well as better management of research. Who will set the research agenda? Current focus is on HIV and AIDS, TB and Malaria but SADC needs to set the right agenda for non-communicable diseases as well.

In the case of patients who travel to other countries and abscond from receiving treatment or are placed on different drug regiments Zimbabwe highlighted that the patient's health is assessed and where possible switch them back to their ARV drug regiment available in Zimbabwe. However, in many cases the solution is to source for the drug regiments these patients are on so that they continue receiving treatment. The main challenge is the cost of these drugs which is high. Responding to issues on the manufacture of ARVs, Zimbabwe has pharmaceutical companies that manufacture HIV drugs

such as Verichem but the drugs are expensive as compared to those from other markets in Brazil and India. The local industry thus suffers in favour of these foreign drug sources which are cheaper.

Other health issues related to the FTA that were noted are:

- Patient retention on treatment compromised; Due to different standards and drug regiments in the countries within the region patients might encounter problems in drug adherence and responding effectively to treatment.
- Stigma is still an area that needs to be addressed
- Medical Aid still has issues with HIV and AIDS. Either one is not taken on board or their subscriptions are doubled.
- The movement of livestock and crops across borders also create a health challenge, particularly in instances where the goods/products are smuggled in.

5.4 Implications for HIV transmission and the Spread of Other Communicable Diseases

'There is no significant decline in HIV prevalence in the region because HIV is merely moving across borders'

The FTA may lead to cross country infections which have a probability to increase prevalence. It may also lead to an increase in non-compliance, vulnerability and overcrowding. There is an increase of commercial sex work activities at places where truckers park for the night, since they are not allowed to move at this time. For Botswana, this is highly noticeable at its border with South Africa and with Zambia, at Kasane (Zimbabwe and Botswana), Francistown. Crowding and long stay at border posts can hasten the spread of diseases such as cholera, tuberculosis, swine flu and H1N1. Namibia lamented the high TB burden the country is already experiencing. Tanzania pointed out to the possibility of an increased HIV burden on health and social services as Mozambican nationals track to Tanzania for trade and medicines.

Botswana has a closed policy on HIV and AIDS treatment. ARVs are for citizens only. Foreign women are not enrolled on the Prevention of Mother to Child Treatment (PMTCT) programme. In the same vein, Angolans and Tswana in Namibia cannot access treatment in that country. This means foreign citizens are not catered for. The Human Charter should be applied to address this gap but the law seems to take precedence over the charter. As such, human rights are not readily addressed. The policy brings challenges when it comes to foreign prisoners where HIV and TB are an issue. SADC may need to put in place mechanisms for the repatriation of foreign prisoners to serve jail sentences in their countries of citizenship.

There is need to provide correct and adequate information for travellers on HIV, TB, yellow fever, influenza and malaria. This can be printed on travel documents, or on cards such as those used for yellow fever. Information centres can be established at border posts to distribute materials with medical

specifications on HIV prevention and treatment, communicable diseases and yellow fever to reduce possible spread.

Adherence to HIV treatment is at risk as some traders are importing fake drugs that are used in place of ARVs such as tiens, herbs, moringa and other structure enhancing drugs that find their way on to the market. Tanzania noted that most of these counterfeited drugs are coming from Uganda and Kenya. SADC member states need to put in place full proof systems and enforce regulatory mechanisms to avoid importation of fake medicines and other commodities such as condoms to reduce the possibility of HIV related deaths from non adherence of drugs and possible drug resistance for those on treatment.

The private sector is said to be addressing HIV and AIDS issues at a macro-level and not at micro-level. The need appreciate the fact that the higher the HIV prevalence the higher the impact on human capital, on individual companies and on the economic sector. The employee is the customer for goods and services that are being traded.

Member States visited pointed out the need for SADC to facilitate better coordination in management of treatment regimens. There is need to harmonise initiatives and policies (ART regimens) across countries as was the case with the SADC campaign on Multiple Concurrent Partnerships that culminated from the Maseru declaration. Initiatives taken at SADC level have an intrinsic collective drive for the flow and continuity of messages across the region. The East Africa Community has harmonised six treatment protocols (DRC, Tanzania, Burundi, Rwanda, Uganda and Kenya) under the Great Lakes Initiative to address treatment issues in the region. At national level, countries need to be better coordinated, making ART programmes sensitive to the regional nature of the epidemic. Suggestions have been proffered to introduce an electronic medical card with client's medical history and treatment regimen under the harmonisation of policies and initiatives to facilitate access to treatment from any Member State.

Currently, there is no antiretroviral production that can sustain the region. There is need to develop a regional strategy on how to produce ARVs within the region or to establish a regional approach to bulky procurement of ARVs.

5.5 Reported mechanisms for addressing regional health issues

This section dwells on strategies put into place by Member States to address HIV and AIDS in their countries. The SADC Member States visited during the study have in place National HIV and AIDS Strategic Plans that give a guiding framework to the national response to HIV and AIDS in line with the SADC 2005 framework developed for Member States by the secretariat.

Member States are mainstreaming HIV and AIDS through Business Coalitions who work together with the Ministries of Trade, Health and Industry and Commerce. The HIV and AIDS mainstreaming seeks to enable development actors to address the causes and effects of AIDS in an effective and sustainable manner both through their work and within their workplaces. Respondents noted that the main challenge with the private sector is their focus and prioritisation of profits while treating HIV and AIDS as secondary. The interests of business are seen as focusing more on how to run a business, how to market, human resources management, with limited focus on occupational safety and HIV and AIDS.

Where HIV and AIDS activities are being implemented they seem to happen at headquarters than other stations. A key informant acknowledged that "more needs to be done in terms of prevention packages for staff working at other stations rather than the headquarters. It is only at the headquarters where health practitioners visit for talks and presentations to staff". This points to a need to strengthen these activities in the private sector for them to reach all levels of employees.

The main focus of activities in the region that address HIV and AIDS issues related to trade are more on the transport sector targeting truckers, bus drivers, commercial sex workers and communities along the Corridors. A number of programmes to address HIV and AIDS issues along the corridors and main highways were initiated under the Corridors of Hope, the North Star Foundation, the Sub Saharan Africa Transport Programme, the Walvis Bay Corridor and two main corridors in Tanzania (Tanzania, Zambia to Zimbabwe and Tanzania, Uganda, Burundi, Rwanda to DRC).

Wellness Centres are being rolled out in all major sub-Saharan transport corridors and a number of centres are already operational along the North-South Corridor including Wellness Centres on both sides of Chirundu (Zambabwe-Zambia) at Musina and Beitbridge (Zimbabwe-South Africa). The activities focus on the Most at Risk Population groups such as CSWs, truckers, SMEs, informal traders, uniformed forces, communities along the corridors, women and adolescent girls. The programmes cover condom distribution; awareness campaigns; focus group discussions; policy development; promoting medical insurance; HIV counselling and testing; dissemination of information on prevention, treatment and care; behaviour change and communication activities; and ensuring that HIV and AIDS clauses are incorporated in bidding and contract documents.

Tanzania highlighted that some corridors were not adequately covered such as the South Corridor that leads to Zambia and to Malawi and the Central Corridor (Dar-es-Salam, Mwanza to Rwanda). There are planned activities with ILO for surrounding communities along the corridors especially where truckers park.

Through the SADC Secretariat, the Global Fund is currently supporting a 5 year regional programme that reaches 32 key border crossing points. The programme includes servicing transport corridors with mobile clinics for drivers to access information, receive counselling and advice. The broad Global

Fund Programme is three pronged including Behaviour Change and Communication; Voluntary counselling and testing education and awareness raising; and targeting companies and firms with wellness programmes to address challenges of HIV and other communicable diseases. The clinics will also service the communities along the same corridors.

Member states are mainstreaming HIV and AIDS activities in the public sector that is in all government ministries and departments. Each government ministry has HIV coordinators in those sectors, and these have been trained as trainers. Mozambique has taken major strides in addressing HIV at the workplace, with a new strategy developed for civil servants. A database has been developed to track civil servants' initiatives in addressing HIV and AIDS. The database is now at testing stage and will become part of job requirements for many offices and departments. In Namibia, HIV and AIDS mainstreaming in the public sector is coordinated in the Prime Minister's Office. HIV and AIDS mainstreaming is through government ministries' sector focal persons. For example in the construction industry, HIV and AIDS issues are included in the tender process to ensure the project incorporates how HIV issues will be addressed. Most of the activities include awareness through information dissemination and condom distribution, working with health providers in the area for the duration of the project.

An important observation coming out from the study is the need to re-define the workplace especially for truckers. The transport corridors that they ply day and night is their workplace and not the company headquarters. Re-defining the workplace will help focus on the programmes to address health challenges at places where they spent most of their time at. Need for a coordinated approach between government and the private sector through sustained partnerships. MS governments should be responsible for implementation and monitoring of HIV and AIDS mainstreaming activities in the private sector.

VI. Discussion of Findings

This section discusses the findings in the context of the literature as a precursor for conclusions and recommendations. The world health assembly pointed out that with an increase in global mobility, the health of migrants has become a key global public health concern (Norwegian Ministry of Foreign Affairs; SIDA). SADC Free trade Area and newly opened borders have led to a dramatic increase in international population mobility. Factors such as the unequal distribution of resources and the growing disparity between the South Africa and her neighbouring economies shape the extent and degree of labour migration. Clearly, international trade and conditions of poverty and unemployment are motivating people to relocate in search of work and the possibility or opportunity of a better life in other countries.

The economic, technological and labour changes taking place because of FTA indicate that people move in much the same way as materials and goods - freely and at short notice. Migrant workers

are responding to unprecedented economic growth, increased trade and tourism, liberal economic policies and the relaxation of travel restrictions. As a result FTAs are likely to be accompanied by rapid urbanization creating imbalances in social and community development. Migrant workers are seen only as sources of labour and governments have failed to provide adequate health care and education services for these populations. In many cases, when economic growth declines, migrant workers are expelled from host countries and forced to return home.

As is the case with many mobile populations, labour migrants are susceptible to health problems including HIV infection and other communicable diseases. Widespread risk and vulnerability factors include substandard living environments, high rates of alcohol use, and sex with multiple partners or commercial sex trade workers. Prevalence rates among those who travel for employment reasons demonstrate the extent of this vulnerability. In southern African mining companies where 95% of the work force are migrant workers, the average HIV infection rates are close to 18% (Interagency Coalition on AIDS and Development, 2008).

South Africa is a significant destination for migrant workers. The SA mining industry, which employs over 300,000 workers from Lesotho, Botswana, Swaziland and Mozambique, offers a clear illustration of the particular vulnerabilities that migrant workers face, due to HIV and AIDS. For example, the town of Carletonville (near Johannesburg), is home to the biggest gold mining complex in the world, employing approximately 70,000 men. Until very recently, most have lived in single sex hostels without their wives or families. It is common for the workers to have two wives, one in their home village, whom they see on rare occasions, and one in South Africa near the mine. Research conducted in this area show very high rates of HIV infection among mineworkers, sex workers and young women in communities surrounding the mines.

Aside from polygynous relationships, which can be quite prevalent in parts of Africa, there are also widespread practices of sexual networking that involve multiple overlapping or concurrent sexual partners. Men's sexual networks, in particular, tend to be quite extensive, a fact that is tacitly accepted by many communities. Cultural or social norms often indicate that while women must remain faithful men are able and even expected to philander irrespective of their marital status. Along with the occurrence of multiple sexual partners, unemployment and population displacements that result from drought and conflict contribute to the spread of HIV.

Significant health gains were made in SADC countries in the 1970s and 1980s. This was mainly through primary health care and public health interventions, such as improving water and sanitation, food security and nutrition. In recent years there have been set backs; Many SADC countries now have relatively high levels of deprivation, with poor access to essential services as well as low levels of human development (such as income and educational status) relative to their economic development levels. Significant disparities have emerged across geographic areas, "ethnic" or "race" groups, and between men and women (EQUINET, 2000).

Parallel inequalities have emerged in the health sector, in access to TB control and treatment, antenatal care coverage, access to safe water and access to quality primary care facilities and referral services. High rates of preventable diseases, child mortality and malnutrition are differentially distributed between geographic, ethnic, gender and income groups. From the range of data available, it is becoming clear that poorer segments of the population have been most negatively affected in terms of reduced access to health.

According to WHO (2009) cross-border movements of people can lead to the spread of communicable infections and diseases such as HIV, malaria, TB and influenza. This is a result of delays experienced at border posts, transactional sex, overcrowding at border points and the volumes of people that travel at any given time.

Regions like SADC are pursuing development through an avenue that can place social, health, security and other issues above trade. Trade Related Aspects of Intellectual Property Rights (TRIPS) do provide a restricted platform for countries to act in interests such as public health, but demand significant institutional resources and capabilities to take advantage of them (Muroyi et al, 2003). In as much as TRIPS protects intellectual property rights on pharmaceutical drugs through patent arrangements that exclude third party use, offering for sale, selling or importing of such products for a minimum of 20 years from the date the patent application is filed, it results in the increased costs of patented drugs which will put a significant burden on public health budgets.

6.1 Strategies for responding to HIV and AIDS issues in the context of the FTA

The Maseru Declaration on HIV and AIDS prioritised five areas that need urgent attention at both regional and national levels, which are prevention and social mobilization; improving care access to testing and counselling services, treatment and support; accelerating development and mitigation the impact of HIV and AIDS; intensifying resource mobilization; and strengthening institutional monitoring and evaluation mechanisms. Both the revised framework and the Maseru Declaration emphasize the importance of strengthening partnerships with civil society organizations, faith-based organizations, business, labour, and international cooperating partners. The need to mainstream HIV and AIDS at both policy and program levels is also underscored. Thus SADC has an immediate task to map the non-government stakeholders that will also provide technical and financial support in mainstreaming HIV in TFA related activities. This is a different brand of partner, different from the traditional AIDS service organization, but one that will sell HIV and AIDS messages to business minded partners that need to see their roles in terms they use every day.

One strategy is to develop models that show individual member country's potential trade loses due to the HIV epidemic, and the gains that can be achieved by coordinating the response to HIV at the regional level. This is due to the fact that most people living with HIV are educated, skilled

and enterprising and require long periods of training and skill acquisition. Since this category of population provides the technical, professional and managerial backbone of the economies of Member States, there is an imminent threat that the epidemic will undermine the socio-economic development efforts in Member States and the integration process in the region in general. This message should be sold across all sectors, and even the officer advancing the cause of the FTA should have adequate access to information on their own level of risk to infection.

SADC could use the high levels of infection in the region as rationale to position the region to better access to funds for responding to the epidemic. SADC could insist on support for responding to HIV and part of negotiations for trade with richer blocs. This is because the levels of infection in the individual countries have placed SADC on the top list of the most affected region in the world. Even though the 15 Member States are at different levels of the maturity of the epidemic, all indicators point towards a severe state of the epidemic (UNAIDS, 2008).

Political Commitment providing comprehensive and integrated mainstreaming is required. The commitments are fulfilled at the national level by domestication and devising enabling policy guidelines, programmes and strategies that promote and attract tangible solidarity. The presence of national political champions promotes and motivates mainstreaming interventions. High level of political commitment results in unquestionable respect and support for HIV and Trade issues from all stakeholders with positive impacts.

Conducive policy environment: Member states created enabling policy environments for mainstreaming HIV activities into all sectors. The countries have various polices, strategies and guidelines from different sectors that guide the various components of HIV interventions. Polices are formulated in a participatory manner with input from all the stakeholders. In countries visited, policy formulation is informed by research and past experience (note this could not be verified during fieldwork). This is a good starting point for SADC led HIV and trade activities.

The policy environment created by some member states led to single national HIV response programmes that are supported by all stakeholders under the leadership of the Ministries of Health and National AIDS Councils or Commissions. The national programmes are the entry points for any mainstreaming interventions by SADC. The policy environment will thus facilitate the mainstreaming of HIV into Trade related activities.

Availability of financial resources and Coordinated Funding is necessary. Funding from the governments, region and development partners should be well-coordinated through the SADC Secretariat. In line with the SADC FTA, SADC should advocate for the increase of resources allocated to the health and HIV sectors in member states. For example, member states could be continually reminded to fulfil the Abuja Declaration commitment to allocate 15% of the total government budget to the health sector. The impact of this will be positive development being made against key health outcome

indicators targeted at improving availability and the attainment of universal access including access to care services in the context of an integrated region. SADC could helped in channelling resources towards interventions that represent good value for money and catalyse the process for member states to identify FTA issues that need to be addressed.

Linking economic growth and trade to social sectors particularly health: Committed and sustained efforts to enhance the good health of all in the region are an indication of the region's appreciation of the inextricable link between development and the health of the population. Meeting people's needs for education and health, in particular reproductive health, is crucial for both individual and the region's development. This appreciation is concretised if health issues, with particular focus on the prevention and management of nutrition and HIV and AIDS are identified as key priority areas for governments in terms of resource allocation.

Addressing HIV issues thus is critical component for enabling the region to achieve economic growth thus transforming it from relative poverty to middle income industrial region. The goal of focusing on HIV and AIDS should be to prevent further spread of HIV and AIDS and mitigate its impact on the socio-economic and psychosocial status of the general population.

VII. Guidelines for Mainstreaming HIV & AIDS into SADC sectors on trade

The Trade, Industry, Finance and Investment (TIFI) cluster comprises of trade and industry, mining and finance and investment. These sectors are intrinsically interrelated and can easily influence development and poverty reduction in the region. This SADC cluster has the mandate to address HIV and AIDS in the region since it has direct interaction with the different players that drive the economies of member states. According to the RISDP, one of the major strategies in dealing with the pandemic is to develop and strengthen the capacity to undertake the mainstreaming of HIV and AIDS at all levels and providing mechanisms and frameworks for the development of guidelines and exchange of best practices in major intervention areas such as mainstreaming of the pandemic. A framework to guide the mainstreaming of HIV and AIDS policy in all socio-economic sectors has been developed in southern Africa in an effort to mitigate the impact of the pandemic, which defines the concept of mainstreaming HIV and AIDS in the Southern African Development Community (SADC) as a step towards implementing the SADC Business Plan on HIV and AIDS. It lays the foundation and principles for the critical steps required to ensure a harmonised approach in the region.

Having the HIV and AIDS mainstreaming framework indicates that SADC understands the importance of mainstreaming these issues. From this assessment the issue that remains to be addressed is the 'how'.

How is HIV and AIDS mainstreamed at SADC Secretariat and at MS? What structures are in place for mainstreaming and how can they be strengthened?

At SADC Secretariat, HIV and AIDS mainstreaming is currently under the Directorate of Social and Human Development and Special Programmes (SHDSP). Mainstreaming at MS level is through the National AIDS Councils, where SADC Secretariat has a focal person to ensure that priority issues are addressed through National Strategic Frameworks. It is important to note that mainstreaming of HIV, should adequately be implemented internally within the SADC directorates so that the extension to externally mainstream activities in member states has adequate grounding. The Secretariat, as the principal executive institution of SADC, should be responsible for strategic planning, co-ordination and management of SADC programmes, including the efforts to mainstream HIV. SADC needs to master internal mainstreaming of HIV so that it can adequately support member states and offer advice. How can this be done?

Mainstreaming is a management issue. In order to move the mainstreaming agenda forward, a paradigm shift is required that would de-link mainstreaming from its thematic areas and focus on its application in terms of institutional management and development. Such a shift would liberate mainstreaming to become a practical management strategy, allowing institutions to better meet the constantly emerging challenges of today's fast paced and globalized environment. Mainstreaming as management will increase the institutional ownership of these cross-cutting issues and will better promote adaptability and change.

In the corporate world as well as the public sector, employing mainstreaming as a management strategy will enhance efforts at bringing such thematic issues as gender, HIV and AIDS, disabilities, poverty, human rights, etc, which may have once been seen as peripheral, into the core business and decision making processes of institutions. This follows the concept of 'simultaneous mainstreaming'; where the entire core cross cutting issues are addressed at the same time. This provides a coordinated approach to mainstreaming cross cutting issues that affect different thematic areas.

For this management approach to mainstreaming to be effective, are proposing the following structural adjustments at SADC Secretariat level:

a) Relocate the HIV and AIDS mainstreaming component from the Directorate of Social and Human Development and Special Programmes to either the office of the Deputy Executive Secretary - Regional Integration or the higher office of the Executive. This will facilitate mainstreaming to reach all directorates more easily than being in another directorate.

b) Where ever this is eventually located between the two offices proposed above, create a Unit for 'Simultaneous Mainstreaming' which houses HIV and AIDS, Gender, Human Rights, Disability and

any other cross cutting issues that may be deemed core to included. This will facilitate a coordinated approach to mainstreaming where the unit is responsible for moving the mainstreaming agenda of all the core cross cutting issues at SADC Secretariat and MS level.

c) Simultaneous Mainstreaming Unit to ensure both internal and external mainstreaming of the said cross cutting issues is undertaken.

d) Develop key performance indicators to track mainstreaming (HIV and AIDS, gender, Human rights, disability) in SADC Secretariat and MS level.

e) During planning meetings; mainstreaming personnel from the Simultaneous Mainstreaming Unit (HIV and AIDS, Gender and Human Rights, disability) be made available for each directorate so as to assist in developing plans with a Gender, HIV, AIDS and Human Rights lens.

f) The Simultaneous Mainstreaming Unit is to strengthen the capacity of the Secretariat to integrate and facilitate the implementation of HIV and AIDS, gender and human rights in all sectors of the SADC Programmes and policies.

g) Directors of the different directorates should ensure mainstreaming in their clusters at SADC Secretariat level and at MS level. Simultaneous mainstreaming HIV and AIDS; Gender and Human Rights. Mainstreaming and capacity development can easily be effected from the Secretariat to the different sectors.

At Member State level, the appointment of SADC Secretariat focal persons was greatly appreciated as it ensures that the SADC agenda is domesticated at country level. However, an area of concern that was highlighted was the modalities through which SADC activities are implemented through committees made up of Member States. It was noted that Member States participants do not have a forum to share information from the Secretariat and vice versa. Member States may participate in meetings but this does not necessarily lead to implementation of FTA activities at MS level. As such, the SADC Secretariat is expected to give strategic guidance at this level. It was proposed that there is a need to establish dedicated teams of Technical members (SADC Free Trade Area Technical Committee) who focus on assessing implementation of activities and enforcement of agreement by Member States and identify gaps to be addressed. This will give SADC an opportunity to follow up on issues and influence leadership on identified priority areas for attention. Structural adjustments that can be undertaken at MS level are:

a) Strengthen the Capacity of SADC Focal Persons at National AIDS Councils to be able to articulate the SADC mainstreaming agenda into all thematic areas in both the public and private sector.

b) Create a Forum for the coordination and sharing of information at MS level. After participation in a Technical Committee meeting at SADC level, representatives should have a channel to communicate issues to stakeholders at country level and vice versa.

c) Working with NACs, development agencies and the private sector, create a coordination mechanism at Member State level to ensure mainstreaming of HIV and AIDS, gender and human rights issues in the private sector.

d) As part of performance appraisal HIV mainstreaming should be part of Directors and Senior Programs Key performance areas.

Through the proposed simultaneous mainstreaming unit, SADC Secretariat can provide mainstreaming technical assistance in different sectors especially in government departments that deal with matters external to the country. They can also create a platform for information exchange and experience sharing of best practices and research findings from across the region.

VIII. Conclusions and Recommendations

Most of the respondents in the study were not conversant of any mechanisms that are in place to deal with the negative impacts of the FTA. The activities that are currently in place are not easily linked to the FTA even though they address issues that emanate from trade liberalisation. This points to the need to bring out the link between thematic programmes and the need to sensitise communities on the cross cutting issues that need to be addressed during implementation of the programme. In this case the link between the FTA and HIV and AIDS was to be cleared articulated. With the proposed simultaneous mainstreaming of HIV and AIDS, gender and human rights, if implemented well, promises higher benefits in addressing negative social, economic and political impacts of the FTA.

Respondents noted that SADC protocols are on paper but little is happening at MS level to action them. There is therefore need for national action plans to implement protocols. On the FTA, respondents were of the view that if implemented properly, it has the potential to reduce the epidemic due to improved standards of living.

From the study and the ensuing discussion, a number of recommendations have been proposed as enumerated below:

g) Harmonisation of Guidelines, Regulations and Policies

- Harmonise customs procedures systems and simplification of procedures in the region to facilitate movement of people and reducing queues at border posts.

- Harmonise HIV treatment at regional level. Mechanisms should be put in place to allow universal access to prevention, treatment and care in the region regardless of country of citizenship. The region should have standardised messages and treatment regiments for ease of access by clients in the region

- SADC to establish a 'pulled pharmaceutical programme' for procurement of drugs for the region

- Expeditious review of the stringent rules of origin for the FTA.

- Free movement of persons is still a constraint that needs to be addressed, visa requirements between member states for example Angola and the DRC

h) Regional approach to HIV and AIDS Programming

- Strengthen mainstreaming at SADC Secretariat and at MS level through simultaneous mainstreaming of core cross cutting issues such as HIV and AIDS, gender, human trafficking, and human rights for an integrated approach that improves and sustains peoples standard of living.

- Ensure that mainstreaming is utilised as a practical management strategy that will increase institutional focus on cross-cutting issues and promote adaptability and change.

- SADC should be an entry point for HIV and AIDS mitigation strategies and funding for the region instead of MS approaching funders individually. MS to streamline activities in line with the SADC framework to remove overlaps and strengthen integration. SADC to develop a common HIV and AIDS agenda and a roadmap for MS.

- Establish private public sector partnerships at all levels to increase interaction and dialogue that help bring to the fore health related issues such as transmission of HIV, spread of communicable diseases and unhygienic conditions associated with crowding.

- Behaviour Change and communication programmes for all departments that man border posts (customs, immigration, police) and scale up condom distribution at border towns and identified hotspots.

- Support and strengthen existing networks of People Living with HIV to promote and improve positive living in the region.

i) Strengthen Monitoring and Evaluation Systems

- One HIV and AIDS M and E system for the region feeding into an established regional data base linked to MS. Data collected at ports of entry and exit should be utilised for planning at MS level and feed into SADC.
- Strengthen Monitoring and Evaluation systems in the private sector and ensure that companies are committed to HIV and AIDS issues and not just focus on profits.

j) Track progress on SADC agenda at MS level

- Establish a mechanism to enforce protocols and track progress and commitment of MS to set goals and objectives. SADC Secretariat needs to be capacitated to be able to initiate, coordinate the implementation and follow-up on programmes at MS level.
- Increased resource mobilisation efforts for the secretariat to carry out activities effectively.
- Ensure political commitment of all MS on the FTA and make sure it is operational on the ground.

k) Document and Share Best Practices

- SADC Secretariat to document and share best practices at regional platforms

l) Develop and Maintain Infrastructure to facilitate Trade

- SADC is encouraged to develop and maintain infrastructure in line with increased trade between countries
- Provide quality yet affordable accommodation for cross border traders in the border towns
- Expand the One stop Border Post concept to all busy border posts to address delays.

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Annexes

Annex 1: List of Interviewees

Botswana		
Dr. Vitalis Chipfakacha	Capacity Building-Mainstreaming HIV/AIDS	
Dr. A. M. Mulumba	Programme Officer HIV Research and M&E	SADC Secretariat
Jabulani Mtetwa	Senior Programme Officer; Trade Directorate	
Willie Shumba	Senior Programme Officer; Customs	
Lovemore Bingandadi	Corridors Advisor; Infrastructure Services Directorate	
Johana Segotlong	Principal Trade Officer	Ministry of Trade and Industry
Mabel Mpofu	Deputy Director	
Miriam Moremi	Chief Programme Officer - Mainstreaming	
National AIDS Coordinating Agency		
Robinson Dimbungu	Chief Planner/Economist	
Ogomoditse Odirile	Principal Programme Planning Officer	
Nonofo E. Leteane	Principal IEC Officer	
Gaxatche Keboi	Principal Information Education and Communications Officer	
Tsiamo Mercia Raditladi	Youth Officer - Intern	
Robert Selato	Principal Research Officer	
Diana Meswele	Ethics, Law and Human Rights Coordinator	
Philiso Phodiso Valashia	Customs Manager	Botswana Unified Revenue Service
Malawi		
Blackson Matatiyo	Research Officer	National Aids Commission
Thomas Bisika	Executive Director	National Aids Commission
Wiskes DG Nkombezi	Assistant Director of Trade	Ministry of Industry and Trade
Mahara Longwe	Partnership and liaison Officer	National Aids Commission

Charity P. Msonzo	Chief Trade Officer	Ministry of Industry and Trade
Wellington Kafakalawa	Monitoring and Evaluation Officer	National Aids Commission
Washington Kaimvi	Director of Finance and Administration	National Aids Commission
Mozambique		
Sundecar Novela	President	MUKHERO: Association of Informal Sector Vendors and Importers
Laurinda de LPS Macaringue	Technica de administracao de rucursos humanos	Investment Promotion Centre
Cerina Banu I Mussa	National Director: International Relations	Min. of Industry &International Trade
Conelio Balane	Executive Director	EcoSIDA (Business Council against AIDS)
Sheila Samuel	Assessora dos Mecanismos Consultivos	Confederation of Mozambican Business Associations
Namibia		
Anna Marie Nitschke	Deputy Director-Dept of Special Programs	Ministry of Health and Social Services
Annatjie Thobias	Chief Health Programmes Officer	
Diana	Deputy Director – International Trade	Ministry of Trade & Industry
Cleo Moono	Manager – Windhoek Branch	Chamber of Commerce & Industry
Peter J. van Wyk	Executive Director	Namibian Business Coalition on AIDS
Edward Shivute	Project Coordinator	Walvis Bay Corridor Group
Diana K. Tjiposa	Chief Trade Policy Analyst	Ministry of Trade and Industry
Edward Shivute	Project Coordinator	Walvis Bay Corridor Group
South Africa		
Morero Leseka	Deputy Director- HIV/AIDS and TB Management	Department of Public Service and Administration
Muzumkhulu Zungu	Community Health Medicine Specialist	National Health Laboratory Service
Moeketsi Modisenyane	Cluster: Africa and South-South Relations	Department of Health

Elizabeth van Renen	Director: SADC International Trade and Economic Development	Department of Trade and Industry
Khanyile Baloyi	Assistant Health Advisor	Chamber of Mines
Robert Muyanga	Manager: Public Relations and Marketing	NEPAD/African Union
Malose Daniel Matlala	Deputy Director: Food Control	Department of Health
Eric Ventura	Regional Coordinator: Migration Health	IOM
Tanzania		
Dr. Patrick Mwidunda	Acting Programme Manager	National AIDS Coordinating Programme
Emma Lekashingo	Acting Head – Care and Treatment	
Bonita Kilama	Acting Head for Epidemiology	
Peris Urasa	Acting Head Counselling & Support Services	
Ambroce B. Lugenge	Principal Trade Officer	Min. of Trade, Industry & Marketing
Hussein S. Kamote	Director of Policy and Advocacy	Confederation of Tanzania Industries
Dr. Raphael BM Kalinga	Director Policy, Planning and Research	
Renatus Kihongo	Special Programme Officer	
Delfinus Kivenule	Statistician	Tanzania Commission on AIDS
Beng'i Issa	Director Finance and Administration	
Geofrey Majengo	Director Advocacy and Communications	
Mudrick Soragha	SADC Focal Person	Ministry of Foreign Affairs
Zimbabwe		
Dr. Tsitsi Apollo	ART Programme Manager	Ministry of Health & Child Welfare
Mr. N.T. Miti	Principal Economist	Ministry of Trade and Industry
Mrs. Mapungwana	Director Business Development	
Ministry of Small and Medium Scale Enterprises		

Mr. Muchandisiye	Director HR	
Mr. Goba	Director Finance and Administration	
Ms. S. Bowora	Research Officer	
Mr. L. Mataire	HR Assistant	
Ms. C. Munhuweyi	HR Assistant	
Ms. T. Chingwere	Senior Economist	
Ms. E. Mutepfa	Cooperative officer	
Miss N. Mapeka	HR Assistant	
Mr. T. Hove	Acting Deputy Director-Research & Policy Development	
Mrs. Kapfudza	Acting Director – Human Resources	Ministry of Transport
Mr. J.J. Pedzapasi	Head - Vehicle Inspection Depot	
J.N.M Matema	Commissioner Road Motor Transport	
Naboth Ziwenga	HIV and AIDS Focal Person	
Mrs. Kajese	Acting Director	Ministry of Public Service
Mr. E Chimanikire	Acting Deputy Director – HIV and AIDS	
Ms. P. Mahoso	Administration Officer HIV and AIDS	
Mr. E. Musiiwa	Administration Officer HIV and AIDS	
Ms. M. Nhachi	Administration Officer HIV and AIDS	
Vimbayi Mudege	National Coordinator – Workplace & Gender	National AIDS Council
Mambeu Shumba	Planning and Implementation Coordinator	
Idah Chimedza	HIV and AIDS Projects Manager	International Labour Organisation
Kattie Kerr	Deputy Chief of Mission	International Organisation on Migration
Monica Czapla	Health Coordinator	
Folen Murapa	Project Officer-Information Campaign	

Annex 2: Key Informant Interview Guide – FTA impact on the spread of HIV Study

General Information: Name of interviewee, organisation, designation, country (As appropriate, complete this information prior to interview).

1. What differences were brought about by the signing and implementation of the FTA?

2. In which sectors has activity increased in this country that can be attributed to the launch of the FTA in 2008 and currently operational in the SADC region? (trade, transport; migration, mining and informal sector activities).

3. What do you view as the economic benefits that the FTA will bring to all levels of society (women, men, children, the poor, the rich) in the different member states?

4. What do you view as the social benefits that the FTA will bring to all levels of society in the different member states?

5. Besides the above what other benefits will the FTA bring to all levels of society in the member states?

6. What do you view as socioeconomic benefits of the FTA at regional level?

7. In relation to HIV and AIDS/communicable diseases what are the likely impacts of the FTA on the epidemic in the region

8. What negative impacts (Social; Health including HIV and AIDS; Economic; Political) are likely to arise from the FTA to all levels of society in the member states that are?

9. What mechanisms are in place to deal with negative social impacts within SADC structures at Regional level; National level; and Local levels. (How are these mechanisms being implemented?)

10. What mechanisms are in place to deal with negative health impacts (communicable diseases, HIV infection) at Regional level; National level; Local level? (How are these mechanisms being implemented?)

11. What mechanisms are in place to deal with negative political impacts at Regional level; National level; and Local level? (How are these mechanisms being implanted?)

12. What mechanisms are in place to deal with negative environmental impacts at Regional level; National Level and Local level? (How are these mechanisms being implemented?)

13. In your view what impact will FTA have on the spread of HIV in the Region?

14. As Ministry/immigration agency/ SADC secretariat /development organisation [e.g. IOM]/ trade sector what mechanisms are in place to respond to the impacts on the spread of HIV in the region?
- Private sector coordination

15. How does SADC mainstream HIV and AIDS, gender and human rights issues in Member States (focus on country of interview)? (processes, partners, strategy).
- Do you have guidelines to facilitate mainstreaming?

16. What are the areas for capacity development that you can identify for SADC to strengthen HIV and AIDS mainstreaming in Member States? (explain, justify and propose how this can be done)

17. What are the key achievements/successes of HIV mainstreaming in the context of the FTA?

18. Identify main strengths, challenges, opportunities and threats, lessons learnt and best practices, if any.

19. Recommendations for HIV and AIDS, gender, and human rights mainstreaming for different SADC clusters and Member States.