High Level Political Roundtable Dialogue on Increased Domestic Investment in the HIV Response and Equal Access to HIV and Health Care Services

18-19 September 2018 | Pretoria, South Africa

Meeting proceedings: Plotting a way forward
## Contents

- Foreword........................................................................................................................................... 4
- About the Meeting.............................................................................................................................. 6
- Executive Summary............................................................................................................................. 7
  - Key Messages..................................................................................................................................... 8
- Next steps ........................................................................................................................................... 9
- Organization of the Discussions......................................................................................................... 10
  - Setting the Scene .............................................................................................................................. 10
  - Facilitating a Transition .................................................................................................................... 10
  - Innovative and Sustainable Financing Solutions.............................................................................. 10
  - Reconceptualising Health and the way Health Care is delivered on the Road to UHC ............ 12
  - Strengthening Health Systems......................................................................................................... 13
- Closing remarks..................................................................................................................................... 14
- Participants.......................................................................................................................................... 16
Champions with African Ministers, Deputy Ministers, Permanent Secretaries, Parliamentarians and representatives from the SADC Parliamentary Forum, National AIDS Councils, UNAIDS, Civil Society Development Partners, Private Sectors and HEARD at the two-day dialogue.
Foreword

AIDS is still with us. Despite great strides in Southern Africa’s response to disease, AIDS remains the number one killer in the region and a significant public health threat across the continent. The shrinking external resources coupled with the stagnant or slight increases in domestic investment in health and HIV and increasing new infections is resulting in a continually widening resource gap between what is required and what is available. Africa is at a critical cross road where, while the current resources still exist, should be preparing for sustainability of its response and building its share of domestic resources.

With this in mind we, the Champions for an AIDS-Free Generation, called the high-level dialogue on increased domestic investment in the HIV response and equal access to HIV and health care services to engage and interrogate the prevailing funding environment and define viable options for increasing domestic contribution to the response and agree on concrete commitments for individual and collective actions on the 18th and 19th of September 2018 in Pretoria. At the dialogue, I was joined by two Champions, former Vice President of Uganda Her Excellency Speciosa Wandira-Kazibwe along with Professor Miriam Were, Chancellor of Moi University.

We would like to recognize the genuine introspection of the challenges and successes of increasing domestic financing for the HIV response and the commitment to ensuring no one is left behind in pursuit of health. We are grateful for the participation and robust and engaged debates from Parliamentarians, Ambassadors,
Ministers, Deputy Ministers, Permanent Secretariats, National AIDS Commissioners, experts, private sector professionals and partners all of whom made the dialogue a success.

We are grateful to our partners, to whom we owe the success of this dialogue, namely the Health Economics and HIV and AIDS Research Division (HEARD) of the University of KwaZulu-Natal, SADC Parliamentary Forum (SADC PF), South Africa National AIDS Council (SANAC) and UNAIDS both the East and Southern Africa and West and Central Africa regional teams.

We would like to extend additional thanks to HEARD for their support throughout the meeting including the development of this report and the policy brief A Case for Advancing Political Leadership for Domestic Investment in Sustaining the AIDS Response in Africa.

We were encouraged by the open healthy debates, suggestions and commitments for actions that will address domestic financing for health and HIV. We are thankful to the different political and leadership sectors from Africa that took part in this dialogue. Among us were the Champions, a select group of African Ministers of Health, Finance and National AIDS Commissions from selected priority countries, Parliamentarians, Diplomatic Corps, RECs, AU, private sectors representation, representatives from the United Nations, CSOs, NGOs and development partners.

We cannot forget that the responsibility of keeping citizens alive and preventing new infections falls on national and regional leadership. Together we can create the next AIDS-free generation and together we can end AIDS as a public health threat.

**Festus Mogae**
Champions Chairperson and former President of the Republic of Botswana
The High Level Political Roundtable Dialogue on Increased Domestic Investment in the HIV Response and Equal Access to HIV and Health Care Services was convened by the Champions for an AIDS-Free Generation programme in partnership with the Health Economics and HIV and AIDS Research Divisions (HEARD) at the University of KwaZulu-Natal, UNAIDS Regional Support Team for Eastern and South Africa (UNAIDS RST ESA), the SADC Parliamentary Forum (SADC PF) and the South African National AIDS Council (SANAC). The meeting brought together Champions, African Ministers of Health, Parliamentarians, Permanent Secretaries, and NACs from selected priority countries as well as private sector representatives, Civil Society Organizations, representatives from the United Nations, AU, development partners and donors.

The purpose of the meeting was to provide a platform for an open discussion on the prevailing funding environment and to seek innovative and viable options for increasing domestic contribution to the HIV response, as well as to agree on a set of concrete commitments for individual and collective action.
Executive Summary

Leading up to the High Level Political Roundtable Dialogue on Increased Domestic Investment in the HIV Response and Equal Access to HIV and Health Care, Champions for an AIDS-Free Generation, collaboration with HEARD at the University of KwaZulu-Natal, developed a policy brief which served as the theoretical basis and focus for discussions for the dialogue. The brief was distributed to dialogue participants in advance. The brief titled A Case for Advancing Political Leadership for Domestic Investment in Sustaining the AIDS Response provided an analysis of the changing funding landscape, options for increasing resources and characterized the role of political leadership in the reprioritizing of HIV and AIDS.

The two day dialogue opened with two presentations which provided a frame for discussions; the first highlighted progress made in the push to end the AIDS epidemic by 2030. The second presentation made a case for advancing political leadership for domestic investment in sustaining the AIDS response in Africa. Thereafter, the Champions chaired Davos-style presentations which were delivered by Honourable Ministers of Health, Permanent Secretaries from Ministries of Health, Honourable Members of Parliament, NACs from selected priority countries as well as private sector representatives, CSOs, representatives from the United Nations, development partners, academics and donors. The dialogue revolved around two themes.

Firstly, despite significant progress made in the HIV response, the reality is that the region needs to upscale prevention efforts and frontload investments in the HIV response to generate the greatest impact – both in reducing new infections and AIDS related deaths, and the financial savings that will result. However, countries are facing a decline in external resources coupled with, at best, moderate increases in domestic investment in health and HIV, resulting in a widening resource gap. There is clear need for countries to transition from plentiful resources to self-sustaining resources. However, greater political leadership and inclusive governance systems are required to effect these changes. Increased scrutiny of budgets that respond to the needs on the ground, reducing inefficiencies, wastage and rooting out corruption were called for, as well as innovative methods for mobilizing domestic resources (and unforeseen pitfalls) were shared between countries Strategies such as increasing the Value-Added- Tax and partnering with diagnostic companies to reduce cost were among strategies discussed during the dialogue and also in the Policy Brief.

Secondly, in the context of Universal Health Coverage (UHC), there has been increasing attention to the social determinants of health and a concomitant shift in dialogue away from a narrow focus on health per se to viewing health as a broader issue which includes investment in education and social systems. While donor support has provided significant resources to fighting HIV and AIDS, it has also resulted in vertical programming and a siloed approach to AIDS care and treatment, often at the expense of other health concerns including broader SRH issues. The commitment to achieving the SDGs and the push for UHC is an opportunity to build a health system which provides integrated and quality health services. However, the delivery of integrated and equitability distributed quality services requires the reformulation
and strengthening of the health system, taking into consideration competing demands and health issues (HIV, TB, SRHR, NCDs), including greater focus on prevention and health promotion. What might be included in a UHC package and how the HIV response aligns with the rest of the package requires some hard discussions about priorities and trade-offs at country level. The importance of the role of the community and the private sector was discussed. Decentralising services to districts, employing community health workers, leveraging traditional leaders and chiefs for health promotion efforts and utilizing external donor funding in a catalytic role to identify integration opportunity were amongst the ideas that were shared. The private sector is also well positioned to identify innovative practices, produce equitable diagnostics and increase efficiencies in the health system.

Key Messages

It is critical for countries to start preparing for the transition from plentiful resources to self-sustaining resources. To achieve this, the following is required:

- **Multi sectoral approach:**
  Coordinating mechanisms could be useful in fostering dialogue and political commitments. In addition, better coordination between Ministries and cluster planning will work to reduce duplication. Development and implementation of an action plan for reaching the Fast-Track targets requires greater engagement between health and finance sectors to ensure the relevance of increased public funding for health. Targets across other SDGs are essential to meeting the SDG for health and these require multi sectoral action.

- **Innovations for mobilizing domestic resources:** The region is still on a learning curve in this regard and while there are many innovative ideas regarding utilization of taxation and other domestic income streams, caution was called to carefully evaluate the potential consequences and end user burden prior to implementing planned interventions.

- **Improving efficiencies with existing resources:** There are high levels of resource wastage and inefficiencies in health service delivery in the region. Potential areas that have been identified where efficiency could be increased included pooled procurement, reforming incentive and payment structures, task-shifting, altering incentives to providers, monitoring performance and regular evaluation of interventions.

- **Greater oversight and accountability in budget processes:** Members of Parliament (MPs) were identified as key players in sustaining the response and health systems but there was also a call for MPs to be better capacitated to be more effective in their oversight roles. This requires greater capacitation of Members of Parliament in budgetary process and sexual and reproductive health and rights issues so that Parliamentarians can gain the necessary knowledge to make informed debates and decisions. High turn-over of MPs requires continual capacitation and may influence their willingness to speak out.
• **Removing AIDS out of isolation into broader health and social development:** It was noted that countries are making efforts to look at the HIV and AIDS response from a more holistic perspective.

• **Health system reorganization and strengthening:** There has historically been a fragmentation of the public and private sector and a silo-approach applied to health service delivery which has resulted in inefficient use of resources and health personnel. Better utilization of existing health resources, increase in quality of services, ensuring equitable access and increasing demand were all viewed as key requirements going forward. The importance of the role of the community and the private sector in achieving this was emphasised.

### Next Steps

• **Countries need to be supported to start thinking about transition plans as part of the AU roadmap.** The role of development partners and regional bodies including SADC and the AU in assisting countries in this process requires further discussion.

• **Roche made a global commitment over the price of diagnostics which not all countries have taken up or benefit from.** Follow up on the commitment is required.

• **Request for technical training and capacitation of MPs in budget processes and key SRHR issues to be supported.**
**Organization of the Discussions**

**Setting the Scene**

The difficulties in trying to expand and accelerate programmatic activities to appropriately respond to the HIV epidemic, while also securing and maintaining the human and material resources required to realise Universal Health Coverage (UHC) remains a challenge for the region. Globally, external aid for HIV is stagnating and, worldwide, international aid is shifting towards other competing priorities such as environmental issues and the refugee crisis, to priority countries (low-income and high HIV prevalence countries). As countries transition from low-income to low-middle income status, they face loss in access to official development assistance (ODA).

During the past two decades developing countries experienced rapid economic growth with the result that between 2005 and 2013, 48 countries changed income categories; 15 moved from low-income to low-middle-income status and 22 countries from lower-middle to upper-middle-income status. Worldwide, official aid for health declined from 33.6% of health expenditures among low-income countries to 19.5% of health expenditures amongst lower middle-income countries.

As a backdrop to country-led commitments to end AIDS by 2030 and to deliver Universal Health Coverage (UHC), an interrogation of the prevailing funding environment and identification of viable options for increasing domestic contribution is required. There remains the real risk of countries falling short of the Fast Track targets given that achieving them relies on the increased allocation of resources, beyond what has already been committed domestically and by donors. The question therefore facing delegates at the roundtable meeting was: in a context of shrinking external resources coupled with the stagnant or moderate increase in domestic investment in health and HIV, and the resultant widening resource gap between what is required and what is available, how do we develop and implement a sustainable HIV response based on domestic resources and ensure equal access to HIV and health care services?

**Facilitating a Transition**

The need for countries to develop a transition plan is a key component of the African Union Roadmap. Evidence from countries that are graduating from external support indicates that the road to transition is fraught with challenges; the need to maintain service coverage with less resources, and to meet co-financing requirements and broader health system challenges such as poor infrastructure, lack of health care providers and weak supply chain management. With changes in funding and resource flows, coordination mechanisms need to change. Key questions include: Who are we developing? How are we developing? How do we look at domestic funds and aid? How do we share the responsibility? There is therefore an urgent need for building sustainability at a systemic level through increased mobilization and better use of domestic resources. As one delegate

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commented, “It is about harnessing the resources and using them for the common good.”

Innovative and Sustainable Financing Solutions

The past two decades have seen strong growth on the African continent, with an average annual growth rate of 4.6% from 2000 to 2016. Countries have benefitted from, *inter alia*, high commodity prices, diversification of trade partnerships, and improved macroeconomic management. This growth will need to be sustained into the future with a renewed political commitment to reducing inequalities, and translating the general economic growth into higher well-being across the board.

Whilst higher income and upper middle income countries (HIC & UMIC) are in a position to allocate domestic resources, low income countries (LIC) remain highly dependent on external financing. A WHO working paper (WHO, 2017) noted that LIC and lower middle income countries (LMIC) have varied in the degree of public investment in health and as a proportion of their total public spending despite similar income levels. This suggests that it is possible to improve public investment and prioritization of health in spite of economic constraints.

In order to harness the potential that domestic resources for health (through various forms of taxation) have to offer, there is need to ensure that domestic spending for health is targeted in a manner that benefits those most in need and funds evidence-based options for maximum impact. There is growing evidence that despite its prevalence, earmarking specific taxes for HIV and health more broadly is unlikely to bring a uniform significant and sustained increase in overall government spending on health. While earmarked mechanisms may have an undeniable health impact, their effects on revenue are mixed in country experiences. Earmarked sources of revenue should be viewed within the context of overall potential sources of fiscal space for the health sector. Earmarking may have a political value in its ability to link financing to national health priorities. Earmarked sources of revenue should be assessed in relation to all potential revenue sources for the health sector and a country’s broader health financing policies.

Delegates discussed some of the problems around ring fencing taxes at country level, including the problem of a lack of clear guidelines as to how the money should be used, weak oversight, competition over utilisation of taxes across sectors, inefficient spending, and, importantly, the need to inadvertently avoid pushing cost onto the consumer. To this end, the delegates noted the need for greater visibility in use of taxes and pooling of savings for equitable distribution of resources. In addition, country examples highlighted that while it is important to investigate remedial measures and primary prevention through taxation, the region was still on a learning curve in this regard. Country experiences were that taxation of commodities that are harmful for health do not necessarily change poor health behaviour.

In terms of use of existing funds and resources, corruption, wastage and inefficiencies were recurring themes. Greater transparency in budgets, more effective monitoring systems to determine whether budgetary allocations are being effectively

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used, forecasting and efficiency in spending and strategic purchasing were amongst the examples offered to use existing resources more efficiently. However, at what level are we advancing political leadership? There was sentiment that there was a focus on higher levels and not lower levels; Members of Parliament (MPs) were identified as an effective member of representation but there was also a call for MPs to be better capacitated to be more effective in their oversight role.

Opportunities
- Call to include more role players in identifying innovative practices, including communities and the private sector.
- Capacitate Members of Parliament to provide a stronger oversight role in budget processes.

Innovations
- The introduction of a corporate social responsibility tax (2.5%) which disburses funds for all health education which is portioned out to districts.
- Conditional grant, strategic and pooled purchasing of health commodities between countries

Challenges
- High turn-over of MPs requires continual capacitation and may influence willingness to speak out. MPs work in silos which runs the risk of members losing track of other initiatives.

Given the push for Universal Health Coverage (UHC), there has been increasing attention to the social determinants of health and a concomitant shift in dialogue away from a narrow focus on health per se to viewing health as a broader issue which includes investment in education and social systems. Integration of services therefore was viewed as being aligned with the social determinants of health framework.

The delivery of integrated and equitable services requires the reorganisation of the health system, taking into account the social determinants of health. This reorganising requires leadership, oversight and stewardship at country level which the meeting participants perceived as lacking most especially among Parliamentarians. The reality, it was reported, is that the delivery of health services remains rooted in colonial structures and much work remains to determine how to best deliver health services that are responsive to the realities within countries. It is expected that integrated health services and health promotion efforts, including broader sexual reproductive health services, will result in better health outcomes than those derived from disease-specific programming.

While donor support has provided significant resources to fighting HIV and AIDS, it has also resulted in vertical programming and a siloed approach to HIV, often at the expense of other health concerns including broader SRH issues. The commitment to achieving the SDGs and the push for UHC is an opportunity to build a health system which provides integrated and equitable services, with one delegate declaring that “we are carrying out the building blocks as we speak”. One of the main challenges will be maintaining clear targeting of HIV prevention and treatment to

Reconceptualising Health and the way Health Care is delivered on the Road to UHC
key and other vulnerable populations within the UHC model.

As part of the discussion around reorganising health systems, the need for a multi-sectoral approach was re-affirmed, wherein all stakeholders are held accountable. Delegates raised the issue of historical fragmentation of the public and private sector and a silo approach applied to health service delivery which resulted in efficient use of resources and health personnel. The group explored the kinds of partnerships that may work to close programmatic gaps. This included strengthened collaborative action between the health and finance sectors at country level, as well as support from development partners (namely World Bank, IMF, WHO and others engaged in both PFM and health financing reforms) to ensure that transition towards programme budgeting for health responds to the sector’s needs.

The private health sector was identified as a potential partner and key stakeholder with the establishment of public-private-partnerships (PPPs) potentially leading to expanded and efficient targeting of services. It was acknowledged that the private sector is at the forefront of technological advances and the utilisation of mHealth interventions aimed at creating efficiencies within the delivery of health services. Governments were called on to forge mutually supportive working relationships between stakeholders which seek to maximise the strengths of the various role-players.

Communities were identified as another key stakeholder in the delivery of health services. Investing in community systems strengthening as part of the HIV response was a strong call amongst delegates. It was highlighted that there is need to strengthen the entry points and access to services that the communities have established either in remote areas or with hard to reach populations. Additional ideas about community involvement and the role of the community in achieving UHC need to be explored in countries as the interface between remote populations and health services. Participants stressed the need for communities to play a meaningful role in delivering health services; and rules of engagement to be explored, based on experiences in other countries. Examples were cited of potential social contracting of community organizations based on a results and accountability framework. Communities should be ultimately influencing spending behavior, ensuring the allocation of resources are directed appropriately and aligned with community priorities.

Opportunities
- Reconceptualising private sector and development partners as ‘partners’ in the HIV and AIDS response
- The potential effectiveness of the private sector partnership
- The potential effectiveness of increased community involvement

Innovations
- Decentralisation of services to districts. Hiring of community health workers, inclusion and training of traditional healers in symptom diagnosis and leveraging chiefs in health promotion efforts eg increase uptake of maternity care and deliveries in facilities.

Challenges
- The private sector generally takes a long term outlook, whilst government have a shorter outlook, in line with election periods. This hinders investment into identifying innovative
practices which potentially only delivers over a longer time horizon.

**Strengthening Health Systems**

As one of the delegates stated, “If we are going to deliver UHC, we need a strong health system.” There was widespread acknowledgment that weak health systems were a major constraint to improving health outcomes in low and middle-income countries (LMICs), and for providing integrated services in particular. At the same time, specific health conditions remain critical concerns, with HIV and AIDS, TB (and increasingly non-communicable diseases) being clear priorities in many countries, due to their impacts on morbidity, mortality and structural disabilities.

In many countries, particularly in southern and eastern Africa, the HIV epidemic continues to pose a major threat to development. Strengthening health systems in LMICs, especially while there remains interest amongst donors to continue to invest in HIV and TB services, should be viewed as an opportunity and priority. The relationships between health systems capacity, HIV and AIDS services, and realising UHC are complex and context specific. Solutions, therefore, to meet this challenge will not be uniform across LMICs — particularly in Africa where different countries and sub-regions exhibit varying strengths, weaknesses and capabilities (both human and structural). Realising the Fast Track targets as well as the SDGs are time bound, with novel approaches and partnerships required to rapidly implement effective programmes that circumvent inherent health system weaknesses.

Recognizing the multi-sectoral approach to the AIDS response, delegates called for increased coordination at national levels and the streamlining of country development frameworks. Coordinating oversight would allow for easy access to information that outlines resources available in countries. Delegates called for better coordination within countries and between countries. In order to measure country progress the meeting urged for harmonizing common result frameworks.

The delegates highlighted that there has been much attention to the supply side and less to demand creation. Improving the quality of services and improving health equity in quality health care offered was another emerging key issue as well as the need to regulate the provision of services. The critical shortage of human resources for health was a shared challenge amongst countries and there was discussion about the tendency to utilise health care professionals as health administrators, with concerns around their skills and competence to be efficient health administrators and especially in light of the shortage of clinicians at the service level.

Widespread mobilization efforts to prevent new infection have slowed and as a result new infections are on the rise globally and adolescent girls and young women continue to account for a disproportionate amount of new infections (67 percent) in young people in Sub-Saharan Africa. Additionally delegates stressed the need to reprioritize prevention efforts in order to end the epidemic. As one delegate said, “We are saving lives but we are not significantly reducing new infections. We need to clearly match saving lives with reducing new infection.”

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5. UNAIDS, “Miles to Go—closing gaps, breaking barriers, righting injustices,” 2018.

Innovations

- In the absences of qualified specialists, countries should invest in post-college specialized training programmes for personal to maintain advanced and costly medical equipment therefore reducing wastage and inefficiencies.
- The training of MPs, especially health caucuses, should be facilitated to capacitate MPs to make informed decisions. SADC PF, HEARD and UNAIDS are better placed to provide such capacitation.

Challenges

- A number of challenges were cited from countries, including the shortage of health personnel, stock outs, staff performance resulting in the provision of poor services. In addition, country representatives cited purchasing and procurement problems, resulting in
- Significant wastage due to over or under purchasing and having to discard expired medication or pay premiums for emergency medication.

Closing Remarks

Given the importance of domestic resource mobilization for health there is need for proactive measures for governments to own spending on health. Key to this is the implementation of sustainable domestic resource mobilization reforms. In addition, there is need for countries to be considering integrated serviced delivery models that will strengthen health systems. This should include the strengthening of supply chain management and public finance management systems which could increase programme efficiencies. Identifying inefficiencies or areas of duplication are critical for laying the foundation for integration. Government-led financing for health will require greater outlays for health from public revenue as well spear heading reforms such as health insurance and strategic purchasing mechanisms to ensure that countries remain on-track to meeting the Fast Track targets and realizing UHC.

The meeting concluded with a call for one agenda and one multi sectoral approach, regional alignment and harmonization of purchasing, national ownership and political leadership and a common results framework.
Participants

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2. H.E. Speciossa Wandira- Zazibwe | Champion
3. Prof. Miriam Were | Champion
4. Dr. Naledi Pandor | South Africa’s Minister of Higher Education
5. Hon. Dr. Alfred Madigele | Minister of Health – Botswana
6. Hon. Monica Mutsvangwa | Minister of Information – Zimbabwe
7. Hon. Julieta Kavetuna | Dep, Minister of Health – Namibia
8. Dr. Jabbin Mulwanda | PS Ministry of Health – Zambia
9. Dr. Zacarias Castigo Zindoga | PS Ministry of Health Mozambique
10. Dr. Aleny Couto | HIV/AIDS Programme Manager at the Ministry of Health
11. Mr. Richard Matlhare | NAC – Botswana
12. Mrs. Keratile Thabana | NAC – Lesotho
13. Mr. Davie Kalomba | NAC – Malawi
14. Dr. Sandile Buthelezi | NAC South Africa
15. Mr. Khanya Mabuza | NAC eSwatini
16. Mr. Fortune Chibamba | NAC Zambia
17. Hon. Fernando José de França Dias Van-Dúnem | SADC PF MP – Angola
18. Hon. Sebastian Karupa | SADC PF MP – Namibia
19. Hon. Sophia Swartz | SADC PF MP – Namibia
20. Hon. Tsehang Mosena | SADC PF Speaker of Parliament – Namibia
21. Hon. Stevens Mokgalapa | SADC PF MP – South Africa
22. Hon. Mary-Ann Lindelwa | SADC PF MP – South Africa
23. Hon. Egbert Clifford Aglae | SADC PF MP – Seychelles
24. Hon. Dr Jessie Habwila | SADC PF MP – Malawi
25. Hon. Emmanuel Lozo | SADC PF Malawi
26. Hon. Godfrey Munkhondya | SADC PF MP – Malawi
27. Hon. Likopo Mahase | SADC PF Speaker of Parliament – Lesotho
29. Hon. Ponde Mecha | SADC PF MP – Zambia
30. Mr. Arthur Kaitano | SADC PF
31. Mr. Deolindo Sumbo de Sousa | SADC PF
32. Mrs. Yapoka Mungandi | SADC PF
33. Mrs. Boemo Sekgoma | SADC PF
34. Mr. Moses Magadza | SADC PF
35. Mr. Francisco Manuel da Luz Alfrendo Junior | SADC PF
36. Prof. Nana Puku | HEARD KZN University
37. Dr. Gavin George | HEARD KZN University
38. Dr. Tamaryn Crankshaw | HEARD KZN University
39. Dr. Molotsi Monyamane | Former Minister of Health – Lesotho
40. Mr. Geoffrey Mujisha | African Think Tank Uganda
41. Dr. Dag Sundelin | Regional Team for Sexual Reproductive Health & Right Sweden Embassy – Zambia
42. H.E. Mr. Zenene Sinombe | Botswana High Commissioner to South Africa
43. Shabnam Zavahir | Roche Diagnostics
44. Bridget Mogale | Roche Diagnostics
45. Mapaseka Steve Letsike | Access Chapter 2/ SANAC
46. Lebowa Malake | SANAC
47. Z. Neshutalu | SANAC
48. Tshepo Sedibe | SABCOHA
49. Dr. Mbulawa Mugabe | UNAIDS
50. Scott McQuade | UNAIDS
51. Dr. Catherine Sozi | UNAIDS
52. Dr. Patrick Brenny | UNAIDS
53. Bechir N'Daw | UNAIDS
54. Natallie Ridgard | UNAIDS
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