TREATMENT BAROMETER

A Survey Of Treatment Provision To People Living With HIV In Southern Africa

ABOUT SATAMo

The Treatment Barometer is a publication of the Southern African Treatment Access Movement (SATAMo).

SATAMo is the regional governing body for the International Treatment Preparedness Coalition (ITPC) and the Pan-African Treatment Access Movement (PATAM) and was formed in 2006. It has member organisations and networks in 13 countries in Southern Africa. The movement's main objective is to ensure access to HIV and AIDS treatment for all. Part of the strategy in achieving this is to hold national governments accountable to the various protocols and declarations in which they have committed themselves to providing treatment, care and support to their people.

SATAMo also administers the Collaborative Fund, which is a unique community-driven funding mechanism run by people living with HIV and their supporters. The Collaborative Fund is a joint partnership between the ITPC and Tides Network of New York.

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ON THE COVER:

Novungile is 25 years old. She weighs 26 kg and is taking TB treatment for the third time. She has virtually no muscle left and has been bed ridden for over a year. Still, despite her physical state, she is expected to make it to the clinic five days a week to receive her streptomycin injection as part of a retreatment regimen. To get there, her mother takes her in a wheelbarrow. Having ten other children, her mother cannot always push her the 3km's each way. Novungile risks failing her treatment. The DOTS model does not work for people like Novungile. Photo: Nick Fletcher. Courtesy of TAC (Equal Magazine, November 2008).

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
CIDRIZ	Centre for Infectious Disease Research in Zambia
CSO	Civil Society Organisation
FDC	Fixed-dose combination
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HTC	Health Provider Initiated HIV Testing and Counselling
IDU	Injecting Drug User
ILO	International Labour Organisation
ITPC	International Treatment Preparedness Coalition
MDG	Millennium Development Goals
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
NGO	Non-Governmental Organisation
OI	Opportunistic infection
PEPFAR	US President's Emergency Program for AIDS Relief
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
SATAMo	Southern African Treatment Access Movement
SCMS	Supply Chain Management System
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UN	United Nations
VCT	Voluntary counselling and testing
WHO	World Health Organisation

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EXECUTIVE SUMMARY

National leaders within the SADC region have professed considerable commitment towards provision of HIV treatment through strategic high-level meetings that have resulted in well-meaning declarations such as the *Maseru Declaration on HIV and AIDS*. Heads of state and ministers of health have demonstrated their understanding of the severity of the AIDS pandemic's impact on the region, which is the worst affected globally, through numerous pledges. Similarly, these leaders have displayed their appreciation of the benefits of treatment through various initiatives such as the *SADC HIV & AIDS Strategic Framework and Programme of Action: 2003 – 2007*.

Yet, these impressive pronouncements and displays of concern have yielded little result for PLWHA in need of treatment. In the absence of supporting action, the outcome of these meetings and declarations remain mere promises and wishful thinking.

A survey on access to AIDS treatment by community activists within SADC countries through SATAMo, shows that although governments have made well-sounding commitments towards ensuring that people with HIV/AIDS receive the care they need at regional, continental and international level, these have not been translated into real action with genuine benefits. Few governments have set tangible targets and even fewer have met the goals they have set out for themselves.

The following issues emerged from the audit:

- More than 80% of SADC governments have not honoured the Abuja Declaration more than 7 years after the commitment;
- Targets for antiretroviral coverage beyond 2008 were not available and it is not clear whether this is because most countries have only set targets for the current year but have not planned for 2009 and 2010, with the exception of Lesotho and Madagascar, which had targets up to 2010 and 2012 respectively;
- Common barriers to treatment include inadequate human resources, long distances to the nearest health facility, poor access to key diagnostic tests, and stigma;
- Reports of stigma and discrimination by health care workers remain high, particularly in countries where there is good access to treatment (e.g. Botswana, Mauritius and the Seychelles). This may erode the effectiveness of potentially good programs, and their long-term sustainability.
- Stock-outs, particularly of OI drugs, are common in more than 80% of the countries surveyed, including those countries with strong ART programmes (e.g. Botswana). Other countries reporting stock-outs include Malawi, Swaziland, Zambia and Zimbabwe.
- Most countries are struggling to provide first-line treatment to those who need it, with eight countries in SADC below 35% coverage and only two exceeding 75% coverage. The longer-term issues around second-line regimens have yet to be addressed in the region;
- Although most countries involved in the survey did not provide a breakdown of the number of people that are receiving treatment based on gender and age,

indications are that between 50% to 60% of those on treatment programs in Southern Africa are women[1], while children remain under-served;

- ART centers are concentrated in urban areas, far from rural areas where the majority of people live. Patients have to travel long distances, sometimes on foot, to reach the nearest health centers and access treatment. This has a direct impact on uptake and adherence to treatment.

In order to improve access to treatment, there is need for concrete action at both regional and national levels. Proposed actions include:

- The establishment of a peer-review mechanism through which SADC governments and civil society monitor and encourage countries to meet treatment targets and honour commitments made.
- A few countries within SADC have the capacity to produce generic ARVs. SADC needs to invest in boosting the capacity of select pharmaceutical companies to supply the region with WHO pre-qualified, generic drugs. Providing additional sources of key ARVs would help to establish greater competition in the pricing of drugs in the region and reduce the chance of stock-outs of key medicines.
- SADC and member states must invest in improved supply chain management systems to ensure more efficient and reliable provision of medicines in national ART programmes.
- SADC member states need to institute laws and policies protecting the rights of PLWHA and vulnerable populations, and to provide clear and accessible mechanisms for reporting and addressing rights violations. This will help to address the stigma and discrimination that PLWHA face, particularly in the health sector when trying to access treatment
- Governments have to bring treatment closer to the people through decentralisation of services – including mobile clinics.

[1] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.

INTRODUCTION

As part of efforts to hold SADC governments accountable to the commitments they have made towards universal access to treatment, the Southern African Treatment Access Movement (SATAMo) conducted a survey of progress in the provision of ARV and OI treatment programmes in the region. Findings from the audit will be used for advocacy at national and regional levels.

This project was initiated during the SATAMo strategic planning workshop, which took place in South Africa from 28 April to 02 May 2008.

Activists realised that despite numerous promises made by national and regional leaders, there was insufficient progress towards universal access to treatment in most countries in Southern Africa. Further, there were few coordinated efforts to monitor and press governments to fulfil their pledges. The *Treatment Barometer* was developed as a tool to monitor implementation of HIV-related treatment programs.

The objectives of this publication are to:

- Monitor provision of treatment and care to PLWHA at national and regional levels;
- Assess progress made towards ART provision at national and regional levels;
- Highlight barriers to treatment scale-up;
- Hold SADC leaders accountable to the commitments made to provide HIV treatment;
- Recommend practical actions from a civil society perspective to scale up treatment provision.

STATE OF THE PANDEMIC IN SOUTHERN AFRICA

Southern Africa remains the epicentre of the AIDS pandemic, is home to nine of the 10 countries worst affected by HIV in Sub-Saharan Africa and has the highest number of people in need of HIV treatment in the sub-region.

The WHO estimates that by the end of 2007, about 33.2 million people were living with HIV and two thirds of these were in Sub-Saharan Africa[2]. This represents 71% of the total treatment need in low and middle-income countries and 72% of the total number of people receiving treatment at the end of 2007[3].

Although it fell short of its target, the 3x5 initiative resulted in considerable progress towards greater ART provision, particularly within Sub-Saharan Africa. More than 800 000 people in the sub-region were receiving ART by the end of 2005, compared to 100 000 in 2003[4].

Southern Africa, in particular, has benefited from a rapid scale-up that was part of the 3x5 initiative's strategy. For example, about 5 586 people in Zambia were receiving treatment in April 2004. This figure shot up to 43 964 by December 2005. Despite these incremental gains, however, there continues to be a large gap

[2] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.
[3] Ibid.
[4] *Equity and health systems strengthening in ART roll out: An analysis from literature review of experiences from East and Southern Africa*. Makwiza. I, et al. Equinet. 2006.

between the coverage of ART treatment and the need. By the end of 2007, average regional ART coverage stood at 36% with most countries falling below 35%. Only Botswana and Namibia had ART coverage that was above 75%[5].

"The number of people requiring antiretroviral therapy continues to fall short of the need, and new challenges are emerging as treatment is scaled up," the WHO progress report noted[6].

This is despite commitments by governments at global, continental, regional and national levels to ensure greater access to treatment.

KEY COMMITMENTS AND DECLARATIONS FOR SADC

Although regional governments have made political commitments in many strategy and policy documents, these have hardly been translated into action. Among these documents are:

- Millennium Development Goals;
- Abuja Declaration on HIV/AIDS, TB and other Infectious Diseases;
- UNGASS Declaration of Commitment on HIV/AIDS;
- SADC HIV & AIDS Strategic Framework and Programme of Action: 2003 – 2007;
- Abuja + 5;
- Maseru Declaration on HIV and AIDS;
- Gaborone Declaration on a roadmap towards Universal Access to prevention, treatment and care;
- Brazaville Declaration on Universal Access to Treatment.

Millennium Development Goals

In September 2000, world leaders meeting at the UN agreed to the Millennium Development Goals which include halting the spread of HIV/AIDS by 2015 and achieving universal access to treatment for HIV/AIDS for all those who need it by 2010.

Abuja Declaration on HIV/AIDS, TB and other Infectious Diseases

On 26 and 27 April 2001, African Heads of States and governments of the Organisation of African Unity (OAU) declared that they would allocate no less than 15% of their annual national budgets to health services in order to meet "the exceptional challenge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases"[7].

[5] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.
[6] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.
[7] The OAU officially became the African Union on 9 July 2002 at the Durban Summit.

However, Botswana and Zimbabwe were the only SADC countries to commit 15% of their national budgets towards health in 2006 and 2007 respectively, although this has not been sustained.

UNGASS Declaration of Commitment on HIV/AIDS

In June 2001, Heads of State and Representatives of Governments met at the United National General Assembly Special Session on HIV/AIDS. The meeting was a major milestone in the AIDS response and Heads of State and other representatives of governments issued a Declaration of Commitment on HIV/AIDS. The Declaration remains a powerful tool that is helping to guide and secure action, commitment, support and resources for the AIDS response.

Maseru Declaration on HIV and AIDS

At their meeting in Maseru on the 4th of July 2003, SADC Heads of State reaffirmed their commitment to combating the AIDS pandemic in all its manifestations as a matter of urgency through multi-sectoral strategic interventions as contained in the new SADC HIV and AIDS Strategic Framework and Programme of Action 2003–2007[8].

Gaborone Declaration on a roadmap towards Universal Access to prevention, treatment and care (2005)

In October 2005, the second ordinary session of the conference of African ministers of health took place in Gaborone, Botswana, resulting in the roadmap to universal access to prevention, treatment and care.

Abuja + 5

The Summit of African Heads of State and Government on HIV/AIDS, Tuberculosis (TB) and Malaria took place in Abuja on 01 and 02 of May 2006 to take stock of Africa's progress towards meeting the goals listed above.

Other commitments include the SADC HIV & AIDS Strategic Framework and Programme of Action: 2003–2007, and the Brazzaville Declaration on Universal Access to Treatment.

Despite all these pledges on paper, very few governments have honoured their commitments despite overwhelming need in the region and incontrovertible evidence of the benefits associated with HIV treatment. Such benefits include reducing sickness and death among PLWHA, less need for hospitalisation[9] and reversing the economic consequences of AIDS thus promoting broader human development goals in the long run. With little political will and limited commitment, treatment is likely to remain a dream for the vast majority of people in need within the region.

[8] Declaration on HIV and AIDS. http://www.sadc.int/english/hiv_aids/key_documents/declaration.pdf
[9] Ibid.

THE SURVEY

PROCESS OF CONDUCTING THE SURVEY

Information for this publication was gathered largely through desktop research using publicly available sources. Members of SATAMo using a standardised questionnaire collated country data. In some instances, interviews were conducted with key stakeholders, including representatives from health ministries. It is however, important to note that this is not scientifically rigorous research, but a community initiative aimed at assessing progress towards the provision of treatment, and monitoring the extent to which regional governments have met their commitments. The survey covers 13 Southern African countries and was compiled over a period of two months. Efforts were made to use the most recent information available in all countries of the survey.

FINDINGS

Treatment provision

- ART coverage within the region remains low despite the high level of need. Most countries are struggling to provide first-line treatment with eight countries falling below the 35% coverage, and some as low as 17%. Only Botswana and Namibia have exceeded 75% ART coverage. Consequently, focus on second-line treatment is limited.
- ARV and OI treatment is not easily available or accessible in most countries, largely because of poor procurement and logistical systems. Stock-outs, particularly of OI drugs, are common in all countries, pointing to the need for improved supply chain management systems.

Targets and commitments

- More than 80% of SADC states have failed to honour their Abuja commitment to allocate no less than 15% of their annual national budgets to health services in order to meet “the exceptional challenge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.”

Common barriers to treatment

- Poor infrastructure with sparsely distributed health centres remains a major challenge for the majority of SADC countries (e.g. Lesotho, Malawi, Mozambique and Zambia). Patients have to travel long distances, particularly from rural areas to cities to access treatment. This is compounded by the fact that most patients cannot afford transport costs and are forced to walk tens of kilometres to the nearest ART centre, which makes obtaining treatment an arduous task.
- Access to diagnostics such as CD4 count tests remains low in most SADC countries.
- Stigmatisation, particularly by health care workers, was cited as one of the key deterrents to uptake of treatment. This was noted particularly in middle-income countries such as Botswana, Mauritius and Seychelles, which, despite access to medicines, experienced low uptake by patients who feared ostracism by both health workers and their communities.

Marginalised groups

- Although most countries involved in the survey did not provide a breakdown of the number of people receiving treatment based on gender and age, indications are that between 50% to 60% of those on treatment programmes in Southern Africa are women[10], while children still remain vastly underserved.

[10] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.

COUNTRY BRIEFS
■ **Angola**
■ **Botswana**

Unless stated otherwise, all information in the country reports was provided by activists using a standardised questionnaire and their personal experiences.

Angola

Treatment provision in Angola doubled from 6 514 in December 2006 to 11 540 in December 2007. However, this only covers 25% of the estimated 47 000 people in need of treatment[11].

Stigmatisation and discrimination remain barriers to scaling up access to HIV/AIDS services. The government's response to HIV/AIDS has been severely hampered by years of conflict and a lack of resources. Angola emerged from 27 years of war in 2002, with its health system badly damaged and an estimated 65% of its primary health care centres out of service. The institutional capacity of the National AIDS Control Programme and human resource capacity across the health sector as a whole urgently need to be strengthened. Scaling up of voluntary counselling and testing services is crucial. Additional support is needed in management, human resource planning, procurement and national supply chain management, surveillance and community preparedness and understanding. Services need to be expanded outside the capital city, especially to the provinces of Kunene and Uige, where HIV prevalence is high, and to Huambo and Huila, where the population has higher density[12].

Botswana[13]

About 300 000 people are living with HIV in Botswana, representing 18% of the country's population of 1.7 million. Of these, an estimated 100 000 are on ART and this figure represents most of those in need of treatment. Unlike most countries in the region, Botswana has no set target as everyone who is eligible for treatment is supposedly enrolled within one month.

Botswana enjoys 79% ART coverage, the second highest in Southern Africa after Namibia, which has 88% coverage[14].

Although treatment for most opportunistic infections is generally available and accessible, the supply of acyclovir, which is used to treat herpes zoster, is erratic in government health facilities. The same applies to valganciclovir and ganciclovir, which are used to treat cytomegalovirus (CMV). This is compounded by erratic supply of HIV testing kits. Diagnostics such as CD4 count tests are not always accessible due to frequent breakdowns of machines. Limited access to diagnostics may delay enrolment on the ART programme.

Despite its successes, however, Botswana's treatment program faces major hurdles. The stigma attached to HIV/AIDS remains a major obstacle, deterring those who would otherwise seek treatment. Fear of rejection, isolation and

[11] Ibid.
[12] PlusNews Global HIV/AIDS news and analysis. http://www.plusnews.org/profiletreatment.aspx?Country=AO&Region=SAF
[13] All information taken from MASA (government ARV programme) and the Botswana Treatment Literacy Coalition BTLC/BONELA needs assessment 2007.
[14] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.

discrimination greatly affects uptake of HIV/AIDS-related services through programs such as ARV, PMTCT and, in particular, voluntary counselling and testing.

In addition, PLWHA in some areas have to travel long distances to access diagnostic tests and medicines, a factor that may interfere with adherence.

In order to promote access to ARV and OI treatment in Botswana, there is a need to scale up treatment literacy and advocacy activities in the community. Stigma mitigation activities are also an urgent requirement. Beyond ART, civil society should advocate for provision of essential drugs at public facilities.

"We need a one-stop information shop where data regarding procurement of ARV's and drugs for OIs can be accessed in Botswana," noted an activist from the country.

Action to curb stigma in Botswana is urgently required. As a starting point, the government needs to enact laws that protect the rights of PLWHA while monitoring the conduct of health workers. Government should also complement civil society's efforts to provide treatment literacy.

Lesotho

Approximately 270 000 of Lesotho's population of 1 880 661 are living with HIV, representing a 14% prevalence rate. Of these, only about 24 411 people are on ART, representing 28% of the estimated 84 791 people in need of ARVs, among whom there are 3 520 children aged 14 and below.

Although meagre, the 28% of those on treatment surpasses the government's treatment target to provide ART to 25% of those who need it in 2008. The government's target is to reach 80% of those in need of treatment by 2010.

The major providers of ART programs in Lesotho are government and faith-based programmes. Treatment for opportunistic infections is not easily available, largely because HIV-related services are not integrated. For example, ART and OI services are provided at different clinics that are sometimes far apart. Even when a patient travels, there is no guarantee that the needed medicines will be available due to drug stock-outs. Treatments for diarrhoea, chest and skin infections are among those least likely to be available on a regular basis. In many cases clinics lack regular supplies of appropriate medications and patients may be turned away based on how fit they appear to be.

Major barriers to ARV treatment in Lesotho include limited access to ART clinics, stigmatisation and challenges with adherence.

Lesotho is a mountainous country and patients have to travel long distances, sometimes from one town to another, in order to access health care facilities. In addition, stigmatisation is rife and PLWHA may forego treatment in fear of other people knowing about their sero-status or seeing them going to clinics. The heightened incidence of TB/HIV co-infection increases the pill burden for PLWHA and also worsens the side effects, leading to a high defaulter rate.

In order to make access to ARV and OI treatment easier in Lesotho, there is a need to integrate ART and OI services so that patients can get treatment under one

roof. It is important to increase the number of health practitioners with specialised training in HIV disease, opportunistic infections and TB. Availability of drugs has to be improved and treatment literacy enhanced to help communities increase adherence.

Civil society needs to enhance advocacy efforts to ensure that AIDS treatment is decentralised and that people can get care near where they live. Training expert patients to take on key tasks in the health sector could also be useful in reducing the negative impact of shortages of health professionals.

Government needs to ensure greater distribution of health centres within reasonable reach of the population, increase human resources and guarantee supply of HIV and OI medication in all clinics. Funding community-based treatment literacy programs would result in greater uptake and adherence to treatment. This should be complemented by the enforcement of workplace HIV/TB policies and programmes, which have not yet been instituted in Lesotho.

Madagascar

With a population of 18 million people, Madagascar's HIV burden is low. An estimated 310 people are living with HIV, representing a prevalence of less than 1%. Of these, 107 are on ART.

As outlined in the National Strategic Plan 2007-2012, Madagascar's treatment programme aims to improve the accessibility and availability of medical care services for PLWHA by placing functional reference centres in 45% of the country's districts. The government's target is to ensure provision of care and ARV treatment to 2 500 people between now and 2012. Treatment for opportunistic infections is not accessible as the medicines are expensive and 97% of HIV positive people are poor and cannot afford to buy the drugs.

Barriers to treatment include lack of coordination between the Ministry of Health and NGOs as well as the failure to decentralise the provision of HIV-related services. In addition, key services are not integrated, e.g. ART and STI services are provided in separate places. Further, the process of purchasing and procuring medicines is long and bureaucratic, which sometimes disrupts treatment and results in drugs expiring while in storage.

In order to improve access to treatment for people with HIV, the government has to work in collaboration with civil society. The Ministry of Health should recognise that civil society organisations complement the health delivery system by providing psychosocial services, which are a key element in the medical care of HIV patients. Similarly, government needs to recognise the value of private sector interventions.

Civil society organisations need to work in close collaboration and support each other's efforts and improve access to prevention, care and treatment services.

Malawi

With a population of 12 million, Malawi has 930 000 people infected with HIV, of whom 146 000 are on treatment. Of these, 61% are women while 39% are men. The government programme caters for 95% of those on treatment. It is estimated that 175 000 people are in need of treatment.

Not all OI treatment is readily available and at times facilities run short of supplies.

Barriers to treatment include stigma due to religious and cultural beliefs; lack of information on ARV treatment; and a shortage of health facilities, with patients having to travel long distances to ARV centres. A direct consequence of these barriers is the challenge of adherence as patients discontinue treatment.

To enhance access, the government of Malawi should consider introducing mobile VCT and ARV clinics to reach more people in need of treatment while further decentralising services, particularly to rural areas. It is also essential for government to increase the number of health facilities that administer treatment. Civil society needs to embark on an aggressive treatment literacy campaign to educate communities about treatment so they can advocate for government to meet targets.

Mauritius

Mauritius, with a population of 1.2 million, is estimated to have 2 110 PLWHA. Currently, 380 people are on treatment.

All those in need can access both ARV and OI treatment, which is provided solely by government. However, a large number of people are co-infected with HIV and hepatitis C.

Despite the availability of ART, the level of stigmatisation and discrimination in the health care system is high and serves as a barrier to treatment. As 80% of PLWHA are injection drug users, they face a dual burden of stigma.

Further, only one health centre administers ART throughout the country, which creates a transport challenge for those who live far from the site.

In order to improve access to treatment for PLWHA, there is urgent need to decentralise health services and particularly ART sites in Mauritius.

Mozambique

Mozambique's HIV infection rate is at 8%, with 1 655 514 people out of a population of 20 530 714 living with the virus.

As of March 2008, a total of 96 613 people were on ART, representing 30.7% of the 314 000 in need of treatment. Currently, 62% of the ART recipients are women and 7% are children, while men constitute 31%. ART provision is funded by both the government and NGOs and the government aims to place 132 000 people on

treatment by year-end. Although OI treatment is available, frequent stock-outs are a challenge.

Barriers to treatment in Mozambique include inadequate access to information, limited infrastructure (with patients in some regions having to travel an average of 50km to the nearest health facility), stigma and a severe shortage of specialised healthcare workers.

Without access to information patients are not in a position to seek HIV and AIDS services. Although 70% of Mozambique's population is rural-based, 70% of the health care facilities are located in urban areas, thereby presenting a challenge for patients who have to travel long distances to access the facilities. Further, uptake of treatment is low in closely-knit communities, as patients do not want to be seen visiting ART sites for fear of ostracism and stigmatisation.

To make access to ARV and OI treatment easier in Mozambique, there is need to decentralise services and improve stock management. Government should ensure effective engagement of civil society and use the knowledge of PLWHA expertise in the area of treatment. Civil society needs to ensure community mobilisation, education and empowerment of key community actors at grassroots level.

Namibia

Namibia is one of the region's success stories in ART provision, with the highest coverage at 88%. ART scale-up in the country has been rapid, moving from 33 593 people in December 2006 to 52 316 in December 2007[15]. Namibia has an estimated population of 2 000 000[16] and prevalence is difficult to establish as no survey has been conducted.

"Treatment roll-out is scaling up but still not accessible to all those in need. There is currently no extra effort being made by the Government of the Republic of Namibia (GRN) to improve service delivery," according to the government's report to UNGASS.

Due to Namibia's vast geographic area, health facilities are far apart and sometimes patients have to travel distances of about100km to access treatment[17]. Stigma and discrimination also remain major obstacles to access and uptake of HIV treatment and services.

Seychelles

The Republic of Seychelles, with a population of 83 500, has an estimated, 217 known cases of HIV, of which 112 are men and 105 are women. Of these, 94 are on treatment (51 men and 43 women). All patients who need treatment receive ART free of charge. The same applies to OI treatment, which is easily available and

[15] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.
[16] National Planning Commission. 2003
[17] *Republic of Namibia Ministry of Health and Social Services UNGASS country report*. Period covered - April 2006 to March 2007.

accessible. The government solely funds the ART programme. Due to its prosperity and the low disease burden, Seychelles is not dogged by the barriers to treatment that bedevil the greater part of the SADC region.

However, stigmatisation by health care personnel tends to drive away patients and hinder uptake of treatment programs, subsequently affecting adherence in the long run. This raises the need to train health care personnel who administer HIV-related services on issues of stigma. In the same vein, there is need for a law to protect patients from discrimination. Health service providers also need guidelines on how to manage HIV-positive patients. Decentralisation of treatment services will also enhance the efficiency of ART provision.

South Africa

An estimated 5.5 million people are living with HIV in South Africa, which has the largest number of infections in the world[18]. South Africa also boasts of having the highest number of people on treatment in the world[19]. By the end of September 2007, the reported number of people on treatment was 428 951[20]. Though the absolute number of people on ART is high, when compared with the need for treatment, South Africa is not even covering half of the people who require treatment now. The number of people estimated in need of treatment range from 889 000 to 1 700 000 based on the UNGASS country report and WHO estimates, respectively[21].

South Africa's target is to provide appropriate treatment, care and support packages to 80% of all PLWHA and their families by 2011[22]. Despite its capacity to provide treatment for all who need it, barriers to treatment in South Africa devolve largely from a lack of political will.

Swaziland

Swaziland is among the four countries that are worst affected by the AIDS pandemic in Southern Africa, with an HIV prevalence of 18.3%[23]. An estimated 200 000 people out of the population of 1 134 000[24] are living with HIV.

By end of March 2008, about 26 148 people were on ART, representing 45% of the 58 000 in need of treatment. Women constitute 60% and children 9% of the total number of people on ART.

The government has pledged to provide ARV treatment to all people who need it in the country. This programme is supported through a budgetary allocation by the Ministry of Finance for ARV drug procurement and the Ministry bolsters the funding available through the Global Fund. As a result, all people who have gone through

[18] *Sub-Saharan Africa AIDS Epidemic Update Regional Summary*. UNAIDS, WHO. 2007.
[19] *Republic of South Africa. UNGASS Country Report*. Period covered – January 2006 to December 2007.
[20] *TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008. WHO, UNAIDS, UNICEF.
[21] Ibid.
[22] *Republic of South Africa. UNGASS Country Report*. Period covered – January 2006 to December 2007.
[23] Swaziland Department of Health
[24] WHO Factsheet. http://www.who.int/countries/swz/en/

VCT and HTC and qualify for ART are enrolled as soon as possible, without having to go through waiting lists.

Despite the government's commitment, however, there are barriers that threaten the programme's success. These include a low percentage (about 24%) of people accessing HIV testing and counselling services, unclear policies on consent for HTC in children, a preference for traditional and alternative medicines, media focus on the side-effects of ART thereby discouraging uptake, and lack of money for transport to access ART in clinics and hospitals.

Bringing services closer to the people through decentralisation of ART services to community level, involvement of the community and support groups in treatment literacy training, and improved 'marketing' of ARV drugs as the best option would go a long way towards ensuring greater access and uptake of ART in Swaziland.

Zambia

It is estimated that 1.6 million[25] people out of Zambia's population of 11 696 000 are living with HIV.

According to ART national coordinator, Dr. A. Mwango, 175,000 people were on ART in June 2008. The estimated number of people needing ART therapy based on the 2007 country report was 370 000.

In addition, the supply of OI treatment is erratic, largely because of inefficient supply chain management systems. For example, acyclovir and fluconazole are not readily available at almost all government-run health institutions and are mostly available at institutions managed by international NGOs such as CIDRZ and MSF, among others.

Barriers to treatment include human resource constraints with a severe shortage of health workers, inadequate diagnostic tests, few clinics, stigmatisation and limited treatment information.

These barriers severely compromise treatment delivery as the shortage of health care workers makes it difficult for government to approve more centres to administer ART due to inadequate human resources to manage the treatment programme. It also results in long queues, with patients having to wait for six to seven hours to access services. The shortage of diagnostic equipment means patients have to travel long distances, sometimes to another town in order to access the tests. Further, most ART sites are concentrated in urban areas and the rural majority have to walk long distances of more than 50 km to the nearest centre. Due to high poverty levels many patients cannot afford the transport costs.

Stigma and discrimination against PLWHA remain huge barriers in most communities hence many people are reluctant to undergo VCT, for fear of rejection once their HIV status is known. So strong is the stigma, that people can lose their jobs. As a result of these barriers, many people resort to traditional healers and quack cures.

[25] Missing the Target. Volume number 4. July 2007.

In order to enhance treatment services to PLWHA, the government of Zambia should embark on an intense programme to train and retain health care workers.

Decentralisation of services and the introduction of mobile ART and OI clinics will ease the transport cost burden on clients and subsequently improve treatment uptake.

It is also important to intensify treatment literacy efforts in order to create demand for services by well-informed PLWHA.

Meaningful engagement of all stakeholders in planning and implementation, including people with HIV and their communities is important for treatment programmes. Zambia needs a more assertive civil society that consults and empowers its constituents to ensure community ownership of programmes, while holding government accountable to its promises.

In addition, there is a need to start looking into procuring third-line regimens, as some people are already showing signs of failure to respond to second-line drugs.

Zimbabwe

With an estimated population of 13.2 million people[26], Zimbabwe is among the four SADC countries worst affected by the pandemic. According to the National HIV Estimates of 2007, HIV prevalence among adults between 15-49 years old is 15.6%. About 1 320 739 people were living with HIV and AIDS[27] and of these, 260 000 were in need of ART[28].

By the end of May 2008, about 104 000 PLWHA were receiving treatment, largely from the government programme. The government's target for the year is 160 000, representing 61% of the number in need of treatment[29].

Major barriers to ARV treatment in Zimbabwe include political and economic challenges, inadequate resources — both human and financial, and a collapsing health delivery system.

The past eight years have been characterised by political turmoil and an economic downturn. Among the consequences are hyperinflation, shortages of basic commodities, mass migration, a reduction in social spending, donor flight and 80% unemployment. These challenges have directly impacted health care.

Inadequate human and financial resources are largely a consequence of the tumultuous political and economic situation. Economic instability has led to mass migration of skilled labour to neighbouring countries and the West in search of better salaries and working conditions. The health delivery system has been most affected by this brain drain.

The situation has been worsened by the flight of donors, whose support had in the past sustained the health delivery system, and compounded by the country's failure to secure funding from a number of GFATM rounds. Further, Zimbabwe is

[26] WHO Factsheet. http://www.who.int/countries/zwe/en/
[27] *Zimbabwe. UNGASS Country Report*. Period covered – January 2006 to December 2007
[28] Interview with Dr. Owen Mugurungi, Head of AIDS and TB Unit in the Ministry of Health and Child Welfare.
[29] Ibid.

neither a recipient of PEPFAR funds nor a beneficiary of funding from others, leaving the government with limited funding options for its treatment programmes.

The reduction in social spending by government, flight of donors and the brain drain, have resulted in the deterioration of the country's health delivery system. This is characterised by shortages of essential medicines, a poor logistics and procurement system, obsolete equipment and collapsing infrastructure. For these reasons, OI treatment is not easily available or accessible in Zimbabwe.

"One cannot even get an aspirin," lamented an activist, aptly describing the level of deterioration in the country's health system.

Zimbabwe has the capacity to manufacture generic ARVs but is not producing them due to lack of the foreign currency needed to import some of the raw materials required to make the drugs. In October 2006, the governor of the Reserve Bank of Zimbabwe (RBZ), Dr. Gideon Gono, pledged to provide no less than US$2 million monthly towards improving the health delivery system and purchasing drugs, including ARVs. Varichem, the local pharmaceutical company that manufactures generic ARVs, only requires US$1 million monthly for ARV production.

The RBZ should honour its commitment to the people of Zimbabwe, and this will be a clear demonstration that the nation's health is a priority.

However, it is important to note that the real changes needed in Zimbabwe are both political and economic. Once change occurs in these vital areas strengthening of all other systems can follow, including improved health delivery, which covers access to treatment.

Civil society can complement government efforts by providing treatment literacy, as civil society organisations are in touch with communities and are in a better position than government to offer this service. CSOs can also complement existing programmes through provision of support services such as counselling and provision of expert patients. Such services will be very useful in a country that is facing severe human resources challenges as a result of the brain drain. These organisations also need to conduct continuous and sustained advocacy to hold government accountable to commitments made.

On its part, the government should set practical treatment targets that are supported by the necessary financial, human and other resources. In addition, it needs to honour commitments made towards ensuring universal access, e.g. the Abuja Declaration and the Millennium Development Goals (MDG).

CONCLUSION AND RECOMMENDATIONS

Although countries in the SADC region vary widely in their political, social, and economic situations, on access to AIDS treatment they face common problems that can be resolved using common solutions as discussed in the recommendations below. Most of the problems in the region have already been discussed extensively at numerous summits. All that is required now is political will to move the solutions forward. Where there is strong political will — for instance in Botswana, Namibia and Seychelles — significant gains can be made in serving the needs of PLWHA.

RECOMMENDATIONS

In order to improve access to treatment, there is need for concrete action at both regional and national levels. Proposed actions include:

Governments

1. Access to treatment for rural populations needs to be enhanced. This means decentralising HIV and associated services across countries, instead of clustering them in and around urban areas. Innovative ways of bringing treatment closer to the people in the short-term need to be investigated, possibly including the institution of transport vouchers to pay for travel to health care facilities or the establishment of mobile clinics.
2. Governments must fulfil the commitments they have made in various treaties, covenants and agreements. In particular, governments can begin by honouring their commitments in the Abuja Declaration by allocating no less than 15% of their annual budgets towards health.
3. Governments must introduce laws and policies that protect PLWHA from stigma and discrimination not only in the health sector but also in employment, and other areas of the public sphere. These anti-discrimination laws must be enforced and PLWHA must have access to means to seek redress for any violations of their rights. Stigmatisation and discrimination are hindering the uptake of treatment programmes, and addressing these issues head-on in communities and among health care workers must be a priority.
4. Governments must set ambitious targets for AIDS and TB treatment, seeking to ensure universal access to these services by 2010. These targets must be integrated into a fully costed national plan. Governments should report annually on their progress and obstacles to achieving these targets on time in a public document available to everyone.

Civil society

1. Community-based treatment literacy and psychosocial support are vital to bolster AIDS treatment programs. CSOs must complement government efforts by providing treatment literacy and expert patient services. This will help curb the negative impact of human resource shortages.

2. Civil society organisations must take on a stronger advocacy role in their countries in order to hold governments accountable to their promises. Without this advocacy, governments have no in-country, internal pressure to perform and deliver.

SADC

1. The SADC Health Desk, working with civil society, must conduct an annual audit of declarations and commitments that have been made about AIDS and AIDS treatment, and how far these have been honoured by national governments. This audit must include a bottleneck analysis to identify barriers to progress in scaling up AIDS treatment and a plan to address these obstacles.
2. SADC should institute a peer-review mechanism through which governments monitor and encourage each other to meet treatment targets and honour commitments made.
3. Some countries within SADC have the capacity to produce generic ARVs. While local production often cannot achieve economies of scale, regional production may provide sources of additional generic competition and alternative sources of drugs, potentially reducing the risk of supply-driven stock-outs. SADC should commission an analysis of the potential benefits and risks of regional production of AIDS medicines, including the feasibility of such an effort.
4. SADC needs to develop a plan to ensure that migrants in SADC can receive appropriate AIDS and TB services wherever they are within the region, whatever their nationalities.
5. The regional body should mobilise resources and implement a common monitoring strategy.
6. SADC needs to develop a set of model laws and policies on stigma and discrimination that are consistent with international law and human rights standards, and backed by scientific evidence. The absence of laws and policies that protect the basic rights of PLWHA in some SADC countries is unacceptable 27 years into the epidemic.

ANNEX 1

Treatment Barometer/ Report Card

As part of efforts to hold SADC governments accountable to the commitments they have made to ensure universal access to treatment, the Southern African Treatment Access Movement (SATAMo) is conducting an audit on progress made in the area of treatment. Findings from the audit will be published in a biannual publication, ***The Treatment Barometer***, which will be used in the region for advocacy purposes. Kindly complete the following questionnaire and submit to regis@tac.org.za or gregg.gonsalves@gmail.com or matilda.moyo@gmail.com on or before **25 May 2008**.

Questions

Country: ____

Population: ____

1. How many people are living with HIV in your country?

2. What is your government's national ARV treatment target for 2008; 2009 & 2010?

3. How many people in your country are on ARV treatment?

   (a) Please provide a break down of the number of people on government, NGO and privately sponsored programmes.

   (b) Kindly provide a breakdown of women, children and other marginalised groups that can access treatment?

4. How many people in your country require ARV treatment?

5. Please name the major barriers to ARV treatment in your country?

6. Explain how the barriers above affect access to ARV treatment.

7. Is treatment for all the opportunistic infections (OI) easily available and accessible in your country? If not, please state which treatments are not available and what you think are the reasons for this.

8. What recommendations can you make that would make access to ARV and OI treatment easier in your country.

9. What do you think should be done to ensure access to treatment for people living with HIV?

   - By civil society
   - Governments
   - SADC

10. Kindly include additional information that you feel is relevant and will add value to the research.

Thank you!

ANNEX 2

ANTIRETROVIRAL THERAPIES: COVERAGE IN SOUTHERN AFRICA

Country	Reported number of people receiving ART 2006	Month and year of report	Reported number of people receiving ART 2007	Month and year of report	Average monthly increase in the number of people receiving ART in the last year	Estimated number of people receiving ART December 2007	Estimated number of people needing ART based on UNAIDS/WHO methodology, 2007	Estimated ART coverage, December 2007	Estimated number of people needing ART therapy based on country report, 2007
Angola	6514	Dec 06	11540	Dec 07	419	12000	47000	25%	45287
Botswana	79490	Dec 06	92 932	Dec 07	1120	93000	120000	79%	110000
Lesotho	14579	Aug 06	21710	Dec 07	46	24000	85000	26%	84791
Madagascar	89	Nov 06	138	Dec 07	3	<200	3200	4%	1206
Malawi	59980	Dec 06	100649	Dec 07	3389	101000	290000	35%	252720
Mauritius	243	Dec 06	321	Dec 07	17	<500	1500	22%	1200
Mozambique	37133	Oct 06	85822	Nov 07	3745	90000	370000	24%	294986
Namibia	33593	Dec 06	52316	Dec 07	1394	52000	59000	88%	-
Seychelles	82	Dec 06	-	-	1	<100	-	-	-
South Africa	291754	Sep 06	428951	Sep 07	12266	460000	1700000	28%	889000
Swaziland	17160	Oct 06	24535	Dec 07	503	25000	59000	42%	58249
Zambia	82030	Dec 06	151199	Dec 07	5764	151000	330000	46%	370000
Zimbabwe	66920	Dec 06	97692	Dec 07	2564	98000	570000	17%	260000

This table shows estimated numbers of people receiving and needing antiretroviral therapy and coverage percentages. 2006 – 7*

*Adapted from TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008. WHO, UNAIDS, UNICEF 2008.

ANNEX 3

ANTIRETROVIRAL THERAPIES IN SOUTHERN AFRICA: SUMMARISED COUNTRY DATA

			Treatment Targets			People on ART				Notes
BOTSWANA[30]	**Number of People Living with HIV**	**Prevalence**	**2008**	**2009**	**2010**	**Total**	**% coverage**	**% of 2008 target**	**% of 2010 target**	
	300000	18%	100%	100%	100%	100000	79%[31]	79%	79%	Botswana's official ART target is to initiate all patients eligible for ART within one month.
Availability of OI Treatment	Largely available and accessible, with the exception of acyclovir for the treatment of herpes zoster, and ganciclovir and valganciclovir for the treatment of cytomegalovirus (CMV) - supply of which are erratic in government health facilities									
Barriers to Treatment Access	• Stigma: fear of rejection, isolation and discrimination discourages uptake of VCT and other HIV/AIDS care and treatment services. • Distance: Long travel to access diagnostics and treatment interferes with service uptake and adherence. • Erratic diagnostic supply: Poor maintenance of equipment, e.g. CD4 count machines, delays enrolment on ART and interferes with treatment monitoring.									
Recommendations for CS	• Scale up of community treatment literacy and advocacy activities, including stigma mitigation activities. • Advocacy for availability of all essential drugs at all public healthcare facilities;									
Recommendations for Governments	• Support CS treatment literacy and advocacy efforts; • Enact laws to protect the rights of PLWHA; • Monitor HCW conduct to guard against poor practice and stigma; • Establish central information centre to collect ART and OI data									

[30] All information taken from MASA (government ARV programme) and the Botswana Treatment Literacy Coalition BTLC/BONELA needs assessment 2007
[31] TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008. WHO, UNAIDS, UNICEF 2008.

<table>
<tr><th colspan="4"></th><th colspan="2">Treatment Targets</th><th colspan="4">People on ART</th><th>Notes</th></tr>
<tr><th rowspan="2">LESOTHO</th><th>Number of People Living with HIV</th><th>Prevalence</th><th>Number of People in Need of treatment</th><th>2008</th><th>2010</th><th>Total</th><th>% coverage</th><th>% of 2008 target</th><th>% of 2010 target</th><th></th></tr>
<tr><td>270000</td><td>14%</td><td>84791</td><td>25%</td><td>80%</td><td>24411</td><td>28%</td><td>112%</td><td>35%</td><td>Lesotho has 3,520 children aged 14 and below on treatment. Most ART programs are run by government and faith-based programs.</td></tr>
<tr><th>Availability of OI Treatment</th><td colspan="10">Poorly accessible:
• Lack of integration of OI with HIV services means that points of care are sometimes far apart.
• Stock-outs, especially for treatment for diarrhoea, chest and skin infections, are frequent.
• Reports of patients being turned away from clinics for OI treatment based on how ‘fit’ they look.</td></tr>
<tr><th>Barriers to Treatment Access</th><td colspan="10">• Long distance travel is sometimes necessary to access services over mountainous landscape.
• Stigma prevents PLWHA from seeking VCT and care.
• Inadequate training of HCWs and communities on HIV, TB and other OIs decreases quality of care and treatment outcomes.</td></tr>
<tr><th>Recommendations for CS</th><td colspan="10">• Advocacy for decentralization of ART provision;
• Scale-up of community treatment literacy.</td></tr>
<tr><th>Recommendations for Governments</th><td colspan="10">• Urgent decentralization of HIV and OI services;
• Increase training of HCWs on HIV, TB and OIs;
• Increase human resources - this includes training patients to take on key tasks in the health sector to reduce the negative impact of severe HCW shortages;
• Support community treatment literacy programs to improve uptake and adherence;
• Institute workplace HIV and TB policies and programs.</td></tr>
<tr><th>Other</th><td colspan="10">• TB/HIV coinfection increases pill burden and toxicities, leading to high defaulter rates.</td></tr>
</table>

<table>
<tr><td rowspan="2">MADAGASCAR</td><td>Number of People Living with HIV</td><td>Prevalence</td><td>People on ART</td><td>Notes</td></tr>
<tr><td>310</td><td><1%</td><td>107</td><td>Number of people on ART expected to increase to 2500 by 2012. Government aims to improve availability and accessibility of care by placing reference centres in 45% of the country's districts.</td></tr>
<tr><td>Availability of OI Treatment</td><td colspan="4">Not easily accessible - OI treatment is not provided free of charge and 97% of PLWHA are poor hence cannot afford expensive OI medicines.</td></tr>
<tr><td>Barriers to Treatment Access</td><td colspan="4">• Lack of integration of key services such as ART and STI services;
• Lack of coordination between Ministry and NGOs;
• Lack of decentralization of services;
• Procurement processes are long and bureaucratic, leading to treatment interruptions and expiry of drugs in shortage.</td></tr>
<tr><td>Recommendations for CS</td><td colspan="4">Increased collaboration and support between different CSO efforts to improve access to prevention, treatment and care.</td></tr>
<tr><td>Recommendations for Governments</td><td colspan="4">• Collaboration with CS: recognition of the value of CS in complementing the health delivery system especially through the provision of psychosocial services, which are a key element in HIV care and treatment;
• Increased recognition of the value of private sector interventions.</td></tr>
</table>

			Treatment Targets		Notes
MALAWI	**Number of People Living with HIV**	**Prevalence Number of People in Need of treatment**	**2008**	**Total**	
	930000	175000	180000	146000	61% of people on treatment are women, 39% are men. Majority of patients (95%) are on government programme, the rest catered for by other organizations.
Availability of OI Treatment	OI treatment not readily available; facilities often run short of supplies.				
Barriers to Treatment Access	• Religious and cultural barriers; • Lack of information on ART; • Shortage of health facilities; • Distance from facilities.				
Recommendations for CS	• Aggressive treatment literacy and advocacy campaign in communities; • Increased advocacy to push government to meet targets				
Recommendations for Governments	• Increased number of health facilities that can administer ART • Decentralization of services, particularly to rural areas • Introduction of mobile VCT and ART clinics				

MAURITIUS	Number of People Living with HIV	Total	Notes
	2110	380	Treatment provided solely by government; available for all eligible patients.
Availability of OI Treatment	OI treatment freely available at government facilities, but treatment of HIV-Hepatitis C co-infection, which is high in Mauritius and linked to injecting drug users (IDUs), is hindered by stigma.		
Barriers to Treatment Access	• Only one ART centre in the country - challenge of distance for people who live far from it. • High levels of stigma and discrimination in the healthcare system - particularly for IDUs.		
Recommendations for CS	• Advocacy for harm reduction measures • Increased community literacy and advocacy efforts • Campaign against stigma and discrimination in health facilities		
Recommendations for Governments	• Decentralization of health services and ART sites throughout Mauritius. • Assess and address issues with stigma and discrimination in the ART programme • Introduce harm reduction measures to address high HIV levels in IDUs		

				Treatment Targets		People on ART			Notes
MOZAMBIQUE	**Number of People Living with HIV**	**Prevalence**	**Number of People in Need of treatment**	**2008**	**Total**	**% coverage**	**% of 2008 target**	**% of 2010 target**	
	1655514	8%	314000	132000	96613	31%	73%		62% of people on treatment are women, 7% are children, 31% are men.
Availability of OI Treatment	Generally available, but frequent stock-outs pose a challenge.								
Barriers to Treatment Access	• Inadequate access to information in communities about HIV and AIDS services prevents patients from seeking these services; • Poor infrastructure; • Poor distribution of services (70% rural population, but 70% of services in urban areas) - patients in some rural areas travel an average of 50km to access a healthcare facility; • Stigma particularly in small, close-knit communities prevents patients from visiting ART sites; • Severe HCW shortage.								
Recommendations for CS	• Ensure community mobilization, education and empowerment at the grassroots level. • Community treatment literacy efforts to combat stigma • Application of knowledge and skills to complementing the national ART programme e.g. through information dissemination, and patient support								
Recommendations for Governments	• Decentralize services; • Improve drug supply management; • Ensure CS engagement and utilize expertise of PLWHA in treatment and patient support.								

			People on ART		Notes
NAMIBIA	**Number of People Living with HIV**	**Prevalence**	**Total**	**% coverage**	
	Unavailable: no studies have been conducted on this		52316[32]	88%	According to the government's UNGASS report, "Treatment roll-out is scaling up but still not accessible to all in need. There is currently no extra effort being made by GRN to improve service delivery."
Barriers to Treatment Access	• **Health facilities are far apart**; patients have to travel as much as 100km to access treatment.[33] • **Stigma and discrimination** remain major obstacles.				
Recommendations for CS	• Community treatment literacy efforts to combat stigma • Increased advocacy for decentralization of services • Increased patient follow-up support for those living far from health facilities				
Recommendations for Governments	• Decentralization and expansion of services • Increased surveillance of data for the HIV programme				

[32] TOWARDS UNIVERSAL ACCESS: Scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008. WHO, UNAIDS, UNICEF 2008.
[33] Republic of Namibia Ministry of Health and Social Services UNGASS country report. Period covered - April 2006 to March 2007.

SEYCHELLES	**Number of People Living with HIV**	**People on ART**	**Notes**
	217	94	ART and OI treatment provided free of charge by the government.
Barriers to Treatment Access	**Stigma** from HCWs hinders uptake of treatment and adherence.		
Recommendations for CS	• Treatment literacy in communities • Advocacy against stigma and discrimination in the health system and the workplace		
Recommendations for Governments	• Decentralization of ART services; • Training of HCW on destigmatization; • Institute laws to protect patients from discrimination; • Develop guidelines for health care facilities on the clinical management of PLWHA.		

			Treatment Targets	People on ART	Notes
SOUTH AFRICA	**Number of People Living with HIV**	**Number of People in Need of treatment**	**2010**	**Total**	
	5,500,000	889000[1]-1700000[1]	80% coverage by 2011	428951	SA has the highest number of infections in the world[1], and the highest number of people on treatment[1]. Though the absolute number of people on ART is high, when compared with the need for treatment South Africa is not covering even half of the people who require treatment. Additionally, official figures on number of people being treated largely do not reflect those who died or been lost to follow up, since the start of the programme.
Availability of OI Treatment					
Barriers to Treatment Access	Despite its capacity to provide treatment for all who need it, barriers to treatment in South Africa revolve largely from political will.				
Recommendations for CS	• Intensify treatment literacy and advocacy activities • Increase capacity of treatment-literate community members to monitor and report on the roll-out of the ART programme in their communities • Increased coordination between different CS groups				
Recommendations for Governments	• Demonstrate political will by ensuring that sufficient resources are available for the roll-out of treatment programmes • Engage communities in planning, implementation, monitoring and evaluation of the ART roll-out • Ensure that human rights are respected and promoted in the health care system				

			People on ART		Notes
SWAZILAND	**Number of People Living with HIV**	**Prevalence**	**Total**	**% coverage**	
	200000[1]	18%[1]	26148	45%	60% of people on ART are women, and 9% are children. The government has committed to providing ART for all who need it in the country, so all people who are eligible for ART are enrolled as soon as possible, without having to go through waiting lists. The national ART programme is supported through the national budget for ARV procurement, which bolsters funding available through the Global Fund.
Barriers to Treatment Access	• Low percentage of people accessing VCT (24%); • Unclear policies for VTC consent in children; • Preference for traditional and alternative medicines; • Media emphasis on ART toxicities which further discourages uptake; • Lack of money for transport to access ART in clinics and hospitals.				
Recommendations for CS	Improved "marketing of ARV drugs" to ensure greater access and uptake of ART in Swaziland.				
Recommendations for Governments	• Decentralizing ART services to community level to make them more accessible; • Improved "marketing of ARV drugs" to ensure greater access and uptake of ART in Swaziland.				

ZAMBIA	Number of People Living with HIV	Number of People in Need of treatment	People on ART
	1600000[34]	155000[35]/370000[36]?	175000[37]
Availability of OI Treatment	Erratic - inefficient supply chain management. For example, aciclovir and fluconazole are not readily available at most government-run health institutions, but only at those run by INGOs.		
Barriers to Treatment Access	• Concentration of ART sites in urban areas, with majority of rural patients having to travel long distances of more than 50km to the nearest centre and high poverty levels preventing many from affording transport costs; • Human resource constraints that prevent government from approving more ART sites and also result in delays in patients accessing services; • Lack of access to diagnostic tests which means that patients have to travel long distances - sometimes to another town - to access diagnostic tests; • Stigma and discrimination are very high - to the point that people can lose their jobs - which discourages people from seeking VCT and leads them to resort to traditional healers and quack cures; • Limited information on treatment for communities.		
Recommendations for CS	• Intensify treatment literacy efforts in order to create demand for services; • Increase assertiveness of CS • Increase CS capacity to consult and empower its constituents to ensure community ownership of programs and to hold government accountable.		
Recommendations for Governments	• Embark on intense program to train and retain HCWs; • Introduce mobile ART and OI clinics; • Decentralize services to decrease the transport cost burden and improve treatment uptake; • Support treatment literacy efforts; • Engage all stakeholders - including people living with HIV and their communities - in planning and implementation; • Begin looking into third-line regimens as some people are already showing signs of failure to second line drugs.		

[34] Missing the Target. Volume number 4. July 2007.
[35] Dr C. Banda, MOH spokesperson, March 2008
[36] Country report 2007
[37] Dr. A. Mwango, ART national coordinator, June 200