Regional Forum of HIV Cross-Border Patient Challenges in the SADC Region 2010 Report

Sandton International Convention Centre, South Africa

20th - 22nd August 2010

MZUZU UNIVERSITY Luke International Norway PINGTUNG CHRISTIAN HOSPITAL

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Mobile populations have been recognized as one of the most vulnerable groups to HIV transmission, and HIV patient mobility might increase the difficulties of follow-up, seeking for treatment and healthcare, and accessible information. There is an urgent need to take action on HIV and AIDS cross-border issues in the SADC region in order to mitigate the impact of HIV and AIDS epidemic in the region. In response to the above and in the quest for making a substantive contribution, Luke International Norway, in collaboration with Mzuzu University in Malawi and Ping-Tung Christian Hospital in Taiwan, organized and initiated a regional forum to discuss HIV cross-border patient (CBP) challenges in the SADC region since 2009.

The second forum of HIV CBP challenges in the SADC region was held in Johannesburg, South Africa from 20 to 22 of August, 2010. The participants included the HIV and AIDS programme managers from the SADC National AIDS Authorities, Coordinators, Health Information System Developers and M&E specialists from Ministries of Health, Academic Institutions and International Organizations. The representatives that attended at the 2010 forum are from ten Member States of SADC, which are Botswana, DRC, Lesotho, Malawi, Mozambique, RSA, Swaziland, Tanzania, Zambia, and Zimbabwe, and from two regional organizations, known as SADC Secretariat and IOM Regional Office for Southern Africa. During the three-day meeting, participants gathered together to share the experience, progress to date and to chart a plan of action for addressing the CBP issues in the SADC region. The current challenges in relation to the CBP issues include that HIV and AIDS prevention and control services across borders are not harmonized and there is scarce data on HIV prevalence amongst migrants in the region, and lack of continuity and objectivity in Member States SADC project. In addition, the current policies and healthcare services in most of the SADC MS are not migrant-sensitive, and gender disparity is disregarded amongst most of the HIV/AIDS programmes.

In response to the challenges highlighted at the forum, it is suggested that HIV and AIDS issues should be mainstreaming into Free Trade Agreement and all the Member States in the region should support SADC HIV Unit and the regional policy frameworks, and the Global Fund SADC project for mobile populations. Bilateral discussions on HIV/AIDS cross-border issues should be continued across Member States and the identity documents of mobile populations should be recognized in order to facilitate the access to healthcare services anywhere in the region. Besides, sharing best practices, mapping partnerships, providing regional medical insurance, using multi-sectoral approaches, and conducting research on HIV cross-border patients are recommended to deal with HIV cross-border issues in the region.

BACKGOUND

International traveling and economic activities are getting more convenient and common within the Southern African Development Community (SADC) region and the situation is mainly attributed to the regional socio-economic integration. Since the SADC region has more than 70% of the total number of people living with HIV and ADIS (PLHIV) in the world, the mobile populations (long distance drivers, migrant workers, etc.) have been identified as one of the most important target populations for disease prevention and care[1, 2]. Besides HIV and AIDS, other CBP health issues also draw attention for communicable disease prevention, treatment and follow-up. However there are gaps and challenges of health care structures, facilities and human resources as well as systems to easily provide HIV related services (general medical treatment, opportunistic infection prevention, ART supplies, etc.) for these cross border patients.

The difficulties of access to and provision of medical services for HIV cross-border patients affect the health of mobile and general population. Both country-level and International studies have shown evidence on how cross border patients contribute to communicable/infectious disease transmission and that it is necessary to embark on regional and international cooperation to tackle the challenges[3-5]. The European Union (EU) was the first region to establish the cross border health care policy and communicable diseases prevention policy to improve the quality of care for citizens living in the region[3, 4, 6]. The SADC region also started the malaria cross border responses in 2004[7]. The similar CBP initiative of HIV prevention and treatment has also been raised in the SADC region to mitigate the effects of the increasing economic activities and population movement.

In response to the above and in the quest for making a substantive contribution, Luke International Norway in collaboration with Mzuzu University in Malawi and Ping-Tung Chrisitan Hospital in Taiwan, organized the first international forum to discuss the HIV CBP challenges in the SADC region and the meeting was held in Zanzibar, Tanzania, in August of 2009. The participants that came from Botswana, Malawi, Mozambique, South Africa, Swaziland, Taiwan, Tanzania, and Zambia, shared the experience and identified the key HIV CBP issues during the three-day meeting. All participants presented current HIV antiretroviral therapy service programmes and preliminary findings of the CBP issues from their countries, and two major challenges were raised including policy harmonization and scarce resources. (Find 2009 Forum Full Report at http://dynamis.no/luke/medialuke/CBP_Report.pdf)

To continue the dialogue and extend the involvement of more SADC MS and regional organizations, the second forum was held in South Africa as a follow up to the Zanzibar forum.

OBJECTIVES OF THE FORUM

- To share the information and update knowledge of HIV CBP in the region.
- To link-up all relevant stakeholders and discuss on the current progress of HIV CBP.
- To discuss possible solutions and mechanisms for HIV cross border patients care and treatment, monitoring and evaluation.
- To discuss and learn from each participating Member State about possible solutions of national policy engagement toward solving the HIV CBP challenges.
- To sketch future direction and form action plan for HIV cross border patients informed by epidemiological survey, M&E health information system development, patient care and treatment guidelines.

PROGRAMME OF HIV CBP FORUM IN 2010

The forum started with the official opening by Dr Thobile Mbengashe who represented the Honourable Minister of Health, South Africa and Mr. Chin-Ray Liu. Dr. Mbengashe, the Chief Director of HIV and AIDS in the National Department of Health of the Republic of South Africa, described the importance of providing HIV related service to the mobile population and the necessity to be integrated with the national HCT campaign which was emerging as a priority intervention in South Africa. His official opening statement was followed by the remarks made by His Excellency, Mr. Liu, the Representative of Taiwanese Government. He also delivered an address on the role of Taiwan government that is ready to take the global responsibility for health improvement and assistance, including technical assistance to the CBP support to demonstrate technical cooperation with the ease and peace situation at Taiwan Strait.

Day 1: Update of HIV/AIDS Situation and CBP Related Information.

The delegations from ten MS of SADC, including Zimbabwe, Lesotho, DRC, South Africa, Malawi, Mozambique, Zambia, Tanzania, Swaziland, and Botswana, gave country presentations to share their statistical data in relation to HIV/AIDS, the national response to the epidemic, the challenges and the recommendations, as well as HIV cross-border related issues. Each presentation is summarized as below by order of presentation.

Zimbabwe

Statistical Data:

Zimbabwe is a landlocked country surrounded by Mozambique, Zambia, Botswana and RSA. With the population size about 12 millions, its estimated that in 2009 HIV prevalence of adults aged 15+ is 14.3%, young adult male aged 15-24 is 3.2%, young adult female aged 15-24 is 6.9%, and children aged 0-14 is 3.1%. By the end of 2009, there are more than 1.1million Zimbabweans living with HIV and AIDS. Among them, over 571,000 persons are in need of ART (CD4<350) and 340,000 persons are even in urgent need of it due to poorer immune function (CD4<200). However, there are only 247,201 people living with HIV currently on ART by the end of June 2010.

National Response:

The national response to HIV/AIDS has been focusing on implementing prevention strategies (including behavior change, condom programming, STI control, blood safety, PMTCT, and male circumcision), ART programme, community/home based care, and providing necessary support to people living with HIV/AIDS and to orphans and vulnerable children to mitigate influence of HIV/AIDS, as well as emphasizing M&E.

Challenge:

Rising poverty level and lacking adequate information on HIV/AIDS have been worsening the HIV transmission in the country. Mobile populations are more vulnerable to HIV/AIDS due to the long period of separation from their family and the unprotected sexual behavior with others while they are away from their spouses/partners. Besides, current ART access regulations in Zimbabwe only allow ARV users to access ART from one ART centre or its satellite sites in order to ensure efficient monitoring and compliance. However, this could increase difficulty for ART users who are away from where they normally access to treatment when they run out of ARVs.

Recommendation:

HIV prevention and care activities for mobile populations should also address their families/spouses/partners and the surrounding communities while they are in the country of origin, destination, or transition. The particular environments and conditions in the “risk zones” that grow around major corridors should be identified and the services of HIV prevention and treatment should be provided to all without discrimination. Furthermore, ARV users should be able to access ART both nationally and regionally, and an established system to ensure their medical record complete (especially ART history) should be developed.

To strengthen the quality of HIV/AIDS care and treatment, both public and private sectors have to

be involved, and accredited facilities which provide HIV care and ART should be decentralized at high volume sites. In addition, it needs to be ensured the integration of HIV/AIDS information by health professionals and the training of healthcare providers.

To uphold patients' human rights and dignity, and facilitate the allocation of resources for HIV and AIDS, especially for CBP , the advocacy and the lobbying of law enforcement for cross-border patients are indispensable.

Lesotho

Statistical Data:

The country is completely surrounded by the Republic of South Africa. HIV and AIDS estimates have been done in 2009 and the results revealed that adult prevalence has increased slightly from 23.2% to 23.6%. This is attributed to increased uptake of the ART, resulting in people living longer. It is estimated that in Lesotho there are 281,000 persons living with HIV/AIDS, and among them 260,000 are adults aged 15+ and 21,000 are children aged 0-14. Each year, there are 55,000 pregnant women in need of counseling and testing to determine their HIV status, and an estimated 13,000 need prophylaxis and treatment to prevent HIV transmission from mother to the child.

National Response:

Lesotho government has been following the "Three Ones" Principle, and has developed and operationalized the National HIV and AIDS Policy, the National Strategic Plan 2008-2011 (Revised), the National Coordination Framework, and the National Monitoring & Evaluation. The National AIDS Commission (NAC), as the coordinating body for the response, has been facilitating synergy of actions and robust support among all the players in the multi-sectoral HIV and AIDS response. In 2008 the country revised ART eligibility criteria to CD4<350. There are over 60,000 adults and children enrolled on ART, which constitutes 60% of people in need of ART.

Mobile population has been recognized as one of most vulnerable groups to HIV/AIDS transmission. The special efforts were made by the country in 2009 to source financial support for migrant populations. A proposal has been developed and approved by SADC to roll out in Oct 2010-early-2013. To scale up the response towards HIV/AIDS, key constituencies that include Public Sector, Private Sector, CSOs (Civil Society Organizations), Institutions and Districts/Communities have been engaged. Some achievements have been realized, e.g. setting-up of management and coordination structures, decentralization of the response, studies undertaken on Modes of Transmission and Key Drivers of the epidemic, Multiple Concurrent Partners and etc. The studies have clearly identified the cross-border challenges as key contributing factors for HIV and AIDS

vulnerabilities.

Challenge:

Due to the financial crisis facing the Government of Lesotho, NAC is currently unable to provide sufficient financial support/grants but still continues to provide technical support to capacity enhancement and coordination of HIV and AIDS activities in the country. However, despite the Policy and Legal Frameworks, cross-border patient services (e.g. IEC/BCC, Condom Programming, HTC and Management of STIs and Treatment, Care & Support) are limited and not well-coordinated at cross-country levels e.g. at border posts between Lesotho and South Africa. The Workplace Programmes are still at their infancy and limited to some mobile populations. For example, the Ministries of Health, Labour & Home Affairs conducted HIV/AIDS orientation and provided services only to the mineworkers. Besides, there is no comprehensive patient monitoring system for follow up of cross border patients and defaulters.

Recommendation:

The Government of Lesotho has recognized the need to scale up the HIV and AIDS response to the cross border issues and some efforts have been undertaken by different players (e.g. NAC has provided technical and financial support (grant2009/2010) to CARE Lesotho to train peer educators amongst mine workers, which will be cascaded to to fellow mine workers and communities in their catchment areas). The capacity building still needs strengthening to cover all the other cross border populations e.g. informal workers, farm workers, sex workers, truck drivers as well as students studying in the other Member States. Besides, all countries in the SADC region need to prioritize HIV cross-border issues, conduct relevant studies, and develop inter-country, inter-sectoral and inter-disciplinary approaches for strengthening collaboration and coordination in dealing with CBP..

Democratic Republic of Congo (DRC)

Statistical Data:

DRC shares borders with Zambia, Angola, Congo, Republic of Central Africa, Soudan, Uganda, Rwanda, Burundi, and Tanzania. The total population is 65.8 millions. Prevalence of HIV in the general population is 3.25% in 2009 and there are more than one million people living with HIV/AIDS. Among them 53% (608,840) are women and 10% (109,250) are children. There are 133,202 persons newly infected in 2009 and among them 55% (73,893) are women and 23% (30,521) are children. In 2007, male circumcision rate is 97.2%, and the use of condoms during casual sex is 21.7%.

National Response:

National response to HIV/AIDS in DRC includes four levels. The first level is community which involves NGOs and CBOs to provide psychosocial support, information, education and communication. The second level is Health Center and Health Reference Center with nurses, laboratory assistants, social and officer data manager to provide services of administration of ARVs, care of drug side effects, OI counseling and basic laboratory tests (ex: rapid test). The third level is General Reference Hospital with general practitioners, nurses, laboratory assistants, assistant pharmacy officer, data manager and etc. to provide services of prescription of ARVs, management of drug side effects, OI counseling and detailed laboratory tests (e.g. CD4 and diagnosis of OI). The fourth level is Central Hospital and University with specialists (internists, pediatricians, and general practitioners), nurses, laboratory assistants, pharmacists, social assistant and staff S&E to provide services of prescription of ARVs, management of rare side effects and rare OI and more detailed laboratory testing (ex: CD4, viral load, ARV resistance monitoring and etc.).

ART was introduced in 2002. Currently, there are 184 health zones integrating ART and 303 authorized facilities dispensing ART. The estimated number of patients in need of ART in 2009 is 283,055and there are 34,967 patients on ARVs based on the Ministry of Health report. Thus the percentage of patients receiving ART among those in need of the treatment in 2009 is 12.4%.

Challenge and Recommendation:

It is more difficult to follow up ARV users if they cross borders to other countries. To strengthen M&E of ART, it's necessary to develop software in the region for tracking patients, standardize indicators of M&E for data collection and national reports production. Moreover, national coverage and stakeholders training have to be consolidated.

Republic of South Africa (RSA)

Statistical Data:

RSA shares borders with Namibia, Botswana, Zimbabwe, Mozambique, Lesotho and Swaziland. It is one of the migrant receiving countries in the SADC region and the categories of migration include economic, students, refugees, asylum seekers, undocumented, double residents, and other migrants. According to the National Census & Community Survey, the size of migrant population in South Africa is 1.6 million, which makes up 3.4% of the country's population. The number of migrants from other SADC countries legally crossing border to RSA has increased five-fold in the past decade. It's claimed that there are 8-10 million undocumented migrants in the country. In terms of relevant international/regional instruments and its domestic constitution and law, RSA has

the role and responsibility to take care of migrants' health.

National Response:

The national response to HIV/AIDS covers the full range of interventions, including Prevention and Social Mobilization, PMTCT dual therapy, National HCT and ART expansion Campaign, Lay counselors, Referral system, M&E, Integrated HIV Surveillance, Cross-border patient embracing, and etc. There are some examples of HIV Cross Border Initiatives in the SADC region. The lessons learnt by RSA to manage this issue are to develop policy and guidelines for equal access to healthcare services, to provide free national ART programme, to strengthen governance of health and migration, to provide financial directive from the National Department of Health for refugees and asylum seekers, and to use 'Place-Based' approach to explore migration and health.

Challenge:

There are scarce data of HIV cross-border related issues among migrant populations that are vulnerable to HIV infection due to loneliness and disconnection from community and family, separation from families and home for extended periods, disposable income that can readily be used on sex, alcohol and drugs, accessibility and availability of sex workers (formal and informal), long waiting times for clearances in border areas, lack of information or knowledge to prevent infection, lack of accessibility for healthcare services, existing discrimination and xenophobia, vulnerability to exploitation and harassment, little legal or social protection in the host community and etc. It is recognized that female migrants are even more vulnerable to HIV/AIDS infection. However there is no adequate attention to the gender dimensions of cross-border mobility. In addition, there is unequal bargaining power to negotiate condom use by CSWs. The alternative income opportunities in the local communities are insufficient and women might be through transactional sex with migrant workers for material benefits (e.g. clothes, food).

Recommendation:

At regional level, based on the SADC Policy Framework for Population Mobility and Communication Diseases, HIV/AIDS management guidelines and cross-border health regulation in the SADC region should be harmonized and coordinated in order to facilitate mobile population access to both curative and preventive services. Besides, HIV cross-border patients' referral mechanisms, disease surveillance and epidemic preparedness should be strengthened in the region.

At national level, each country should develop and follow its National Strategic Framework for Migration, Development and Health that needs to contain strengthening health system, allocating required resource (HR, finances, drugs, equipment and etc.), providing training to healthcare providers, emphasizing preventive interventions, involving community and cross-border

population, disseminating information and education, conducting research in relation to this issue, and establishing Bilateral Agreements with neighboring countries and etc.

Malawi

Statistical Data:

Malawi is surrounded by Tanzania, Mozambique, and Zambia. There are 13.06 million people in Malawi. The national prevalence of HIV in adults aged 15-49 is 12%. There are about 1 million people living with HIV/AIDS and 384,000 persons in need of ART. Approximately, there are 700,000 orphans whose parents died of AIDS. HIV transmission in the country is mainly due to unsafe heterosexual sex, and mother to child transmission. It is averaged that 1.6 % adults become HIV newly infected annually. High risk groups include sex workers, police, teachers, fish vendors, and MSM.

National Response:

According to the National HIV and AIDS Action Framework (NAF), the objectives of national response focus on prevention and behavior changes, treatment and support, impact mitigation, mainstreaming and decentralization, research and M&E, resource mobilization and utilization, as well as policy and partnerships. Currently, HIV M&E system is growing bigger than the general HMIS (Hospital Management Information System) in the Ministry of Health.

Malawi has a free public health service that allows all to get free service including ART. The number of facilities that provide ART has increased from 9 in 2003 to 377 in 2009, and those along the borders provide services to all attendees including cross border patients. The data has shown that there are 289,388 patients that ever initiated ART by March, 2010 and 73% of them are alive and still on treatment, 27% are lost in ART program because of death (12%), default (15%) and stopped treatment (around 1%). 1.6 million people have done HTC in 2009 and among which, 2/3 are women.

Challenge and Recommendation:

There are insufficient human resources to support the scale-up and the adoption of the new WHO ART / PMTCT Guidelines. It will need more inputs including HR and drugs. In addition, there is also a need to determine contribution of HIV cross-border patients in the service target populations; and it should be discussed on how to capture their data easily (e.g. using National ID System).

Mozambique

Statistical Data:

Mozambique shares borders with Tanzania, Malawi, Zambia, Zimbabwe, Swaziland and South Africa. The population size is 20 million. 70% inhabitants live in rural areas and 30% live in urban areas. According to the preliminary analysis of the Demographic Community-Based Survey (INSIDA) in Mozambique, the prevalence of HIV among Mozambican adults aged 15-49 is 11.5%. If consider the areas where these people dwell, it is 15.9% in urban areas and 9.2% in rural areas. Regarding to the awareness of HIV/AIDS, 98% of women and 99% of men aged 15-49 heard of HIV/AIDS. The data also revealed that knowledge of prevention from HIV infection has improved. 71% of women aged 15-49 said that using a condom and 73% of which said that restricting to a single uninfected partner, can prevent HIV infection. Although knowledge has improved, only 1⁄3 of the adult population had comprehensive knowledge about the epidemic. 25% of young adults aged 15-24 reported that they have had sex by the age of 15; and 9% of girls and 15% of boys aged 12-14 reported that they have had sex.

The data from the survey (INSIDA) will be analyzed further to update demographic impacts of HIV/AIDS and to achieve better understanding of the relationship between the prevalence and behavioral factors.

National ART Program:

The number of primary level facility that offers ART has obviously increased since 2006. There are 194,096 patients on ART by the time June 2010. Each district has an informatic system of registration to collect data in relation to ART program, such as dropout, death, new patient on treatment and etc. At provincial and district level, HIV-QUAL program is used to provide information about medical tests, therapy and adherence, cotrimoxazole prophylaxis and TB screening.

Challenge:

There is an increase of the number of ART dropouts and poor adherence to treatment/testing due to long distances of travelling for treatment and fear of stigma and discrimination. Besides, the inclusion of children in pediatric ART is weak and the awareness of communities on the pediatric ART is still low.

Recommendation:

It is recommended that to involve private sectors and community authorities in order to ensure the dissemination of HIV information and to maximize the success of national responses to

HIV/AIDS.

The border provinces of Mozambique have implemented meetings with their neighboring countries to establish Memorandums of Understanding (MOU) in relation to HIV cross-border issues. It is important to improve methods of exchanging information in regards to diseases and to accelerate actions for control and prevention of epidemics between countries. More efforts have to be made in order to facilitate the movement of patients crossing the borders and to establish better mechanism for patients' follow-up (e.g. creating a specific way of patient registration in order to secure a correct flow of HIV patients' information between countries, creating a reference guide in Portuguese and English, and defining the changes from one to another therapeutic line when HIV cross-border patients receive treatment in other countries).

Zambia

Statistical Data:

HIV prevalence among the total population in Zambia is 16-14%. There are 1,063,309 Zambian living with HIV/AIDS. Drivers of the adult epidemic in Zambia are due to multiple concurrent partnerships, low and inconsistent condom use, low rates of male circumcision, mobility and labour migration, vulnerability and marginalization and cross-cutting issues. The neighbouring countries are DRC, Tanzania, Malawi, Mozambique, Zimbabwe, Botswana, Namibia and Angola.

National Response:

National ART program which provides ARVs free of charge has started since 2005. The number of ART service centres for both private and public sectors in all 72 districts has increased from 62 in 2005 to 316 by March 2009. There are 1,356 VCT sites established countrywide and 12,000 professional health providers and 166 community counsellors have been trained in counselling skills; 265 professional health providers and 166 community counsellors have been trained in rapid HIV finger prick testing. Besides, PMTCT programme and the Home Based Care (HBC) minimum standard guideline had been developed to provide guidance to all HBC service providers.

Some success has been achieved, e.g. stigma reduction and other positive changes identified at individual and community level, Disability Peoples Organizations and other vulnerable groups now addressing HIV/AIDS and S&D(Stigma and Discrimination), increased interfaith dialogue-ZINGO-leading to more open discussion of HIV, S&D and gender issues, and increased number of Positive Living Support Groups.

In order to deal with HIV cross-border issues, the guidance is provided by the NAC and there are

SADC GF proposal to cater for and CSO's advocacy for mobile population (e.g. The Cross Boarder Traders Association of Zambia and The Truck Drivers Association of Zambia). To prevent HIV transmission, information on prevention of HIV is provided by CSO (such as COH) to people passing through the Zambian borders, and information on the key drivers of the HIV have been shared with stakeholders in the HIV and AIDS sector and those working in border areas. The efforts have been made to increase the awareness of HIV/AIDS among those long distance truck drivers and commercial sex workers. Condoms in public health facilities are free to all people. Moreover, SFH(Society for Family Health) provides condoms at an affordable price at all the entry border points.

Challenge:

In Zambia, ARVs will be only provided to patients with treatment record and this might stop many HIV cross-border patients from access to ART. Besides, different ART regimens in the SADC region, language barriers between countries, and inadequate finances to pay for ARVs in the countries where free ART is not provided to non-nationals will also increase difficulties for them to seek for treatment and healthcare. For some specific mobile people, such as International LDTDs, their long period of stay at border towns, far away from their homes/spouses, and alcohol consumption will raise chances of engaging in risky sexual behavior.

Recommendation:

Prevention of HIV infection is cheaper than treatment, thus it is necessary to intensify prevention strategies, such as awareness, MC, condom use and etc. Successful mainstreaming of HIV and AIDS will benefit to increase HIV and AIDS awareness and contribute to reduction of stigma and discrimination. To identify drivers of the HIV epidemic and to facilitate the prioritization of HIV and AIDS programming, establishing strong M&E system is important. For HIV cross-border patients, establishment of Smart Care Card system across the SADC region will enable them access to ART anywhere and anytime. In addition, securing buy-in from many stakeholders and political leadership will facilitate effective implementation of HIV and AIDS programmes. To ensure programme successful, it is indispensable to improve evidence-based programme design, to scaling-up and make sure predictable financing for effective and appropriately targeted programmes, to implement programmes sustainably to excellent quality and equity including the needs of mobile populations, and to conduct impact assessment of national HIV and AIDS policies and programmes.

Tanzania

Statistical Data:

Tanzania shares borders with Burundi, DR Congo, Kenya, Malawi, Rwanda, Uganda and Zambia. Its population size is 40 million and HIV prevalence is 5.7 % based on the Population Based Survey in 2007-2008.

National Response:

The national response to HIV/AIDS include prevention (BCC, peer education, condom use and etc.), care and treatment (STIs, HCT, referral and etc), community systems strengthening and regional harmonization (policies, protocols for prevention, treatment and mitigation) & cross-cutting issues (gender, MARPs).In addition to government and international development partners, there has been greater involvement of CSOs (NGOs, CBOs and FBOs). People living with HIV/AIDS are also involved in the national response, especially in advocacy and reduction of stigma and discrimination. PMTCT programs have been extended to all districts and have covered more than 600 health facilities. Supports provided to orphans, MVCs (Most Vulnerable Children) and other vulnerable groups have also increased. The number of patients on ART is over 272,000.

Challenge:

Prevention efforts do not sufficiently address sexual and reproductive health matters and often lack continuity in far-to-reach areas and access to ART in the rural areas is still difficult. Some important issues (such as gender inequality, stigma, and discrimination) are not sufficiently addressed and resources (HR, finance, and materials/equipments) are insufficient. Besides, population mobility increases the challenges of HIV/AIDS control and prevention.

Recommendation:

It's important to coordinate all the stakeholders working on the national response to HIV/AIDS. Conducting baseline study for cross-border population (e.g. miners, truckers, traders) and surrounding communities on behavior change, attitudes, knowledge and care treatment is necessary. Moreover, regional M&E systems/tools need to be harmonized in order to routinely monitor and disseminate data generated through service delivery points at the selected border sites.

Swaziland

Statistical Data:

Swaziland is surrounded by Republic of South Africa and Mozambique. The population size is 1.1 million according to the 2007 Census. HIV prevalence of total population in 2007 is 19%. According to the ANC sentinel surveillance in 2008, HIV prevalence is 42%. 26% of people living with HIV/AIDS are in the 15-49yrs age group, and if stratified by sex, women aged 15-24yrs and men aged 30-39yrs have higher prevalence.

National ART Program:

The national ART program in Swaziland started since 2003 and there are about 46,883 people on ART in March 2010. The initiation of ART is under new WHO treatment guidelines, which is CD4<350 or WHO stage III and IV. ART is offered free of charge to all eligible patients, regardless of nationality. 3 months ARVs supply is able to be prescribed to stable patients who have been on ART for more than one year and have demonstrated good adherence to treatment. Laboratory services such as FBC (Full Blood Count), LFTs (Liver Function Tests), RFTs (Renal Function Tests), CD4, VL(Viral Load) are also offered free for people living with HIV/AIDS. Treatment of most OIs requires payment of the hospital fee (~USD 1) or the community clinic levy (~1⁄4 of USD). To ensure M&E, indicators are tracked and data are captured by manual and electronic for both pre-ART and ART registers. Each patient has an appointment booklet and unique identifier (Pre-ART and ART number). Including PIN (Personal Identification Number) from national IDs is a plan in the near future.

Challenge:

Mobile population has been facing some challenges on HIV/AIDS control and prevention, which are divided into five dimensions. First of all, the national policies and ARV initiation guidelines in relation to HIV cross-border patients in the SADC region are not harmonized and the size of which on treatment is still unknown, thus clients started on ART in Swaziland may not be able to refill in some countries in the SADC region. Second of all, cross-border patients may not be able to get treatment or adherence to treatment in other country due to socio-cultural barriers (e.g. fear of xenophobic attacks, healthcare providers unwilling to provide services to non-nationals, and etc.), language barrier, lack of understanding of different country protocols and procedures, and etc. Third of all, monitoring and follow-up of HIV cross-border patents is a problem because their movements may cause missing appointments and lead to difficulty in monitoring treatment outcome. Fourth of all, drug stock management will be difficult due to increased number of visitors from other countries and ART regimens difference between countries. Fifth of all, data management is a problem since there is no recognized referral system/tool in place between

countries and documentation of treatment is poor, which leading to all the data counting on patients' self-report.

Recommendation:

It is necessary to develop SADC countries' referral tools and have regular meetings of countries sharing borders on discussion of cross-border patients, such as treatment protocols and cross-border related policies. ARV treatment protocols and national policies should be harmonized in order to make sure all has free access to treatment in the SADC region.

Botswana

Statistical Data:

Botswana is surrounded by RSA, Namibia, Zambia, and Zimbabwe. A MOU has been signed with Namibia to improve Public Health in areas of HIV/AIDS, STI, Malaria and TB. The total population in Botswana is 1.7 millions according to the 2001 Census. HIV prevalence in the general population is 17.6%, and there are 300,000-350,000 persons living with HIV/AIDS in 2010. There is a decline in HIV prevalence among 15-24 years age group from 12.6% in 2004 to 8% in 2008. 56% of the population have known of their HIV status compared to only 25.4% in 2004.

National ART Program:

MASA (Setswana for "new dawn"), the government's national ARV therapy program, started since 2002 and its goal is to provide free-of charge ART to all eligible citizens, non-citizen spouses of citizens, and their children. There are 32 ART sites and 178 satellite clinics dispensing ARVs throughout the country by the end of May 2010. The total number of persons on ART from 2002 to May 2010 is 150,033 which is over 90% of the eligible HIV infected persons access to ART and their adherence rate are good. To ensure MASA M&E System, paper-based data collection tools are used countrywide and electronic data systems with standardized indicators of patient record are also established in order to increase potential of dada analyses and data incorporation.

Challenge and Recommendation:

To prevent HIV/AIDS transmission, only HIV knowledge is not guaranteed to desired behavior change. Although HIV testing coverage is improved, there are still many people without awareness of their HIV status. Besides, HIV/AIDS programs integration, referral system, and supply chain management are still weak and capacity constraints (HR, skills, infrastructure etc.) have to be solved. About M&E, there are insufficient IT in the districts and health professionals have no basic IT training.

Day 2: HIV/AIDS Cross-Border Issues and Group Discussion

During the day-2 session, Dr. Vitalis Goodwill Chipfakacha, the representative from the SADC Secretariat shared the current status of economic development in the region and its relationship to the communicable diseases transmission and prevention and the draft policy framework for CBP challenges. Ms. Sikulile Ngqase, the representative from the International Organization for Migration (IOM), shared the current status of mobile groups and migrants in the SADC region regarding to their health needs and human rights toward accessing services without discrimination. Dr. Mubiala Nicodeme, the HIV programme supervisor of Malawi Northern Health Zone, shared the field experiences of challenges of mobility for ART follow-up and monitoring and the possible consequences of ARV drug resistance. Mr. Clement Mtika, the coordinator of Rainbow Clinic of Mzuzu Central Hospital in Malawi presented the preliminary result of ART cross border patient pilot survey in Malawi. Dr. Joseph Yu, acting superintendent of Pingtung Christian Hospital (PTCH) and international director of Luke International Norway (LIN), shared the experiences of ART electronic data system (EDS) in Malawi. Mr. Johnson Huang, software development consultant of Luke International Norway, presented the experience of developing user-friendly health information system (HIS) to assist follow-up and data management of HIV patients on ART in Malawi. Each speaker's talk is summarized as follows.

Mainstreaming HIV into Free Trade Agreement and Its Subsequent Migration Patterns

The Southern African Development Community (SADC) is one of the Regional Economic Communities in Africa recognized by the African Union, that group together individual countries in sub-regions for the purpose of achieving greater economic development and integration. There are 15 Member States of SADC and they are Angola, Botswana, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. SADC has launched the Free Trade Agreement in order to ease goods and services flow without tariffs or government imposed restrictions, free movement of labour, free access to markets, and free movement of capital between and within countries. However, some impacts follow the Free Trade Agreement, such as cheap imports, seasonal migratory workers, increasing cash crop production, decreasing food self-sufficiency, loss of land and Dutch disease* etc., that might contribute to incremental vulnerabilities and risks of food insecurity, decreased adherence to ART, drug scene, gender disparity, and increased poverty. Eventually, the poverty and landlessness attributed to Free Trade Agreement cause the increment of internal and external migration and growing pressure on health service system of countries in the region.

* In economics, the Dutch disease is a concept that purportedly explains the apparent relationship between the increase in exploitation of natural resources and a decline in the manufacturing sector. (From http://en.wikipedia.org/wiki/Dutch_disease)

Thus, the mainstreaming of HIV and AIDS in the SADC region is to understand the impact of development efforts on the epidemic and the impact of the epidemic on development, to place the response to HIV and AIDS in the core agenda of all sectors (the public, NGO and the private) of all SADC Member States, to use the comparative advantage of different stakeholders to put in place strategies and programmes to address the epidemic, as well as to recognize the complementarity amongst stakeholders and their mandates in order to prevent duplication and ensure optimal utilization of resources. The issues of gender disparity, human rights, poverty, and environment exploitation have to be put into consideration simultaneously while mainstreaming HIV and AIDS into economic development. Trade and industry departments, ministries' policy review, customs and immigration, national revenue services, transport sector, ministries for health, donors (bi-multi-laterals), and border inhabitants should be involved into mainstreamed responses.

SADC Draft Policy Framework for Population Mobility and Communicable Diseases

The SADC draft policy framework for population mobility and communicable diseases aimed at policy makers, programme managers and other stakeholders dealing with mobile people, provides them regional guidance to protect mobile people's health and to control communicable diseases in the face of population mobility in the SADC region, complements the ongoing work on general policy harmonization in the region, and augments existing policies and strategies on specific diseases for all the SADC Member States. Therefore, it should be generally applicable to all communicable diseases and have to cover all the cross-border movement without discrimination, no matter whether migrants are legal or undocumented, and regardless of duration of stay at their destination as well.

The policy framework has addressed the current issues and suggested principles of guidance on policy harmonization and coordination, universal access to health care services, surveillance and M&E and epidemic preparedness, and community involvement and health promotion, as well as operations research and strategic information.

The guiding principles of policy harmonization and coordination are that diseases management guidelines and treatment regimens should be harmonized across borders, formal cross-border referral services and mechanisms for continuity of care for chronic communicable diseases should be established, health facilities utilization along common borders by both sides should be formalized, and joint programmes of action for communicable disease control along common borders should share harmonized strategies and control activities.

Although the universal access to care is pledged, there are still huge barriers of accessibility for non-citizens. Thus, the guiding principles of universal access to health care services in the

framework are to allow all the SADC nationals access to healthcare services in the public sectors, to re-supply drugs in the public sectors for chronic communicable diseases (such as AIDS and TB), to prioritize mobile population groups and to establish a regional mechanism to finance the control of communicable diseases among cross-border mobile people, and to keep health systems up to standard to minimize movement in search of treatment. Besides, preventive service has been highlighted as the cornerstone of all communicable disease control efforts in the guiding principles, and environmental and structural issues leading to the vulnerability of mobile population, such as poor living and working conditions, unsupportive laws and regulations, and gender disparity, have been addressed.

The guiding principles for surveillance and M&E and epidemic preparedness are to harmonize case definitions and notification systems, to define regional mechanisms for monitoring communicable diseases threats with a clearly identified lead organization, to update regional health emergency and epidemic preparedness and response plan regularly, and to harmonize Port Health Services in line with International Health Regulations. For community involvement and health promotion, the guiding principles emphasize that mobile people and destination communities should be involved, adequate information on communicable diseases and preventive means should be provided, languages used should be appropriate to the target groups, and messages should be consistent across borders. For operations research and strategic information, the guiding principles are to share good practices across Member States, to scale up pilots in the region, and to conduct more research on vulnerabilities of mobile people and priority groups.

Besides, additional guiding principles for Malaria, TB, and HIV and AIDS have been addressed individually; and the translation of policies into practice should be monitored at different levels by various stakeholders, which are SADC Ministers of Health, SADC Secretariat, Member States' Health Ministries, WHO, UNHCR, INAIDS, IOM, NGOs, CSOs, bilateral donors and etc.

Healthy Migrants in Healthy Communities

International Organization for Migration (IOM) is an intergovernmental organization established in 1951 and its vision on migration health is that migrants and mobile populations benefit from improved standard of physical, mental, and social well-being, which enables them to substantially contribute towards the social and economic development of their communities and host societies. Labour migrants, irregular migrants (including undocumented migrants) and displaced persons affected by conflict or natural disasters are three main categories of mobile groups in the SADC region. Migrants and mobile populations are more vulnerable to ill health and many factors affect their well-being during the migration process. Thus public health strategies have to ensure

migrants' health rights, to reduce excess mortality and morbidity, to minimize negative impact of the migration process, and to avoid disparities in health status and access to healthcare services. Moreover, the issue of migration health goes beyond management of diseases. It is indispensable for involving broader social determinants, such as housing, education, occupational health, nutrition, food security, water and sanitation. Multi-sectoral approaches need to be used to address the health needs of migrants.

In 2010, IOM's Regional Office for Southern Africa, in partnership with the Swedish International Development Cooperation Agency and the Norwegian Ministry of Foreign Affairs, has launched expanded HIV Prevention and Health Promotion Programme for Migrants and Mobile Populations in Eastern and Southern Africa. The revised programme, renamed "PHAMESA (Partnership on HIV and Mobility in Eastern and Southern Africa)" carries forward lessons learnt from the successful implementation of the PHAMSA (Partnership on HIV and Mobility in Southern Africa) Programme since 2004 and include broader migration health issues to assist countries in Eastern and Southern Africa to address the vulnerability of mobile populations to health risks including HIV throughout all phases of the migration process, and to respond to the health needs of migrants, as well as the public health needs of host communities through service delivery and capacity building, advocacy for policy, development research and information dissemination, regional coordination, and PHAMESA governance and control. Labour migrants, forced migrants and irregular migrants have been targeted by the programme.

An IOM study of regional assessment conducted in 2009 has found that migrant workers in Southern Africa have relatively inadequate access to HIV prevention and treatment services although they are more vulnerable to the infection. One of the regional gaps and challenges is that transport workers, informal cross-border traders and other mobile populations have long waiting time at the border posts. There is a lack of regional coordination and harmonization on HIV prevention and ART programmes in the SADC region. Besides, epidemiological data of mobile populations in the region is still lacking in, especially those 'hidden migrants' such as undocumented migrants, that are difficult to reach because of their preferred invisibility.

Regional recommendations are to develop and implement regional advocacy and communications campaign targeting government, service providers, employers and migrants on migrants' right to health; to implement regional programme targeted at government officials that directly interact with migrants to improve their understanding of migrants' right to health; to conduct comparative research of sero-prevalence, behavior and knowledge of HIV status, and sexual networks, as well as socio-economic indicators in spaces of vulnerability in migrant sending, transit and receiving areas. In short, the most effective intervention that will ultimately reduce HIV vulnerability of migrant workers & mobile populations is to develop projects and programmes that target "spaces of vulnerability" as opposed to "persons of vulnerability", and this approach is in line with both a human rights and a public health-based approach to the health of migrants and the communities

they interact with.

Challenges of Mobility for ART Follow-up and Monitoring and the Possible Consequences of ARV Drug Resistance

Although there is a long-term recognition of the relationship between migration and vulnerability to HIV infection, access to ART for migrants remains largely unrealized. A rational public health strategy toward HIV and AIDS prevention and treatment should not discriminate against non-citizens or migrants in provision of ART because denying such treatment to them will frustrate efforts toward controlling HIV epidemic. From the perspective of adequately caring for those already infected interruptions in HIV treatment can lead to illness, development of drug resistance and even death, as well as an increase of social welfare costs and deterioration of economic development.

In Malawi, HIV patients should be followed up in two weeks after initiating ART, and then in a monthly basis until six months. After six months, review visits can be increased to once every two months if stable and adherent. Patients' general health, ART side effects, and drugs adherence should be assessed and monitored while their visits. Taking the right dose of ARVs on a regular basis is important to block HIV replication and to prevent the virus from mutation. Accumulated missed doses of medications could allow the virus to replicate again and lead to drug resistance mutations. Because drug resistance mutations often decrease the activity of many ARV agents within an individual class, the emergence of a single major resistance mutation can have important effects on a patient's response to multiple ARV agents.

Cross-border HIV patients are allowed to get 6 months drugs supply in Malawi when stable although there is no guideline on mobile people with HIV. They usually visit once a year and this compromise the follow-up and monitoring with higher chance of non-compliance of treatment and development of drug resistance. Thus, follow-up and monitoring of ART users that are from mobile groups is comparatively more difficult. It is recommended that citizenship-based discrimination in the provision of ART must be eliminated among all the SADC Member States, and migrant-friendly services and M&E mechanisms should be created in the region.

HIV ART Patients' Cross-Border Survey: A Pilot Study in the Mzuzu Central Hospital, Malawi

To explore ART users' experiences in relation to crossing borders, a survey which was funded by Ping-Tung Christian Hospital, Taiwan had been conducted in the Mzuzu Central Hospital, Malawi. With an expected sample size of 800, all the ART users visiting Rainbow Clinic in the Mzuzu Central

Hospital during the period of survey from the 8th July to the 3rd August 2010 were enrolled into the study after obtaining their oral consent to respond to interviewers. A self designed survey tool was used to collect data and descriptive and differential statistics were used for data analysis. To protect patients' privacy and confidentiality, all the data were collected anonymously. This study had been approved by Malawian Research Ethics Committee before implementation.

There are actually 799 ART users recruited for data analysis and 63.5% of them are females. Their average age is 34.6, average age of starting ART is 31.8, and average time of having been on ART is 2.8 years. There are 11 non- Malawian respondents that come from other countries, which are Tanzania (8), RSA (1), Zambia (1), and Zimbabwe (1). Among them, 8 persons came to Malawi for work and 3 are residents here. There are 100 Malawian respondents that will go abroad to other countries, which are mainly to Tanzania, RSA, Zambia, Zimbabwe, Mozambique, and etc. Among them, 62 persons go abroad for work, 25 for travel, 2 for study, and 9 are residents there. Besides, 81% of whom will go abroad with ART and 19% without ART; 59% of whom reported that they will stay abroad longer than 3 months; and 87% of whom reported that they can't get ARVs supply abroad.

Stratified analysis and chi-square tests are performed to examine the impact of gender (male, female), current age (35 years old and less, older than 35 years old), and age of starting ART (35 years old and less, older than 35 years old) on respondents' cross-border behaviour. The results showed that there is no statistically significant difference while stratified by gender or by age of starting ART. However, respondents aged older than 35 have higher prevalence rate of having cross-border behaviour ($p<0.05$). To examine the impact of cross-border behaviour on default experience and drug compliance, whether having default experience and whether having drug compliance of $\geqq$95% adherence rate since last visit have been stratified by cross-border behaviour. The results showed that respondents who have cross-border behaviour have higher prevalence rate of having default experience ($p<0.05$), and have lower prevalence rate of having good drug compliance ($\geqq$95% adherence rate) since last visit ($p<0.05$).

One of the limitations in this study is lack of looking at respondents' cross-border experience in the past; and all the data collected are from respondents' self-report, which means that there is a chance of hiding true home country if they are undocumented. However, the study results indicated that there is significant relationship between cross-border behaviour and default experience and drug compliance. Thus, it is recommended that harmonized policies in the SADC region should be developed in order to allow all the HIV patients (no matter of their nationality) access to ART anywhere in the region. Besides, a standardized survey tool in relation to HIV cross-border issues and ARVs resistance surveillance should be developed in order to expand the study nationwide and even in the whole SADC region.

Experience of ART Electronic Data System (EDS) in Malawi

Malawi launched the national ART scale up program since 2004 and the Rainbow clinic in the Mzuzu central hospital (MCH) was the largest ART service deliver site in the northern region of Malawi. By the end of March 2010, 211,246 patients were alive and on ART, equivalent to 55% coverage of the estimated 383,897 population in need of ART in Malawi. Among the 371 ART deliver sites, there are 11 sites with more than 5,000 registered clients and manual supervision is becoming a challenge with teams taking 2 days to supervise one site. (MoH, Malawi) During this rapid expansion phase, the MoH recognized the importance of maintaining complete and accurate patient data for individual clinical care and for monitoring and evaluation purposes.

Recognizing the limited scalability and supervision difficulty of the paper-based monitoring system, the MoH has decided to invest in the development of Electronic Data Systems (EDS) for ART. A task force for the development of an EDS for ART was formed under the leadership of the Department for HIV and AIDS in the MOH. The task force was charged with the creation of an electronic system that would support rapid expansion of the ART program and that would work within the constraints of Malawi's public health services. This task force gathered key stakeholders together, developed specifications, and facilitated a pilot of the ART EDS system. The Task Force included representatives from:

- The Department for HIV and AIDS in the Ministry of Health chairs the EDS
- Central Monitoring and Evaluation Division of MoH (CMED)
- The US Centers for Disease Control and Prevention (CDC)
- Baobab Health Trust (BHT)
- Luke International Norway (LIN)
- National AIDS Commission (NAC)
- National Health Information System (NHIS)
- The World Health Organization (WHO)
- Médecins Sans Frontières (MSF)
- Dignitas International
- Lighthouse Trust

- Clinical and management staff from key ART providers and IT system developers

The larger role of the EDS task force, chaired by the MoH, will be primarily to discuss and agree on important strategic decisions (like site selection, data management issues, etc.) prior to implementation. Secondly, to meet regularly with relevant stakeholders and partners to update on status of the national roll-out.

With the support from US-CDC, the MoH of Malawi had conducted an EDS pilot project with 4 district hospitals (Nkhata Bay, Rumphi, Dedza, and Salima) in 2007 and gain the valuable experiences for the system roll-out. There are some benefits for applying EDS include accuracy and completeness of data, better timeliness of data, reduce the burden of manually monitoring and evaluation and improved patient care quality. The EDS can assist service provider to avoid data entry error, easily calculate the body-mass index (BMI), and accurately determine pill-count and adherence levels to support adequate decisions for patient management. The next appointments date for client is scheduled reliably by the system, taking account of the exact amount of ARVs available and possible clinic days.

There were some lessons learned from the EDS project in Malawi. Similar to all kind of health projects in the SADC region, the ownership of the system and program has been a challenged which may reduce the accessibility of the system. This can best be achieved by instilling a sense of ownership of the system at each facility. It is crucial that the local heath authority and staff at the site fully adopt the system as the MoH system. Other lessons learned include suggesting appoint a local EDS point persons, maintaining paper forms and EDS at same time, provide training before deployment and regular re-training, provide software customization for individual sites which may need further functions, client confidentiality, system interoperability for client transfer and long term vision for the EDS development in the country. Considering the needs of client movement within the country and cross the borders, the EDS taskforce in Malawi already adopted the international health data standard for ART patient message, health level 7 (HL7), to be able to exchange medical records between different systems.

The electronic data system has now been rolled out to 13 sites and a further 5 sites are planned for 2010 in Malawi. LIN and BHT are the major implementation partners with the MoH of Malawi.

Establishment of User-Friendly Hospital Information System for Data Management of HIV/AIDS Patients in Malawi

Health informatics (also called health care informatics, healthcare informatics, medical informatics

or biomedical informatics) is a discipline at the intersection of information science, computer science, and health care. It deals with the resources, devices, and methods required to optimize the acquisition, storage, retrieval, and use of information in health and biomedicine. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems. It is applied to the areas of nursing, clinical care, dentistry, pharmacy, public health and biomedical research.

Study showed that information technologies (IT) can assist hospital and health care services to reduce frequency of medication error and improve the quality of care[8-11]. However these technologies can not benefit the health system in Africa without tackling the challenges of strengthen fundamental infrastructure, sustainability, easy use interface, high turnover rate of HCWs, and computer literacy[12-15].

When the Pingtung Christian Hospital (PTCH) assisted the Taiwan Medical Mission (TMM) and National AIDS Commission (NAC) to setup the Rainbow clinic in MCH in 2004, the electronic data system had been considered and established to be able to manage the increasing number of ART clients. The Rainbow electronic data system (REDS) was designed with pharmaceutical inventory system, laboratory information system and various clinic management reports with both networking and single use workstation version. The most important function is the fingerprint identification for ART clients which may be implemented for the countries without national identity[16]. Following the guidance and standard from the national EDS taskforce in Malawi, the PTCH EDS development team worked with TMM, MoH and US-CDC to conduct pilot project in Nkhata bay and Rumphi district hospital in 2007. The Taiwan Electronic System for Management of ART (TESMART) was invented with user-friendly interface with easy and sizable touch-screen icons, logic guided process, and validation sensor. Each patient will visit the registry, vital data assessment and drug dispensary units. Through the data collected from time log of patient flow, each patient consumed about 10 minutes to complete the visitation. The patient and information flow was shown as the figure 1.

Considering the challenges of managing ART CBP in the SADC region, it will be worthwhile to invest the information technology at various levels of the health systems. The fingerprint identification system (FPIS) integrated with the HL7 patient transfer message standard and national data warehouse can be very useful to provide cross country ART service deliver and patient management. It can be further developed and integrated for HIV drug resistance and emerging infectious diseases (EID) surveillance purposes.

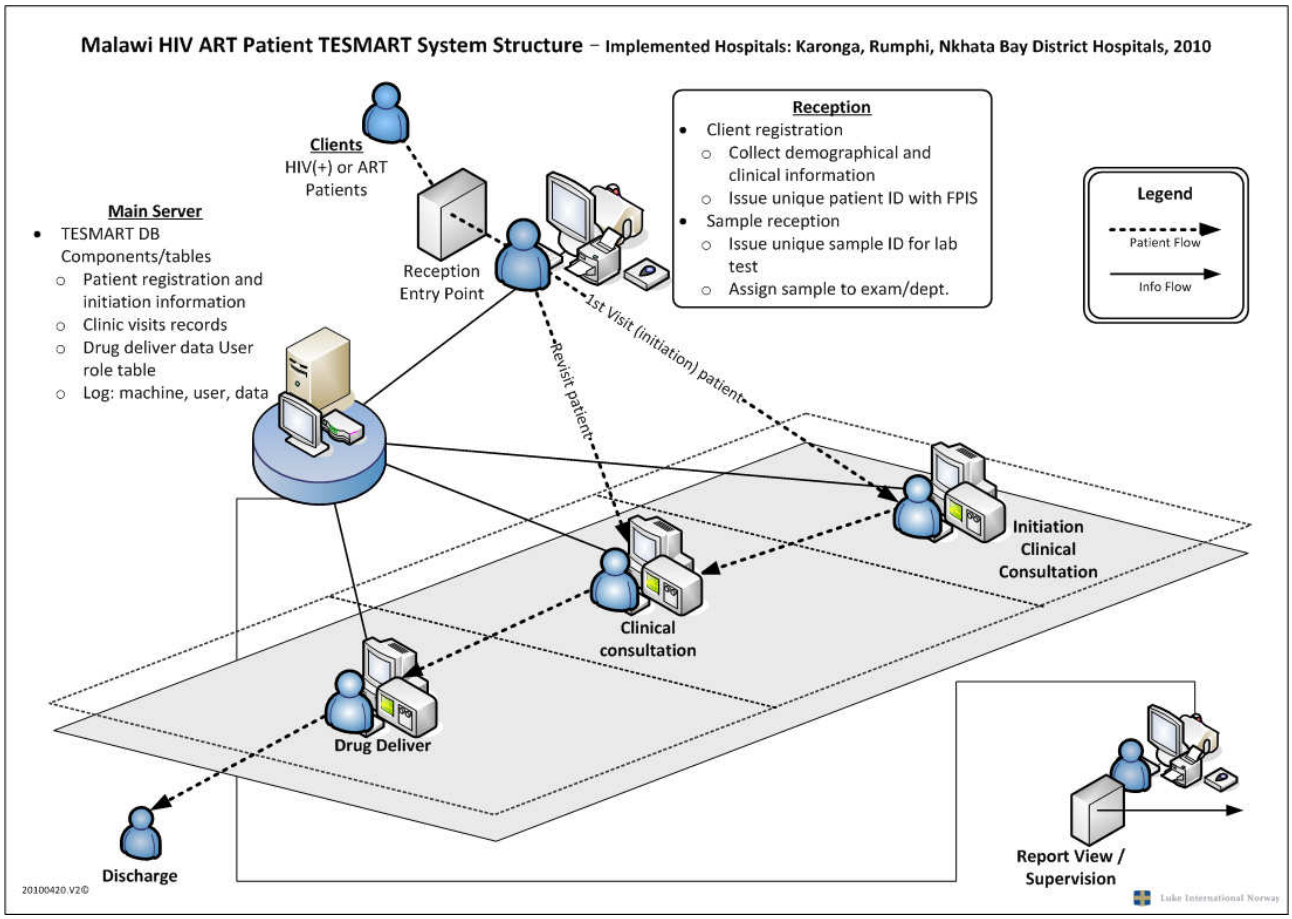

Figure 1. The patient and information flow of TESMART system for ART clinic in Malawi.

Group Discussion of CBP Challenges

The following is the results of group discussion on four topics of important issues regarding to cross-border patients' challenges.

1. Define the cross border patients

Cross-border patients are mobile persons crossing country borders and may require health related services at any given time. The reasons for crossing borders are work (such as seasonal workers, informal cross-border traders, long distance truck drivers, commercial sex workers, temporary workers not covered by medical insurance, contractors and etc.), for seeking healthcare services in other countries (due to reasons of accessibility, availability and affordability of services, as well as stigma), and for asylum (e.g. refugees).

2. How to improve the HIV ART CBP survey tool for further implementation

During the discussion session, the group discovered that the HIV ART CBP survey tool will be useful with adoptive modification to fulfill each country's needs. The group suggested adding the country of residency to increase the specificity and usefulness of the survey. The definition of type 1 and type 2 CBP should be clearly defined in the instruction page. Since each country has different research approval protocol and review system. It is necessary for each country to have one professional to be in charge of the application of CBP survey. The forum research committee was formed with the input from Zimbabwe, Malawi and Taiwan. The committee will try to search the funding opportunity and tuning the overall research protocol for HIV ART CBP survey.

3. Possibility of introducing smart card system within the SADC region for CBP

Introducing smart card system within the SADC region requires allocating budget (financial support), human resources (e.g. IT specialists, data clerks, and specialists for capacity building and for inter-country coordination), logistics (e.g. electricity/power, computers, software, networks, smart cards, card scanner, security, and contracts with reputable suppliers), M&E System (e.g. recognized indicators for M&E), coordination and sensitization workshops (including of facility, national, and regional) and standardized protocols. The possible challenges are political buy-in-nationally and inter country budget and resource constraints, reputable suppliers for quality software and logistics, standardization of the card and M&E system by Member States, system breakdown and maintenance, supply chain disruptions, unstable power supply or power cuts and etc.

4. How to coordinate cross-border referral services and mechanisms for continuity of care for patients with HIV

Five steps are suggested to coordinate regional referral services and mechanisms for continuous care of HIV cross-border patients in the SADC region.

Step 1 is to do a situation analysis to understand impediments to referral system, ART regimen differences, ways of countries recording patients' details, and national policy on accessibility.

Step 2 is to identify gaps and similarities across Member States in the region.

Step 3 is to develop SADC operating framework in order to harmonize M&E requirements of baseline, milestones and targets regarding to indicators, standardized data collection tools, policies and guidelines, as well as capacity building in the region.

Step 4 is advocacy and resource mobilization.

Step 5 is implementation and M&E

All the steps should be consultative.

Day 3: Future Direction for HIV/AIDS Cross-Border Issues

The main task for day-3 was to discuss and generate the practical action plan for CBP related program. Participants went on group work and generated the following recommendations that are summarized as below.

The Southern Africa Region has a high HIV prevalence in the region, with a decline in HIV prevalence in some countries. Mobile populations, such as long distance truck drivers, informal cross-border traders, seasonal workers, mining workers, irregular migrants and etc., have been recognized as one of the most vulnerable groups to HIV transmission. There are augmented challenges due to migration and patient mobility, which might increase the difficulties of follow-up, seeking for treatment and healthcare, and accessible information on HIV prevention and control. However, the healthcare services are usually not accessible to most of the mobile population, especially undocumented and illegal migrants. Women are still the most affected, but a lot of HIV programmes disregard the issue of gender disparity. In addition, HIV and AIDS prevention and control services across borders are not harmonized. There is lack of data on HIV prevalence amongst migrants in the region, and lack of continuity and objectivity in Member States SADC project.

The health of migrants and health issues related to migration are crucial public health challenges in the SADC region, and the impact is widespread, no only on migrant-sending countries but also on immigrant-receiving countries. The Resolution on the “Health of Migrants” was endorsed by the sixty-first World Health Assembly in 2008. The SADC Secretariat is responsible for strategic planning and management of the programmes of SADC, coordination and harmonization of the policies and strategies of Member States, and financial and general administrations. The Global Fund, the SADC Policy Framework for population mobility and communicable diseases in the region, and the SADC Framework for developing and sharing best practices on HIV and AIDS are existing and available resources for HIV and AIDS Cross Border Issues in the region.

Way Forward

- HIV and AIDS issues should be mainstreaming into Free Trade Agreement and all the Member States in the region should support SADC HIV Unit and the regional policy frameworks, and the Global Fund SADC project for mobile populations.
- Each Member State should have a focal person for SADC project and recognize identitydocuments of mobile populations to enable them to access healthcare services anywhere in the region. ART protocol should be harmonized in order to reduce drug resistance.

- Bilateral discussions on HIV and AIDS cross-border issues should be continued across Member States. Besides, sharing best practices, mapping partnerships, providing regional medical insurance, using multi-sectoral approaches, and conducting research on HIV cross-border patients will facilitate dealing with HIV cross-border issues in the region.

- Luke International Norway (LIN) should liaise with SADC focal point and proceed with bilateral activities on cross-border patient projects, as well as establish closer contact and collaboration with SADC Secretariat, IOM, Global Fund Proposal Partners, Regional Partnership Forum and RCM.

PARTICIPANT LIST

No	Name	Title	Organizations	Contact Information
1	Mr. Dede Watchiba	National Coordinator	PNMLS (NAC), DRC	dedewatchiba@yahoo.com
2	Mr. Luc Kanyimbo	Monitoring and Evaluation	PNMLS (NAC), DRC	lkanyimbo@yahoo.fr
3	Ms. Malerotholi E. Letsie	Technical Support Officer - Berea	National AIDS Commission, Lesotho	letsiem@nas.org.ls
4	Ms. Lisemelo Moholi	Section Head – Technical Support Directorate of Stakeholders Coordination & Support	National AIDS Commission, Lesotho	moholilc@nas.org.ls
5	Mr. Raymond Yekeye	Director Programmes	National AIDS Council, Zimbabwe	ryekeye@nac.org.zw
6	Mr. Wilfred Dube	Provincial AIDS Coordinator	National AIDS Council, Zimbabwe	secretariat@nac.org.zw
7	Ms. Thembi H. Dlamini	Treatment Care and Support Coordinator	NERCHA, Swaziland	thembidl@nercha.org.sz
8	Dr. Sithembile N. Dlamini	Clinical Systems Mentorship Advisor (ART Program Officer)	Swaziland National AIDS Programme	sithembile.snap@nercha.org.sz
9	Mr. Osward Mulenga	Director M&E and Research	National AIDS Council, Zambia	omulenga@nacsec.org.zm
10	Mr. Mwilu L. Mumbi	Civil Society Specialist	National HIV/AIDS/STI/TB Council, Zambia	mmumbi@nacsec.org.zm
11	Dr. Victor Mukonka	Director- Public Health & Research	Ministry of Health, Zambia	vmukonka@gmail.com vmukonka@moh.gov.zm
12	Mr. Mubita Luwabelwa	Deputy Director - Planning & Budgeting	Ministry of Health, Zambia	mubitaluwa@gmail.com
13	Dr. Robert M. Josiah	Head- Care and Treatment Unit	National AIDS Control Programme, Ministry Of Health and Social Welfare, Tanzania	rmwjosiah@gmail.com
14	Dr. Aroldia D. Mulokozi	Research Officer	Tanzanic Commission for AIDS (TACAIDS)	amulokozi@tacaids.go.tz
15	Dr. Banyana C. Madi-Segwagwe	Health Policy Analyst (TA for Policy Development)	SADC Secretariat	bmadi@sadc.int
16	Dr. Vitalis G. Chipfakacha	Technical Advisor - Capacity Building and Mainstreaming HIV	SADC Secretariat	vchipfakacha@sadc.int

No	Name	Title	Organizations	Contact Information
17	Dr. Luisa I. G. Cumba	Provincial Health Director - in Tete Province	Ministry of Health, Mozambique	luisacumba01@yahoo.com.br
18	Dr. Quinhas F. Fernandes	Provincial Health Director - in Manica Province	Ministry of Health, Mozambique	quinhasf@yahoo.com.br
19	Ms. Sikhulile Ngqase	Migration Health Project Officer	International Organization for Migration	sngqase@iom.int
20	Ms. Naledi M. Mlaudzi	Director - Department of Health Sector Relations and Partnership	Ministry of Health, Botswana	nmlaudzi@gov.bw
21	Ms. Koona Keapoletswe	Acting Director - Department of HIV/AIDS Prevention and Care	Ministry of Health, Botswana	kokeapoletswe@gov.bw
22	Mr. Kelvin Saukila	Senior Monitoring and Evaluation (M&E) personnel	Ministry of Health , Malawi	ksaukila@yahoo.co.uk
23	Dr. Damson Kathyola	Director - Research Department	Ministry of Health , Malawi	d_kathyola@yahoo.com
24	Dr. Frank M Chimbwandira	Director - HIV & AIDS Department	Ministry of Health , Malawi	fchimbwandira@yahoo.com
25	Dr. Mubiala E. Nicodeme	HIV Programme Supervisor	Malawi Northern Health Zone	nic_ubial@yahoo.fr
26	Mr. Clement Mtika	Coordinator- Rainbow clinic	Mzuzu Central Hospital, Malawi	clementmtika@yahoo.com
27	Dr. Chia-En Allen Lien	Medical Officer	Department of Health, Taiwan	allenlientw@gmail.com
28	Prof. Yohane Nyasulu	Dean - Faculty of Health Sciences	Mzuzu University, Malawi	yohanenyasulu@yahoo.com
29	Dr. Kwong-Leung Joseph Yu	Acting Superintendent	Ping-Tung Christian Hospital, Taiwan	Kwongleung.yu@gmail.com
30	Dr. Margaret N. Ntlangula	National senior specialist medical advisor HIV&AIDS	Ministry of Health , South Africa	pearl.margaret@vodamail.co.za
31	Mr. Moeketsi Modisenyane	International Health Liason Office Director	Ministry of Health , South Africa	modisem@health.gov.za
32	Mr. Joseph Wu	Country Director in Malawi	Luke International Norway	wcsg@lukeinternational.no
33	Mr. Johnson Huang,	Information Technology Consultant	Luke International Norway	mr.dragon9@hotmail.com
34	Ms. Lucia Lo	Project Coordinator	Luke International Norway	littlechingtw@gmail.com
35	Mr. Ray Yan-Tzong Cheng	Project Assistant	Luke International Norway	711479@yahoo.com.tw
36	Ms. Ally Lee	Project Assistant	Luke International Norway	
37	Ms. Zoey Huang	Project Assistant	Luke International Norway	

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LIST OF CONTRIBUTORS

Forum Organizer:

Luke International Norway (LIN), Malawi
Mzuzu University (MZUNI), Malawi
Pingtung Christian Hospital (PTCH), Taiwan

Important Dates:

Date of HIV CBP forum: 19-22 Aug. 2010
First draft report: 21.Sep.2010
Second draft report: 17.Oct.2010
Third draft report: 10 Nov. 2010
Final draft report: 3 Dec. 2010
Report distribution: 17 Dec. 2010

Acknowledgement:

We sincerely acknowledge the funding received from the Department of Health, Taiwan (ROC), and the host country South Africa, and the SADC Secretariat for their full support for making this forum successful. Also we appreciate the contribution of Ms. Lisemelo C. Moholi from NAC, Lesotho, toward making this report more complete.

List of Authors

- Joseph KL Yu – Pingtung Christian Hospital, Taiwan; Luke International Norway, Norway
- Joseph Wu* – Pingtung Christian Hospital, Taiwan; Luke International Norway, Malawi
- Lucia Lo* – Pingtung Christian Hospital, Taiwan; Luke International Norway, Malawi
- Ray Cheng – Luke International Norway, Malawi
- Yohane Nyasulu – Mzuzu University, Malawi

*Correspondent:
Joseph Wu, wcsg@lukeinternational.no; Lucia Lo, littlechingtw@gmail.com

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavior Change Communication
CBO	Community-Based Organization
CBP	Cross-Border Patient
CD4	Cluster of Differentiation 4
COH	Corridor of Hope
CSO	Civil Society Organization
CSW	Commercial Sex Worker
FBC	Full Blood Count
FBO	Faith Based Organization
GF	Global Fund
HBC	Home Based Care
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Hospital Management Information System
HR	Human Resource
HTC	HIV Testing and Counseling
IEC	Information, Education, and Communication
IT	Information Technician
LDTD	Long Distance Truck Driver
LFT	Liver Function Test
MC	Male Circumcision
M&E	Monitoring and Evaluation
MOP	Ministry of Planning
MOU	Memorandum of Understanding
MS	Member State
MSM	Men who have sex with men
MTCT	Mother-to-Child Transmission
MVC	Most Vulnerable Children
NAC	National AIDS Commission
NGO	Non-Governmental Organization
OI	Opportunistic Infection

PIN	Personal Identification Number
PMTCT	Preventing Mother-to-Child Transmission
RFT	Renal Function Test
SADC	Southern African Development Community
S&D	Stigma and Discrimination
SFH	Society for Family Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counseling and Testing
VL	Viral Load