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From the Editor

In true *AIDS Analysis* style, we kick the year off amidst much controversy. Fatima Hassan in her rather interesting article, "Auditing the national anti-retroviral (ARV) treatment programme," takes a fleeting glance at the progress of the roll-out of the public sector treatment programme in South Africa. Her findings are alarming.



In this edition, we have also decided to publish two letters (the second a response to the first) that were originally published in *The Star* this January. Peter McLaren carefully outlines what he believes are reasons for the HIV epidemic reaching mammoth proportions in South Africa. As astonishingly misinformed as Mr McLaren may seem to be, one comes to realise that there are many Mr McLarens in South Africa, of every racial and religious grouping, and that there remains much to do to educate and inform everyone about HIV and AIDS in our country. Nathea Nicolay (an AIDS actuarial specialist at Metropolitan) attempts to do just that in her brilliant response. Enjoy!

Don't forget to visit the ***AIDS Analysis Africa Online*** website at www.redribbon.co.za for archived articles, statistics and reports on HIV/AIDS in sub-Saharan Africa.

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Auditing the national anti-retroviral (ARV) treatment programme

By Fatima Hassan

In November 2003, the South African government announced the adoption of a national ARV treatment programme. The decision had come too late for thousands of people who had by then already suffered and died prematurely of AIDS as they did not have free access to the life-saving medicines. However, in a country where 5 million people are living with HIV and AIDS and where about 500 000 people need immediate access to treatment, in the next few years, the potential for the programme to save lives and keep people healthy and productive appear encouraging. But much needs to be done if these goals are to be achieved.



Even though more people are on ARV treatment in the public and private sectors than about two years ago – a change largely brought about by intensive lobbying against a government policy that resulted in huge delays in delivering treatment – the numbers remain far off the initial target set by government.

Though aiming for 53 000 in the first year of the programme, at present, only 20 000 people are receiving ARV treatment in the public sector, most of whom are women. With respect to paediatric access, fewer than 3000 children are on treatment in the country. Interestingly then, government now aims to have 53 000 people on treatment by Year 2 of the programme, a figure that is blind to the daily and immediate reality of about 500 000 people living in SA.

In the private sector, about 45 000 people are on treatment. The latter figure includes medical schemes, workplace treatment programmes and the private unfunded sector.

What these figures suggest is that meeting the initial overwhelming demand for treatment may take a long time. However, given that from 1 January 2005 medical schemes must fund ARV treatment as a prescribed minimum benefit, and that several large companies have now realised the benefits (largely financial) of providing treatment in the workplace, this figure is likely to rise in the next few months, but perhaps not substantially. Already, reports from some companies suggest a low take-up of treatment programmes largely due to stigma and fear of disclosure on the part of the employees. The lack of proper adherence to treatment is also now emerging as a public health problem. What is needed is greater commitment from the private sector and big business to ensure that it plays its part in reducing stigma in the workplace through awareness and education; and that through efficient workplace programmes that address prevention and treatment, the burden on the public sector is reduced. The trade unions have an equally difficult job ahead. Not only must they ensure that there is better take-up of treatment programmes; but they must also actively encourage early diagnosis through voluntary counselling and testing for everyone. They will also have considerable responsibility in educating employees who are on treatment about the many issues related to adherence to the drugs.

Of course government's planned introduction of social health insurance towards the end of 2005 (as part of the proposed national health insurance system) will go some way in ensuring that formal sector employees have compulsory, affordable and appropriate medical cover. This is therefore an opportune time for employers and the unions to pick up the pace. Whilst there are more companies than five years ago that have HIV and AIDS workplace programmes in place, there are far too many that have yet to formulate and implement a workplace policy and programme or even gauge the impact that AIDS is having on their workforce and markets.

But government too must hurry. As a country we have already wasted many years in trying to turn the tide – we simply cannot afford to waste any more. Contrary to what the health minister offers as an excuse for the small numbers of people on treatment – that is, 'an overburdened health care system' – there are other compelling reasons that explain the delay in expanding the programme. In this article, I shall deal with two.

It is true that apartheid left us with a damaged health service, but ten years on, the delays that we are experiencing should be overcome with dedicated and unambiguous leadership. A quick glance at provinces such as Gauteng, the Western Cape, the Free State and the Northern Cape illustrates my point. In these provinces, health care workers are showing unprecedented commitment to scaling up capacity and services speedily. They are finding creative solutions to ensure that many lives are saved. The same sense of urgency and commitment is needed in other provinces and at a national level.

Regrettably, at a national level two important areas of management are lacking, resulting in a suffering treatment programme and “an overburdened health care system” to which the minister alludes. Speedy resolution in these areas is required at a national level to remedy this.

First, a national human resource plan for the public sector is sorely absent. We are witnessing high levels of attrition in the public sector amongst nurses, pharmacists and doctors. This is prompted by low morale and unsatisfactory working conditions, clearly affecting the ability of many provinces to scale up their capacity. Yet, to date, we do not have a national human resources plan, let alone one designed for emergencies. Ideally, a plan must be implemented to deal with attracting, training and retaining health care workers in the public sector. At some treatment sites, it is reported that there are no pharmacists or there is an insufficient number of doctors and nurses. Despite this, posts are being frozen in some provinces such as the Eastern Cape. The absence of a plan to address these human resource shortages will seriously undermine our public health system, and in particular the national ARV programme.

The second task that the minister has been slow to finalise is the tender process for ARV medicines. Though the process commenced in February 2003 and was due to have been completed by July 2003, to date, it has not. Though several companies were shortlisted in August 2003, there has been no clear move towards awarding the tender contracts. The concern is not that provinces cannot procure medicines. They can do so using interim mechanisms. The issue is that the procurement regulatory framework limits the amount that can be procured by provinces in the interim. The monetary limitations that apply to the interim process do not apply to the national process awarding the tender contracts. Hence, the national process is able to guarantee greater volumes of medicines. Treating an increasing number of patients in the provinces has become a huge challenge as a result.

What this means in the private sector is that a worker who cannot afford to belong to a medical scheme or who has no access to a workplace treatment programme will have no choice but to depend on the public sector programme. While the delays in implementing the programme can be overcome, it can only be done if government, labour, business and civil society are serious about making it a success. This involves planning, acting decisively and with a greater sense of urgency and commitment, and ensuring that programmes are implemented and that they remain accessible to the many people whose lives depend on them.

Fatima Hassan is an attorney focusing on the law with respect to treatment access. She is attached to the AIDS Law Project (ALP) and the Treatment Action Campaign (TAC).

Put simply, Aids is contracted through amoral sex

by Peter McLaren

Further to the headlines in *The Star* of January 7, "Mandela Aids Grief", I am appalled to hear, even from such high profile people as our beloved ex-president, that they still are not stressing the issue that HIV/Aids is an illness almost exclusively spread through the lack of good human morals.

Almost every religion in the world says that sex should only take place in the sanctity of a strong life-long monogamous relationship. But, we are teaching our children as young as five or six that sex is all right so long as it is "safe" sex, i.e. use a condom. Our children are even taught how to fit a condom properly, through the use of sex toys and visual aids.

I hear almost every day, people trying to get governments of the world to supply anti-retrovirals to people who are HIV positive or who have full-blown Aids.

This is not a sickness that has been caused by industry or government negligence. Plain and simple, it is caused through indiscriminate, amoral sexuality.

I have not heard one member of our government publicly announcing that the government is not responsible for people's moral behaviour or the lack thereof. HIV and Aids are now being asked to be grouped with sicknesses such as cancer and tuberculosis. Those are not caused through lack of morals. I recommend that the government become the first country in the world to adopt a national policy that says that only those people who can prove that they contracted HIV/Aids through a serious long-term monogamous relationship will be treated at the government's expense.

I further recommend that the parents of children born with HIV/Aids be convicted of criminal negligence and be sentenced to life imprisonment. To those who are living with HIV/Aids I say you live by the sword and so shall you die by the sword.

The government should channel those meager funds and resources available for anti-retrovirals to the teachings in schools and all places of learning that there should be no sex outside of a strong life-long monogamous relationship.

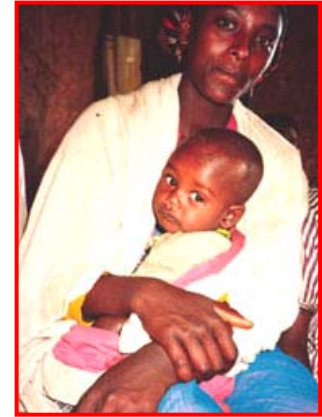
I will then sleep a little easier in knowing that my very hard-earned tax is going to a cause that was not created through loose amoral sexual behaviour.



Blaming Aids on amoral sex speaks of ignorance

by Nathea Nicolay

I am stunned by the ignorance and insensitivity around the issue of HIV/Aids that still persist with the South African public at large. Peter McLaren's letter in *The Star* of January 11 headed "Put simply, Aids is contracted through amoral sex" filled me with great despair. More than 50% of the estimated 5-million HIV-positive people in South Africa are women who were in most cases undempowered to negotiate safe sex with their partners.



Many of these women are poor rural wives of the migrant labourers who work in the cities. Women are three times more likely to contract the disease than men due to their anatomy. If they have been faithful to their husbands, where is the amoral behavior and why die by the sword as McLaren put it? His arguments are flawed and speak of ignorance and self-righteousness.

White apartheid South Africa benefited from the labour of young black men working on the mines and the roads without caring about the destruction that migrant labour was causing to the family structure in South Africa. Single-sex mining hostels are now being phased out by some forward-thinking mining companies, that realize the role they played in making it difficult for miners to live close to their families.

The HIV prevalence rate in the mining sector is between 20% and 30%. HIV/Aids can therefore partly be attributed to the breakdown of the family structure in South Africa due to the inequalities of the past. How many white families have employed live-in black domestic servants who would have found it difficult to have the "ideal family structure" that McLaren is talking about? McLaren says other illnesses cannot be avoided, however, illnesses such as cancer can be contracted through behavioral weakness such as smoking.

We are not living in a perfect world in which everybody can be with the same partner for life. What will he say to his widowed daughter who remarries and discovers she is HIV positive because her new partner did not know his status?

We estimate that more than 300 000 are expected to die of Aids this year – almost double the number of tsunami victims. Currently it is estimated that half a million South Africans are in the final stage of the disease and most likely in need of anti-retroviral therapy (ART). Only around 65 000 South Africans are receiving ART with less than 50% of the patients treated in the public sector.

McLaren argues that the meagre HIV/Aids funding should be channeled to education. Firstly, generous funding for HIV/Aids is available and secondly, some provincial budgets go unspent due to lack of infrastructure and recourses even if funding is channelled elsewhere. It is not a shame to be HIV positive and the sooner a person realizes his/her status, the better chance they will have of increasing their life expectancy by 10 to 20 years.

The reality is that people like McLaren contribute to the stigma and discrimination facing HIV-positive people. This causes people to be afraid to test or come forward and receive advice and counselling on how to remain positive and healthy for many more years before reaching the Aids sick phase. Too many South Africans discover they are HIV positive only when are starting to show symptoms of being Aids sick.

Finally, I would like to quote confession from a married woman published in a human rights report: "he used to beat me to have sex with him. He would beat me and slap me when I refused. I never used a condom with him. When I got pregnant I went for a medical check-up. When I gave birth and the child past away, they told me I was HIV positive. I cried, the doctor told me: 'wipe your tears the whole world is sick'."

a Metropolitan AIDS Solutions Communiqué

Disclaimer

The views and opinions expressed in this publication do not necessarily reflect those of Metropolitan. As always, we encourage responses on any of the issues covered.

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