

Overview of treatment access in the SADC region

In the following article, Adila Hassim offers an overview of the state of antiretroviral treatment programmes in the SADC region. She also highlights some of the major challenges that confront the region if treatment programmes are to continue to expand and be sustained.

The 'era of treatment'

It has been twenty years since HIV was discovered (National Institute of Health, 1995): In 1987, AZT was the first antiretroviral (ARV) registered for treatment of HIV infection. By 1996, AZT in combination with new antiretrovirals had become the standard of care for people with AIDS, and became known as combination therapy using HAART (highly active antiretroviral therapy). As a result of widespread use of ART in Europe and North America, HIV/AIDS mortality dropped by 80 per cent. These drugs were all extremely expensive and thus unaffordable and inaccessible to the developing world. As a result of the slow response to demands for treatment access in developing countries, the gap between those who need ART and those who are receiving it has widened. In the SADC region, approximately 10 million people have died of HIV-related illnesses.¹ Globally, six million people are in need of ART.² As at 2003, only 400 000 have received treatment, with less than 7 per cent of those on treatment living in developing countries. The challenge to narrow this gap is daunting, but not impossible. This is what the World Health Organisation (WHO) has sought to prove by initiating its campaign to get 3 million people on ART by 2005 ('3 by 5' campaign). This is a response to the declaration in September 2003, by the leaders of the WHO, UNAIDS and the Global Fund, that the lack of access to ART is a global emergency.

Time has shown that the traditional prevention mantra is not sufficient to halt or reverse the reach of HIV/AIDS. Treatment initiatives are a necessary complement to a comprehensive response to the pandemic. Regrettably, millions have died in the interim. The response to the question of why treatment is necessary varies, depending on the source. Some cite labour and production feasibility, inflation reduction, increasing foreign direct investment, national security, reducing the rapid increase in orphans, and unburdening health systems. At the core of the justifications for treatment, however, is the prevention of premature death. It is integral to the protection of our basic human right to life, health, dignity and equality. In the period of time that it took this journal to be produced, tens of thousands of people in Africa have died of an AIDS-related illness.

It is only now, after a long and difficult battle, that we can safely say that we have entered an 'era of treatment'. There is finally a concerted commitment to increasing the number of people who have access to treatment. The Millennium Development

¹ SADC HIV/AIDS Framework and Programme of Action, 2003-2007: Managing the HIV and AIDS Pandemic in the Southern African Development Community.

² The range is from 4-8 million people.

Goals (MDGs) adopted at the Millennium Summit of the United Nations in 2000 call for action to halt the spread of HIV/AIDS. Improving the health status of the poor is an important component of the MDGs. In 2001, a Special Session of the United Nations General Assembly adopted the Declaration of Commitment on HIV/AIDS, and also in 2001 the African Summit adopted the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. The Declaration expresses concern over the escalation of HIV/AIDS and other infectious diseases in Africa, and a commitment to exploring methods of constraining the pandemic nationally and regionally. These declarations culminated in the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in order to increase resources. The Global Fund disburses grants to countries to assist prevention and treatment programmes. Closer to home, in 2003 the SADC Heads of State and Government adopted and signed the Maseru Declaration, or Communiqué on the 2003 SADC Heads of State and Government Summit on HIV/AIDS, which includes testing and treatment as a priority area (see Appendix).

Despite these declarations, the international commitment to treatment targets remains a concern, with only limited contributions from governments being made to the Global Fund. Funds are needed to continue with programmes that have already begun, and if contributions do not increase significantly, those who are receiving treatment will not be able to do so for much longer.

The United States recently threatened to reduce the total amount that had been approved by Congress for the Global Fund if that amount is more than one-third of the Fund's total donations, and has announced that it will withhold \$120 million unless other countries meet their obligations by 30 September 2004 (CBS News, 19 August 2004). The U.S. government justified this as leverage to get other countries to contribute. While this political cat-and-mouse game plays itself out, the Fund struggles to make the finances available for 2005 projects.

The era of treatment thus refers more to the fact that treatment issues have had increasing rhetorical attention and political space rather than serious financial support. A sustained commitment is needed for the urgent and effective implementation of treatment protocols. Without adequate international financial aid and the necessary national political will, such treatment efforts are ineffectual.

THE TREATMENT GAP IN THE SADC³ REGION⁴

COUNTRY	POPULATION (MILLIONS)	ESTIMATED NUMBER OF PLWAS (0-49 YEARS)	ESTIMATED ART NEED IN 2005	REPORTED NUMBER RECEIVING ART JUNE 2004 (15-49 YEARS)	ART COVERAGE (%)
Angola	14.1	240 000	32 000	700	2.2
Botswana	1.8	330 000-380 000	60 000	18 000	30.0
Dem. Republic of Congo	51.2	1 100 000	160 000	2 500	1.6
Lesotho	1.8	290 000-360 000	54 000	1 000	1.9
Malawi	12.8	900 000	130 000	3 760	2.9
Mauritius	1.2	unknown	unknown	unknown	-
Mozambique	19.2	980 000-1 700 000	190 000	2 840	1.5
Namibia	1.8	210 000	29 000	400	1.4
South Africa	44.4	5 300 000	750 000	59 000 ⁵	2.7
Swaziland	1.1	210 000-230 000	32 000	3 200	10.0
Tanzania	37.7	1 200 000-2 300 000	260 000	1 650	0.6
Zambia	10.9	730 000-1 100 000	140 000	8 500	6.1
Zimbabwe ⁶	12.9	1 500 000-2 000 000	290 000	6 000	2.1

³ Seychelles has recently withdrawn from SADC. Membership currently stands at 13 countries. Madagascar has applied for membership.

⁴ Table compiled by author. Statistics sourced from WHO '3 by 5' country profiles, 2004. Reported numbers of people receiving ART include the public and private sectors.

⁵ The latest report of the South African HIV Clinicians' Society indicates that 45 000 people are receiving ART in the private sector. Including the estimate of 14 000 people on ART in the public sector, this totals 59 000.

⁶ Statistics sourced from the WHO. However, the Zimbabwean Minister of Health, Mr Parirenyatwa, was quoted as saying that 1.82 million people are infected with HIV/AIDS, with 340 000 people in need of ART, while only 5 000 people are currently receiving ART (*The Lancet*, Vol. 4, July 2004, p. 387).

Targets for ART in the SADC region

Most SADC countries have now developed policies on HIV/AIDS that include a treatment component. There is, however, a glaring gap between policy and implementation. In some cases, this is due to a lack of resources or expertise in planning an effective programme, while in others it is due to a lack of political will.

Treatment targets for 2004/2005 as set by the government of each country are:⁷

Angola	5 500	Botswana	47 500
DRC	not declared	Lesotho	28 000
Malawi	not declared	Mozambique	21 000
Mauritius	not declared	Namibia	not declared
South Africa	53 000	Swaziland	12 000
Tanzania	220 000	Zambia	100 000
Zimbabwe	55 000 ⁸		

It is estimated that more than 90 per cent of people living with HIV/AIDS live in resource-limited settings (WHO, 2002:22)⁹. A scaling-up approach to treatment access, which builds on limited but existing resources, dissemination of best practices and strengthening national health systems, has been identified as integral to the progressive roll-out of ART (WHO 2004).¹⁰

⁷ These statistics are drawn from the WHO '3 by 5' country profiles. For South Africa, however, the figure is based on the Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, 19 November 2003, Table 0.2, 42.

⁸ According to recent press statements by an official in the Ministry of Health and Child Welfare, the target is to get 3 000-4 000 people on treatment every month for a period of 12 months. The report states that about 500 people are on ART so far. 'RBZ disburses US \$1m for ARVs', *The Sunday Mail*, 29 August 2004.

⁹ 'Scaling up Antiretroviral Therapy in Resource-limited settings', WHO, June 2002.

¹⁰ '3 by 5' Progress Report: December 2003 through June 2004', WHO, 2004.

Strategic plans aimed at scaling up treatment access require considered timelines and schedules. Treatment targets are therefore an essential component of strategic planning. Without benchmarks and targets, there is no systematic progression towards a goal of increasing the number of people who have access to treatment as speedily and effectively as reasonably possible. Targets provide a clear objective to regional and district health service providers, and encourage a response that is driven by vigour. This is what the WHO '3 by 5' campaign is premised on; it is also based on calculations by experts that the goal is achievable.

Declaring that HIV/AIDS has precipitated a public health emergency requires a concomitant urgent response. Country experiences, such as Mozambique's, have shown that setting clear targets enables the scaling up of treatment and assessment of priority needs (Attawell & Mundy, 2003:3). Setting of targets makes government policies clear, and can form a basis for funding proposals. In Lesotho, a country with a 30 per cent adult HIV-prevalence rate, the Ministry of Health is committed to meeting its target of 28 000 people on ART by 2005, and has secured funding from a range of external donors.¹¹ Lesotho has provided an example of the progress that can be made in spite of an immature health system and limited resources. It is, in fact, a remarkable contrast to the slow progress of treatment roll-out in South Africa.¹²

In SADC, a co-ordinated regional response, with information exchange, dissemination of best practices and engagement with international assistance programmes will build on national plans. The SADC HIV/AIDS Framework affirms that the harmonisation and co-ordination of programmes and policies in the region is required in order to counter the spread of a virus that respects no borders. Regional population dynamics, such as migrant labour and displaced persons, mean that insulated national strategies alone will not constrain the spread of the pandemic. Strategies at every level should correspond to the gravity of the public health situation.

¹¹ This includes support from the Clinton Initiative, Boston University, the Ontario Hospital Association in Canada, the WHO, the Global Fund and the World Bank.

¹² See section on National Political Will and Governance.

Challenges to the implementation of public sector treatment plans in the SADC region

Regional political and economic issues have had an impact on the progression of HIV/AIDS, and will also affect systematic treatment efforts. Civil strife in the DRC, migratory patterns (due to civil war, famine and employment) in the countries that border South Africa, refugees and poverty are some of the issues. In Angola, for example, one of the challenges to roll-out is the social reintegration of ex-military personnel (WHO, 2004). In Zimbabwe, the economic and political turmoil has affected health care services and reduced donor support. Against this backdrop of poverty and social instability lie the challenges to the effective implementation of national treatment plans.

One of the most notable achievements of civil society activism in recent years has been to weaken the monopoly of the pharmaceutical industry, thus reducing prices of ARVs, but despite the reduction in drug prices, challenges remain. None of these are unforeseen. Treatment activists have long been aware that the struggle for treatment access would not end with the adequate procurement of ARVs. Comprehensive health system transformation is equally necessary for a proper and equitable response to HIV/AIDS. At the same time, ART programmes are the vehicles to achieve this transformation. It is therefore unnecessary and dangerous to postpone or delay treatment plans until there is an adequate health system in place, and a linear approach to overcoming these challenges will only delay the delivery of ART and exacerbate the existing treatment gap. Effective public sector roll-out across the region is impeded by the following factors.

Drug supply

The impact of patent protection

That drug prices have fallen does not mean that an affordable and sustainable supply of all necessary drugs will automatically follow. Prices of some key drugs still remain high. In particular, there is a need for fixed-dose combinations (FDCs), alternative drugs for second line treatments, and for affordable paediatric formulations and paediatric FDCs. Patent protection of these drugs means that there is less generic competition. As a result, intellectual property regulations continue to impede access to treatment.

In general, the intellectual property system is a social institution that began as privileges that were granted to entrepreneurs, and which has enabled them to create monopolies. Over the last few centuries, the system has become more sophisticated and accessible through codification.¹³ The recent practice of referring to patents as 'intellectual property rights' (IPRs) blurs the true nature of these devices as privileges or incentives; that they have a limited lifespan; and that they are mainly held by corporate entities and not individuals.

In relation to HIV/AIDS, the impact of patent protection has been harshly felt in the inequitable access to essential drugs. While there has been some decrease in prices, companies continue to assert intellectual property rights to limit production of cheaper generic substitutes of key drugs. For example, Triomune, a generic FDC of Cipla, needs licences from Boehringer-Ingelheim and Glaxo-Wellcome before it can enter the market in South Africa.¹⁴

The lack of generic competition on second line drugs makes the cost of such drugs prohibitive. For example, in Khayelitsha, South Africa, the first line treatment costs US \$363 per year, but the second line regimen costs US\$1 285 per year (Darder & Boulle, 2004). These drugs are also not available in FDC formulation, which is known to simplify delivery and increase adherence.

The availability of generics results not only in price reduction; where a variety of sources of generics is available (either through importation or local manufacture) it is more likely that there will be a sustainable drug supply.

The international intellectual property system, which manifests itself in the TRIPS agreement, is not inflexible. The Doha Declaration¹⁵ is an interpretation of TRIPS at the highest level of the WTO, and specifically recognises the need for the supply of

¹³ Paris Convention for the Protection of Industrial Property; Berne Convention for the Protection of Literary and Artistic Works; International Convention for the Protection of Performers, Producers of Phonograms and Broadcasting Organizations (1961); Treaty on Intellectual Property in Respect of Integrated Circuits (1989); Agreement on Trade-Related Aspects of Intellectual Property Rights (1993).

¹⁴ Triomune is not yet registered for use in South Africa. It has, however, been pre-qualified by the WHO, which suggests that registration will not be an obstacle.

¹⁵ Declaration on the TRIPS Agreement and Public Health, 14 November 2001, adopted by the WTO Ministerial Conference, Doha.

generic drugs to address the public health needs of countries with disproportionate disease burdens. It provides that 'each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted' and to 'determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency' (WTO, 2001:para. 5(b) (c)).

In terms of the Doha Declaration, national legislatures are entitled to adopt patent laws aimed at protecting the public interest. In keeping with this regime, the Zambian health minister recently announced that the country has begun to locally manufacture generic ARVs with assistance from Cuba. The manufacturer is awaiting approval of an application for a compulsory licence by the government before the ARVs are marketed (Kaiser, 2004). Regrettably, Zambia's example has not been followed by other countries in the region. South Africa's patent legislation reflects the 'TRIPS-plus' requirements of the developed world, despite the need for flexible intellectual property regulations. In Tanzania, as in other Southern African countries, the patent legislation as it stands does not allow the importation of generic drugs or the local manufacture of patented drugs (WHO, 2004). In recognition of the potential that the Doha Declaration poses, the World Health Assembly has urged member states to use such flexibilities to adapt national legislation, and to guide the negotiation of bilateral trade agreements (World Health Assembly, 2004).

The longer the delay between the Declaration and the use of its provisions, the weaker it becomes. In the meantime, the restrictions on drug supply adversely affect treatment plans.

Donor funding

Issues surrounding the funding of drug procurement further hinder drug supply. Conditions attached to the disbursement of donor funds for the procurement of drugs limits accessibility to such funds. The President's Emergency Plan for AIDS Relief (PEPFAR) was announced in 2003, as a five-year, US\$15 billion initiative to fund prevention, treatment and care programmes in developing countries. PEPFAR would be a laudable demonstration of U.S. commitment to addressing the pandemic in Africa if it were not encumbered by conditions that reflect the conservative moral worldview of the Bush administration. PEPFAR not only contains 'moral' prerequisites, but also economically driven prerequisites, for example, the deference to brand-name pharmaceuticals. The

purchase of generics that are pre-qualified by the WHO, particularly Fixed Dose Combinations (FDCs), is actively discouraged. The advantage of administering FDCs is not only that it encourages patient adherence, it also reduces the costs of production, storage and distribution. The result is to block the entry of generics into the market, thereby hindering treatment scale-up. The condition of using brand-name drugs means that of the number of people needing treatment and who could potentially access treatment with the use of generics, only about one-quarter of them will in fact be treated.¹⁶ Thus one effect of PEPFAR is to support a parallel system for treatment delivery instead of strengthening existing national health systems.

Health infrastructure

The reasons for inadequate health infrastructure are many. With regard to the implementation of ART roll-out, the three areas of greatest concern are human resources, technological capacity and monitoring and evaluation.

Human resources

Arguably, the greatest weakness in the health infrastructure of Southern African countries is the critical shortage of human resources. This is a result of the freezing of new posts, poor working conditions, and the migration of health care workers to the private sector and overseas in search of better work experience and career opportunities. In Malawi, for example, 60 nurses are trained a year, while every year 100 nurses leave to work abroad. In 2001/2002 just six countries in the SADC region lost approximately 3 000 nurses to the United Kingdom.¹⁷ Wage increases, while a necessary component of a recruitment and retention strategy, are not sufficient to retain staff, and other factors such as stress, lack of career-pathing, the inability to provide proper care due to scarce resources, ineffectual management and long working hours combine to make the health sector an intolerable work environment.

A further threat to human resource capacity is HIV infection among health care workers. A South African study found that the HIV sero-prevalence rate among healthcare workers is 15.7 per cent, (Shisana, cited in Ncayiyana, 2004:584-585), and this will

¹⁶ Interview with Stephen Lewis, available at www.pbs.org/newshour/bb/health/july-dec04/aids_7-19.html.

¹⁷ South Africa, Zimbabwe, Zambia, Botswana, Malawi and Mauritius. 'The Health Workforce in Africa: Challenges and Prospects', Africa Working Group of the Joint Learning Initiative on Human Resources. WHO, World Bank and Rockefeller Foundation. Global Health Trust, March 2004, p.27.

undoubtedly affect staff availability and morale. Staff clinics that provide a supportive environment, counselling and treatment are needed to care for health care workers themselves living with HIV/AIDS. Without this, staff shortages and absenteeism will increase and further weaken the already overburdened health system.

Health problems in Africa are generally related to primary health care, and there is therefore a greater need for nurses than specialist physicians. An appropriate human resources plan would include staff clinics for the treatment of HIV/AIDS, opportunistic infections and other illnesses; while a plan for the region will need to consider increased nurse-based and volunteer worker care, and also the role of traditional health practitioners. Although they are often consulted for medical advice and treatment, there is limited recognition of, or investment in, traditional medicine. This is a necessary *quid pro quo* for steps that should be taken by governments to improve the regulation of traditional health care practices (Lewis, 2004). Regulations that ensure the safety and quality of traditional health care services, and the registration and training of health care practitioners will serve to integrate traditional healers into public health systems, and will encourage traditional healers to play a greater role in strengthening health systems.¹⁸

Technological capacity

The efficient supply of technological services is integral to the roll-out of ART. Laboratory and pharmacy facilities, trained laboratory technicians and pharmacists, and the acquisition and maintenance of equipment are inadequate, particularly in rural areas. A laboratory infrastructure is necessary for the diagnosis of HIV and related opportunistic infections, and to monitor the effectiveness of treatment (viral loads and CD4 cell counts in particular). Lack of access to laboratories and prolonged waiting times between tests and results slow the pace of treatment delivery. It would be unrealistic to expect that all sites should be able to conduct CD4 and viral load tests, but it is possible, at sites with limited access to laboratories, that health workers are encouraged to rely on clinical markers such as weight gain instead. Where there is a need for tests for patients who are not exhibiting positive clinical markers, tests will have to be conducted off-site. This requires a transport and delivery system to allow efficient, safe and speedy return of test results.

¹⁸ In South Africa, a Traditional Health Practitioners Bill is currently before the second house of parliament (National Council of Provinces). Its stated objectives are to ensure safety, efficacy and quality of health services and training of practitioners.

Management systems

Simple management systems are needed for the proper operational monitoring of roll-outs to address weaknesses in health systems, tracking of patients, adherence and possible viral resistance. Monitoring systems need not be costly or complex. In Malawi, creative solutions have been sought which include reducing the frequency of monitoring visits of those patients who are clinically stable, developing simple record-keeping systems, and a periodic drug inventory monitoring system.

Stigma and adherence

Stigma and discrimination permeate the entire prevention-treatment-care continuum of controlling HIV/AIDS. Stigma has a major impact on an individual's right to dignity and equality. At the treatment level, stigmatisation is felt within the health sector, where health care workers are insensitive or judgemental in relation to patients who are HIV-positive, and in the broader community once a person's status is known. This reduces the number of people that participate in voluntary counselling and testing (VCT), a vital entry point for treatment. The fear of openly taking antiretrovirals (ARVs) affects adherence to the treatment regimen, and disclosure of status to family members has been an important factor in increasing adherence. Once there is treatment interruption there is a risk of viral resistance, which necessitates switching to a different drug regimen. Since second line treatment is not easily available, treatment options are limited. High rates of adherence are also known to improve the virological and clinical effects of treatment (WHO, 2003:34). Thus stigma also has an impact on an individual's ability to access health care services.

In resource-limited settings, community participation is an important vehicle for treatment delivery and information transmission. Greater involvement of people living with HIV/AIDS and of the broader community will help to break down discriminatory attitudes and embrace treatment potential. This will require education and counselling to enhance community preparedness.

National political will and governance

An effective response to the pandemic depends on national leadership taking action that demonstrates the integrity of stated political commitments. This requires government to formulate strategic plans in consultation with all sectors of society, set reasonable targets, implement the plan in an open and transparent manner, and facilitate access to information regarding the progress of implementation.

The centrality of political will to successful roll-out plans cannot be over-emphasised. Even with a conducive legal environment and good economic conditions, poor leadership can derail treatment efforts. South Africa, for example, has one of the most progressive constitutions in the world and an exemplary human rights framework. Its health expenditure exceeds that of most developing countries, yet its health indicators are comparable to some of the least-developed countries. It took years of activism before the government announced its decision to implement a national ARV treatment plan, and since the introduction of the plan the Minister of Health has shown a lack of commitment to reaching its targets. There are presently, at most, 10 000 people receiving ART in the public sector,¹⁹ whereas the target set by the government for March 2005 is 53 000 people on ART. This is more than 100 000 people fewer than initially targeted in the government's operational plan, and even the reduced goal of 53 000 will not be met at the current rate of roll-out.²⁰ The response of the health ministry has been to justify this by stating that the reason for the low number of people on treatment is a slow take-up due to stigma and insufficient health care workers. This is a misrepresentation of the reality of long waiting lists and of people being turned away because they 'look healthy'.²¹ It is also a telling indication of the (lack of) commitment of the government to its treatment plan. On the other hand, that Botswana has achieved 30 per cent ART coverage²² is evidence that with commitment comes progress.

Can the goal of broad treatment access in the SADC region become a reality?

The answer to this question must be positive. The challenges outlined above are not insuperable. Pilot studies in resource-poor settings²³ have demonstrated that ART is feasible and effective. The outcomes of ART delivery in these settings have been said to be comparable to those in rich countries. As pointed out earlier, the MSF project in Khayelitsha, one of the poorest urban informal settlements in South Africa, has achieved

¹⁹ The figure is likely closer to 6 000, according to UNAIDS estimates. The accepted range is between 6 000 and 10 000.

²⁰ Updated first report on the implementation of the Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment for South Africa. AIDS Law Project and Treatment Action Campaign, July 2004.

²¹ Interview with Portia Ngcaba, TAC Eastern Cape Provincial Organiser, 26 October 2004.

²² See SADC treatment gap table above.

²³ Pilot studies are being conducted in South Africa, Malawi and Mozambique by Médecins Sans Frontières. See also article by Belinda Beresford in this journal, which discusses the MSF Lusikisiki ARV site.

excellent adherence rates. In Lusikisiki, a remote village of the Eastern Cape province in South Africa, there are more people on treatment than the total in certain other provinces in South Africa. Just one hospital in Botswana, Princess Marina Hospital, provides ART to more than 8 000 people. These examples demonstrate that community participation and civil society engagement propel action. The advocacy of treatment activist groups and people living with HIV/AIDS has been largely responsible for focusing world attention on the need to increase access to treatment, and their role continues to be important in order to achieve the goal of treatment expansion. While national leadership cannot be replaced as the driver of national treatment plans, the success of such plans is dependent on the engagement of civil society. This requires a sincere partnership with an open exchange of information so that civil society organisations can assist in implementation and educate their members as to the availability of treatment. An ethical prerequisite of treatment access planning is to involve people living with HIV/AIDS at all stages of planning and implementation. The planning of the WHO '3 by 5' campaign took place in this way, and such an approach can and ought to take place at national level.

The examples above also teach us that resource constraints need not impede treatment access. After a recent visit to the rural village of Arua in Uganda, the UN Secretary-General's Special Envoy for HIV/AIDS in Africa observed: 'There are eleven hundred people receiving antiretroviral drugs, generic fixed-dose combinations in one tablet, taken twice a day. The adherence rate is well over 90 per cent, the success rate is close to 90 per cent, the simple regimen has shown few side-effects.... the community, especially the several vibrant groups of people living with AIDS, is intoxicated with excitement and accomplishment. It's one of those rare instances where even stigma feels as though it has evaporated in the ether of success.'²⁴

A little carried away, no doubt. But the message is plain. Challenges in even the poorest settings can be overcome with the right strategy and requisite commitment. With time, the challenges will change and will need to be addressed as they arise, but this can hardly be a reason for paralysis now.

²⁴ Stephen Lewis, UNAIDS: Notes for press briefing on recent trips to Uganda and Lesotho, September 2004.

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