

HIV/AIDS AND HEALTH SECTOR RESPONSES IN SOUTH AFRICA

Treatment Access and Equity: Balancing the Act

EQUINET
DISCUSSION
PAPER **7**



Regional Network
for Equity in
Health in Southern
Africa

In co-operation with



Oxfam

By

Antoinette Ntali, Petrida Ijumba,
David McCoy, Ashnie Padarath,
Lee Berthiaume



Health
Systems
Trust

NOVEMBER
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Editors: R. Loewenson, C. Thompson

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Executive summary

South Africa is among the most inequitable countries in the world. Globalisation, the apartheid legacy, and a failure to implement government policies designed to redress past disadvantage, all contribute to inequity in access to basic social services, including healthcare and HIV/AIDS treatment and care. South Africa represents a highly symbolic case because of its ability to reflect the social and economic inequities that exist at the global level.

Current estimates indicate that South Africa has the largest number of people living with HIV/AIDS in the world. About 5 million people are infected and HIV/AIDS is the leading cause of death in the country. The epidemic is severely affecting the future of many South African children, and accounts for almost 75% of all new orphans. HIV/AIDS is disproportionately affecting disadvantaged communities, the communities with least access to general treatment and care. There is evidence that many South Africans, particularly in rural areas, are pushed deeper into poverty as households lose their breadwinners and much of the household's income is spent on healthcare. Women between the ages of 15 and 49 living in informal urban areas are most at risk.

This paper is one of a series of papers commissioned by the Regional Network for Equity in Health in Southern Africa (EQUINET) for a programme of work with Oxfam GB on 'Equity issues in HIV/AIDS, Health Sector Responses and Treatment Access in Southern Africa'. This programme of work seeks to inform the policy debates and advocacy that have grown around health sector responses to HIV/AIDS in the region. This paper reviews the equity challenges and concerns related to access to HIV/AIDS programmes in South Africa, with a focus on antiretrovirals.

The information contained in the paper was gathered through a literature review of local and international publications, grey print and personal communication with key stakeholders.

There is gross inequitable distribution of human and financial resources between the private and public health sectors, and in the public sector between the predominantly rural poor provinces and urbanised provinces. The private sector, accessible to less than 20% of the population, consumes more than 60% of the healthcare budget and employs more than 70% of the healthcare specialists. There is also inequity between spending on levels of care. Primary healthcare consumes about 15% of healthcare spending and estimates indicate that this is unlikely to increase in the medium term.

South Africa's health services are being overstretched by the HIV/AIDS epidemic. HIV/AIDS is a major cause of hospital admissions and, at primary level, health workers' morale is being affected as they become overburdened by HIV-related illness and HIV-related morbidity and mortality among health workers.



Policy inconsistency and political indecisiveness has weakened the rollout of HIV/AIDS programmes. Access to Voluntary Counselling and Testing (VCT) and prevention of mother-to-child transmission (PMTCT) programmes have also been constrained by poor infrastructure, an absolute shortage of human resources and insufficiency of skilled management capacity, stigmatisation, and inadequate integration with other healthcare services. Lack of capacity to effectively plan and implement HIV/AIDS programmes has led to poor utilisation of financial resources, particularly in disadvantaged provinces. Access to these services reflects patterns of inequity associated with treatment, benefiting those in mostly urbanised provinces where there is better infrastructure, better distribution of human resources and fewer social and cultural constraints.

Access to Highly Active Antiretroviral Therapy (HAART) is small. Of approximately 5 million South Africans infected with HIV, and out of more than 500,000 who could benefit from HAART, less than 20,000 are receiving it. The majority of individuals accessing the drugs are doing so through private sector medical schemes or workplace programmes. It became policy to provide HAART in the public sector in mid 2003.

Many healthcare professionals are poorly prepared for providing AIDS care. Relatively few have received training in the clinical management of the disease, or in counselling and testing. The majority of professional nurses, who are also charged with supervision of PHC facilities, are not trained in clinical use of antiretrovirals (ARVs).

One of the key challenges for South Africa will be to ensure that interventions to provide access to antiretroviral therapy (ART) are appropriately balanced with broader social and economic interventions to alleviate poverty and malnutrition. The vicious cycle of HIV, poverty and malnutrition will not be adequately broken by a medical intervention. Leaders and role models could make a difference by choosing to speak publicly and frequently about HIV/AIDS. Strengthening of Information Education and Communication (IEC) campaigns that target particularly disempowered groups, with appropriate language and cultural references, will therefore continue to be an important intervention that should not be neglected.

A further key challenge will be to expand access to treatment in ways that will not reinforce or accentuate the already existing health systems inequities. This will require reforms to reduce the public-private divide, as well as a more equal distribution of available health resources geographically. Strengthening the health system in under-resourced areas and those that are serving disadvantaged communities will require addressing the human resource capacity shortfalls of the health system.

Finally, the expansion of ART services must be managed in such a way that does not undermine other key and vital health services. These include HIV prevention efforts, but also key maternal and child health services, TB control programmes and STI services. The opportunity costs of expanding treatment must be kept to a minimum, and should be determined on the basis of transparent public health principles.

Key recommendations of the paper are to:

- improve the coordination of HIV and health systems development interventions
- provide a meaningful social welfare benefit in the context of AIDS
- promote a more equitable distribution of public resources
- develop an appropriate long-term human resource plan
- prioritise the development of healthcare infrastructure in under-resourced and rural areas
- monitor expenditure on HIV/AIDS
- clarify criteria for access to treatment
- widen business and private sector cover of HIV prevention and care empower communities to engage with the health system.



1. Introduction

The HIV/AIDS pandemic is a human catastrophe with far reaching implications for individuals, households, communities and countries. No other disease has so radically accentuated the present inequalities in healthcare access, basic human rights and economic disparities.¹ The epidemic is depriving nations of their young and most productive people. Africa will have 71 million fewer people by 2010 because of AIDS and populations may start contracting by 2003 in South Africa, Botswana and Zimbabwe. The epidemic is deepening poverty, reversing human development achievements, worsening gender inequities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply and putting a brake on economic growth.²

For a number of years now there has been growing awareness on the part of the international community that the inequality between rich and poor nations in the care and treatment of people living with HIV/AIDS represents not only a “moral scandal”³ but also a major economic, political and social challenge that threatens world stability. The distribution of highly active antiretroviral therapies (HAART) in high-income countries has proven to be effective in drastically reducing morbidity and mortality associated with HIV infection.⁴ However, those in low and middle income countries, where 95% of the estimated 42 million infected people live,⁵ have mostly not had access to HAART and the world is now confronted with the necessity of accelerating access to care and treatment in developing nations.

Economic globalisation, the apartheid legacy, and a failure to implement government policies designed to redress past disadvantage, all contribute to inequity¹ in access to healthcare, including access to HIV/AIDS services and interventions. South Africa is a highly symbolic case study in that the in-country inequities mirror global inequities, and lessons gleaned from within the country may be of value more widely.

This paper is one of a series of papers commissioned by the Regional Network for Equity in Health in Southern Africa (EQUINET) for a programme of work with Oxfam GB on ‘Equity issues in HIV/AIDS, Health Sector Responses and Treatment Access in Southern Africa’. This programme of work seeks to inform the policy debates and advocacy that have grown around health sector responses to HIV/AIDS in the region.

This paper reviews the equity challenges and concerns related to access to HIV/AIDS programmes in South Africa, with a focus on antiretrovirals. **Section two** describes the HIV/AIDS epidemic and its impact on society and the health system. **Section three** outlines some of the inequities in the country and their impact on health and healthcare. **Section four** explores the country’s response to the epidemic, and highlights a range of factors that have affected this response. **Section five** deals specifically with the provision of antiretrovirals. The concluding section raises some key issues in need of further consideration.

2. HIV/AIDS in South Africa

*'It is the poorest South Africans who are most vulnerable to HIV/AIDS and for whom the consequences are inevitably most severe.'*⁶

2.1 Distribution of HIV/AIDS

South Africa is grappling with HIV/AIDS. South Africa has one of the highest HIV/AIDS prevalence rates in the world. On average, 1 in every 4 pregnant women is infected with the virus.⁷ A 2000 burden of disease study in South Africa⁸ concluded that HIV/AIDS is the leading cause of death. About 5 million people out of a population of 42 million are infected with the virus and an estimated 600 people are dying every day from AIDS.

HIV/AIDS is a major cause of illness, a burden on the healthcare system and is having a visible impact on South Africa's workforce, productivity and skills base. Children are major casualties of the epidemic.⁹ It has been suggested that the Human Development Index of South Africa may be 15% lower in 2010 than it would have been without the impact of HIV/AIDS.¹⁰ According to Loewenson and Whiteside under-five infant mortality will rise to 150 per 1000 live births in 2010, indicating that 15% of South African children will die before their fifth birthday. Life expectancy for South Africans in 1990 was about 63 years, and was set to rise to 68 in 2000 and 72 in 2010. The impact of AIDS has reversed expected gains so that by 2000 life expectancy had in fact fallen to 58 years, and will plummet to 43 in 2010.¹¹

Table 1: Key indicators of HIV/AIDS in South Africa, sub-Saharan Africa and the world, 2002 (all figures in millions)

| Indicator | South Africa | Sub-Saharan Africa | World |
|---|--------------|--------------------|-------|
| Adults and children (ages 0–49 years) living with HIV/AIDS | 5.0 | 29.4 | 42.0 |
| Adults (15–49 years) living with HIV/AIDS | 4.7 | 26 | 37.1 |
| Women (15–49 years) living with HIV/AIDS | 2.7 | 15 | 18.5 |
| Children (0–14 years) living with HIV/AIDS | 0.25 | 2.6 | 3.0 |
| AIDS orphans (ages 0–14 years) currently living with HIV/AIDS | 0.66 | 11.0 | 14.0 |
| Adult and child deaths from HIV/AIDS | 0.36 | 2.4 | 3.0 |
| Adult and children newly infected with HIV | No data | 3.5 | 5.0 |

Source: HIV InSite 2002¹²

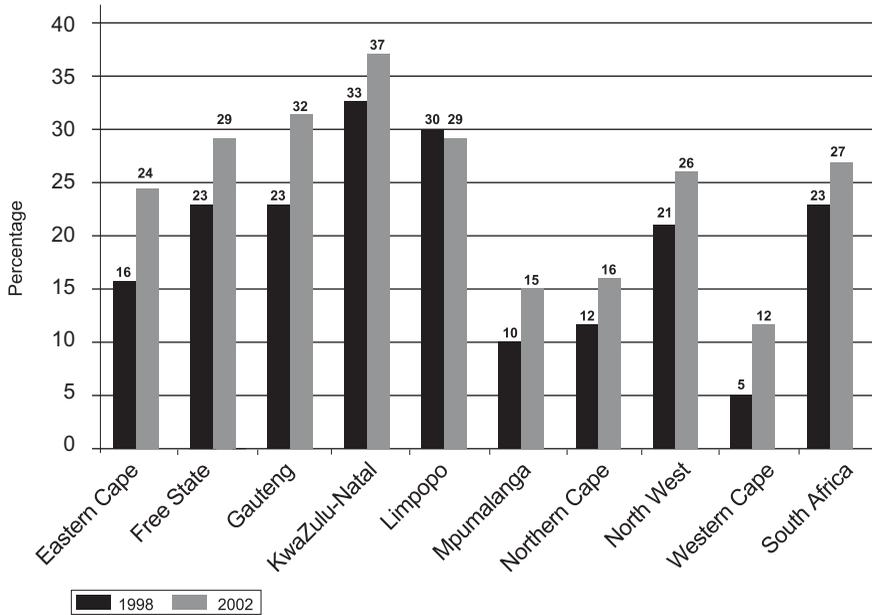
The Medical Research Council estimated that in 2000, HIV/AIDS was the cause of 40% of adult (aged 15–49) deaths and 25% of all deaths. Adult deaths have had a major impact on society.¹³ For example, 3% of South African households are headed by children aged 12–18. Projections show that



without treatment to prevent AIDS, the number of AIDS-related deaths will increase to more than double the number of deaths from all other causes within the next ten years.

Levels of infection vary between provinces as shown in Figure 1 below, although every province except Mpumalanga has experienced a substantial increase in prevalence in the period between 1998 and 2002. However, there has been decline in prevalence among the younger age group.

Figure 1: HIV prevalence by province among antenatal clinic attendees 1998-2002



Source: National HIV Survey in South Africa, Department of Health, 2002

Social and economic inequalities largely explain the high prevalence rates of HIV/AIDS in South Africa.¹⁴ Entrenched poverty and gender inequity, wide scale sale of sex, an institutionalised system of migrant work, and high levels of road haulage coupled with persistent stigma, have all contributed to the spread of the epidemic.¹⁵ There is evidence that disadvantaged communities are more prone to HIV infection. This is borne out by case studies among workers, which indicate that it is mainly the unskilled and semiskilled who are more susceptible to the infection;¹⁶ and by research that shows rates of infection are highest among those living in informal urban areas.¹⁷ There is significant evidence that many South Africans are pushed deeper into poverty as households lose their breadwinners and much of the household's income is spent on healthcare.¹⁸

In 2002, among adults aged between 15 and 49, 18.4% Africans were infected compared to 6.2% Whites, 6.6% Coloured and 1.8 % Indians. In the same age group infection rates were 28.4% among urban informal dwellers as compared with 15.8% among the urban formal; 12.4% for those living in tribal areas and 11.3% for those living on farms.¹⁹ Estimated HIV prevalence among those belonging to medical schemes (largely the wealthiest section of society) is estimated to be around 5–6%, well below the national average.²⁰

In South Africa the infection rate among men is 74% of that of women.²¹ The epidemic is fuelled among women for a number of reasons. Many women exchange sex for material favours and as a means of daily survival. Patriarchy and financial dependence on men mean that women cannot control when, with whom and in what circumstances they have sex. In addition, women are not expected to discuss or make decisions about sexuality. It is difficult for women to request, let alone insist on using, a condom or any form of protection, and if they refuse sex or request condom use, they often risk abuse, as there is a suspicion of infidelity. The many forms of violence against women mean that sex is often coerced, in itself a risk factor for HIV infection.²² For married and unmarried men, multiple partners (including sex workers) are accepted as a norm. Women are frequently expected to have relations with or marry older men, who are generally more experienced, and more likely to be infected. Men seek younger and younger partners in order to avoid infection and in the belief that sex with a virgin cures AIDS and other diseases.²³

Race and socio-economic status are also correlated with awareness of HIV status. Urban dwellers with higher levels of education are more likely to be aware of their HIV status; women more likely to be aware than men; and Africans are significantly under-represented in the group that have been tested for HIV.²⁴

2.2 Household impact of AIDS

HIV disproportionately affects disadvantaged communities. In a survey of 771 AIDS affected households,²⁵ those households hardest hit by HIV/AIDS were usually the most underserved in terms of basic public services like sanitation and piped water. Almost half the households reported having insufficient food at times and that children in these households often went hungry.

An average of 34% of monthly income was spent on healthcare, although overall rural households spent a greater proportion of monthly income (54 %) on healthcare than urban households (29%). This is significantly higher than the 4% average spent on healthcare by non-AIDS households. The actual amount spent per month, ranged from R8 to R4000, reflects the range in household income of between R40 and R24,500. Although poorer families spend a greater percentage of their income on care, the actual amount they spend is likely to be less than the actual expenditure of families that are better off.²⁶

The researchers concluded that some of the long-term ramifications of the HIV epidemic are:

- deepening poverty among the already poor
- disruption and premature termination of schooling for children, especially girls
- increasing early childhood malnutrition
- increasing strain on extended family networks.

HIV/AIDS has had a significant impact on communities, families and individuals throughout South Africa. The same survey on 771 AIDS affected households²⁷ found that for households surveyed:

- 22% of children under 15 years had lost a parent.
- 64% of AIDS-sick individuals were female. The average age was 33 years.
- More than 12% of households had sent their children away to live somewhere else, usually with a grandparent or other relative. More than 40% of caregivers took time off from work or school to care for the ill person, adding to the loss of household income and under-schooling.

Using the definition of an orphan as a person under 18 years whose mother has died, it is estimated that there were over 885,000 orphans in South Africa in 2002. Of the overall total, 38% would have been orphaned as a result of AIDS. In Mpumalanga and KwaZulu-Natal, approximately 50% of all orphans were orphaned as a result of AIDS. Two provinces, KwaZulu-Natal and Gauteng, between them currently account for about 53% of all AIDS orphans. Overall, AIDS accounts for almost 75% of all new orphans and 3% of South African households are headed by children under the age of 18 years.²⁸ A study of 35 families in KwaZulu-Natal found children as young as four caring for parents sick with AIDS, and more than half the children were not attending school while they cared for their parents.²⁹

An assessment of the situation of children in South Africa indicated that poverty and HIV/AIDS are part of the underlying and exacerbating causes of violations of children's rights. Child abuse and violence were also noted as key challenges, with evidence to suggest that many of the affected children are AIDS orphans.³⁰

2.3 Impact on Health Services

South Africa's health services are becoming overstretched and burdened by the HIV/AIDS epidemic. The Department of Health estimates that in 2000, 628,000 (25%) of public hospital admissions were for AIDS-related illnesses. Hospitals are already bearing the brunt of the epidemic. At Chris Hani Baragwanath Hospital in Johannesburg about 40% of all adult admissions are HIV-infected.³¹ At King Edward VIII Hospital in Durban, 60% of paediatric admissions are HIV-infected. In 2002 the public health sector spent R3.6 billion on hospital care for AIDS patients^{32,33} and 46% of patients in public hospitals were HIV positive.³⁴ 17.5% of PHC workers are living with HIV and 16% of hospital workers. Between 6000 and 12,000 healthcare workers may be dying each year as a result of AIDS related illnesses.³⁵

3. Existing equity challenges in South Africa

After years of institutionalised inequity, South Africa's first democratic government was elected into power in April 1994. The major goal underpinning policy development of the newly elected government was the promotion of equity and eradication of the injustices built up over many years. The scale of the challenge is signalled by the fact that South Africa remains one of the most inequitable countries in the world.

The early years of democratic government were underpinned by the Reconstruction and Development Programme (RDP), which put strong emphasis on a developmental approach to public policy.³⁶ The RDP was quintessentially about developing the infrastructure of the country through public works and community development programmes. It promised employment, building houses and the injection of resources and development into hitherto neglected areas of the country. This developmental policy was an attempt to fulfil the promises enshrined in the Freedom Charter, which included popular access to human rights, education and housing. However, the deepening impact of globalisation soon took root and in 1996 the developmental approach embodied by the RDP was replaced with the Growth, Employment and Redistribution (GEAR) policy. Ironically, since one of the main impacts of globalisation has been job losses and not increased employment, GEAR shifted the emphasis from broad-based social development to economic growth, and increasing employment as the catalyst for redress of previous disadvantage.³⁷ Subsequent economic growth has not been at the level anticipated by the Treasury, and the country has experienced steadily increasing levels of unemployment coupled with the entrenchment of poverty and little inroads in the reduction of apartheid era inequity.³⁸

3.1 Socio-economic inequalities

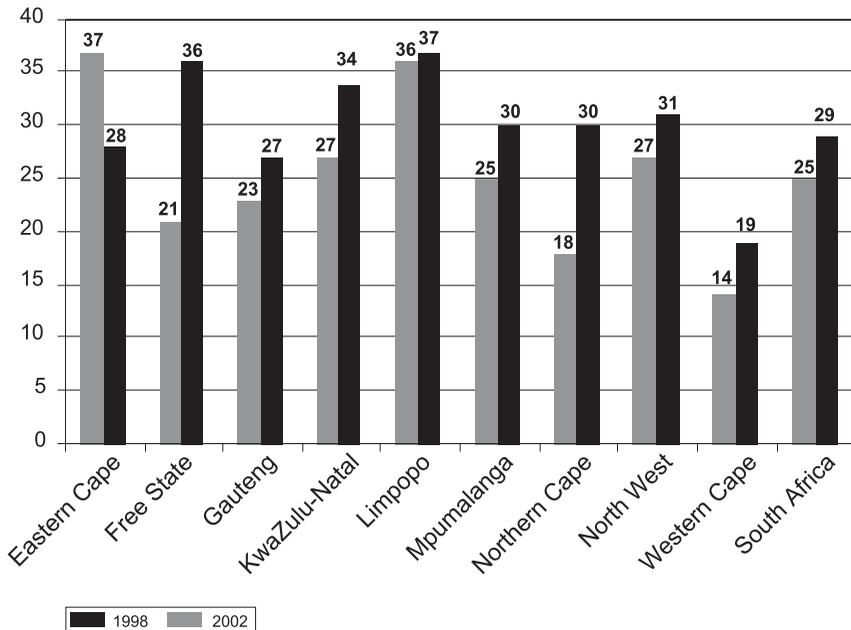
Inequities persist across race, gender, geographical area and rural-urban sector. With a GDP per capita of US\$11,290³⁹ South Africa is rated as a middle-income country. However, distribution of income is highly inequitable and South Africa has one of the highest gini-co-efficients in the world. The poorest 40% of households (equivalent to 50% of the population) receive only 11% of the country's total income, while the richest 10% of households (equivalent to only 7% of the population) receive over 40% of total income.⁴⁰ Inequality of income distribution between race groups is extensive, and accounts for 37% of total income inequality. Poverty has strong gender dimensions in South Africa with female-headed households having a poverty rate 50% higher than male-headed households.⁴¹

Rural poverty is not as visible as that of urban residents but much of South Africa's countryside remains highly impoverished. According to government estimates, 72% of the poor live in rural areas, where the poverty rate reaches 71%. Few jobs are available in the countryside, and the best agricultural land, about 87%, is mostly under the ownership of white farmers.

A government report on social development released in May 2001 found that 65% of South Africans live below the poverty line. Almost all are blackⁱⁱ – Africans, Coloureds and Indians. Of these poor, 19 million people (46% of the total population) appear ‘trapped in poverty,’ living at or below R353 (\$55) per adult per month.⁴²

Household incomes are linked to the security and quality of employment and there is wide variation in poverty between provinces in South Africa. Unemployment in South Africa is almost 30% and the majority of the unemployed are African.⁴³ Levels of unemployment vary between provinces and are especially high in Limpopo, the Free State and KwaZulu-Natal provinces. Trends in unemployment (Figure 3) indicate rising unemployment levels across all provinces except Eastern Cape. (Possible reasons for this outlier include the growth of tourism in the area, the growth in the manufacturing sector around East London and Port Elizabeth, the impact of HIV/AIDS and migration from the Province to other parts of the country in search of employment.)

Figure 3: Unemployment by province in 1998 and 2002



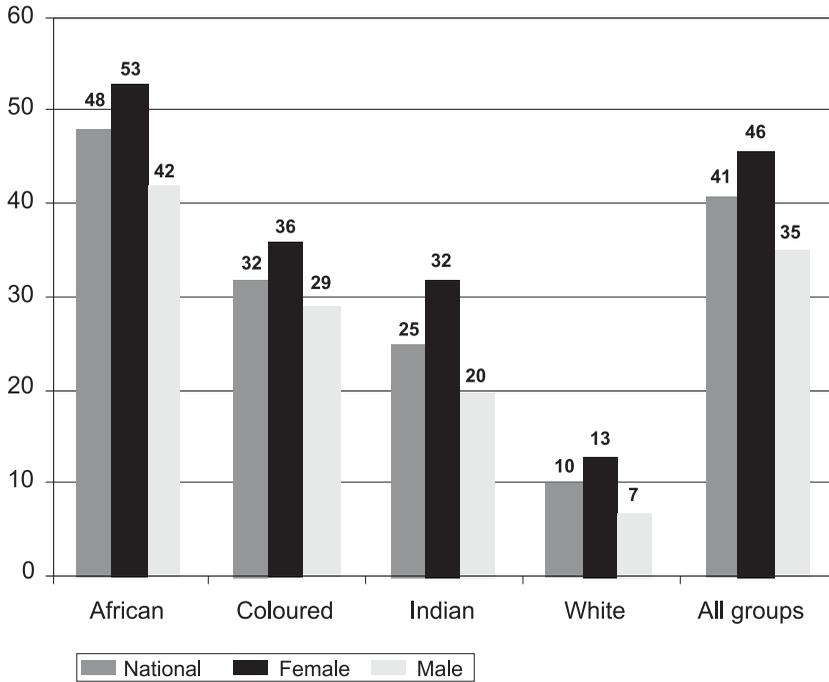
Source: Stats SA 1998 and 2002

ⁱⁱ The racial categories of African, Coloured, Indian and White, instituted by the Apartheid Government, are used through this paper.



Unemployment is highest in groups identified as having greater levels of poverty: black South Africans and females (see Figure 4).

Figure 4: Unemployment by race and gender, 2002

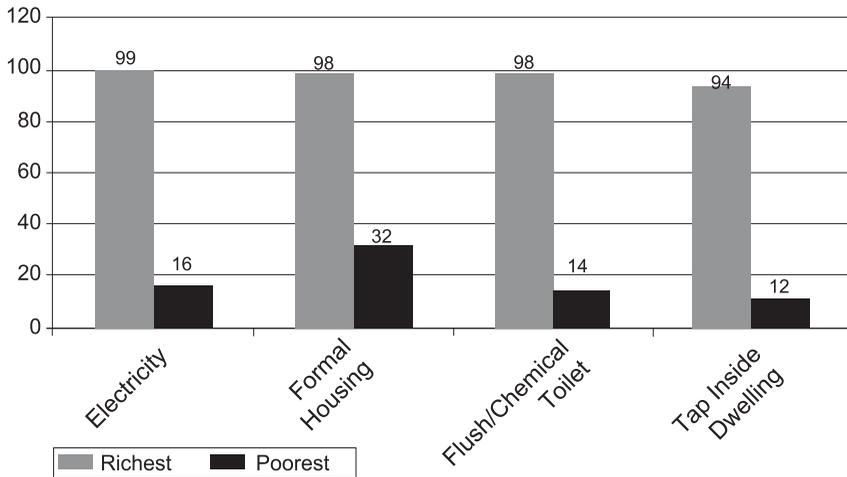


Source: Stats SA 2002

3.2 Inequality in access to and utilisation of services

32% of households have access to piped water in the dwelling, 54% have a flush or chemical toilet and 42% have a telephone or cellular phone in the dwelling.⁴⁴ Figure 5 shows that sixfold differences exist between the richest and poorest income quintiles in access to basic utilities. Increasing levels of poverty mean that even where water and electricity access has been extended, in reality households are too poor to pay for these services and experience disconnections.

Figure 5: Access to basic facilities according to income



Source: Stats SA 2000

(Access to electricity is defined as using electricity for cooking)

In theory, every South African has access to free primary healthcare. However, in practice there is extreme inequity in the quality of healthcare. The greatest healthcare inequities are between the public and private sectors, although within the public sector, inequity persists between and within provinces. Although the private sector is accessed by less than 20% of the population, it employs 77% of all specialists, providing quality of care equal to the best in the world. At the other end of the spectrum, access is sometimes almost non-existent. A poor rural family may have to travel many kilometres to the nearest clinic, only to find the clinic closed or out of stock of medicine.⁴⁵

For the majority of the South African population reliant on the public health system for their healthcare needs, access is hugely variable. The 2000 National Primary Health Care Facilities Survey indicates that some facilities are inadequately equipped to handle the health needs of the communities they serve, even before factoring in the impact of an escalating HIV/AIDS epidemic.⁴⁶ While the situation has improved since 1998, in 2000 and on a daily basis, only 74% of clinics offer Expanded Programme on Immunisation (EPI) services, and only 60% offer antenatal care. Only 63% of fixed clinics had been visited by a doctor to consult patients in the month preceding the survey and nurse supervisor visits had declined to 67% in 2000 from 79% in 1997.

In rural communities, home for the majority of the poor, PHC facilities lack ambulances for emergency services, have inadequate transport for community outreach, experience regular electricity interruption, telephone

disconnections and water shortages. For example while 73% of urban clinics have functioning telephones, this is true for only 54% of rural clinics. With regard to electricity, 73% of urban clinics experience uninterrupted supply as opposed to 60% of rural clinics. 50% of satellite clinics had no ambulance available for emergency services, and one third of respondents indicated that they considered their mobile clinics unsuitable for the road conditions they had to deal with.⁴⁷

Provincial disparities are essentially structural in nature, stemming from differential allocation of resources during the apartheid era. Some of the nine provinces incorporate a number of academic complexes, which contribute to health services in a multitude of ways, while others straddle former rural homelands, and have not only had to integrate staff and facilities from as many as three different homelands, but also have to provide care in far flung and remote areas.

Utilisation of PHC facilities stands at 2.3 visits per capita per year, well below the nationally established PHC norm of 3.5.⁴⁸ Low utilisation may be an indication of lack of access and/or low acceptability and appropriateness of the services. For example utilisation is especially low in Mpumalanga Province (1.5 per capita), which has under-developed infrastructure, and highest in Western Cape Province (3.8 per capita), which is mostly urbanised and has well established community health centres.⁴⁹

3.3 Healthcare financing

South Africa spends approximately 8% of its Gross Domestic Product (GDP) on healthcare, of which more than half is accounted for by medical schemes financed directly by households and employers.⁵⁰ The total consolidated national government budget for 2003/2004 is R334.

The biggest inequality in financing is between public and private healthcare. Approximately 60% of all South African healthcare spending goes into the private sector, although less than 20% of the population can use private healthcare regularly. Medical schemes benefits for civil servants comprise a significant public subsidy to the private sector. In 2001/2 average contributions to private medical schemes was approximately R5900 per beneficiary per year. In contrast the average per capita public health expenditure was R830.

Within the public sector, per capita expenditure in the public health system remains inequitable across the nine South African provinces. Current inequities reflect previous patterns of advantage and disadvantage, with historically well resourced provinces, particularly Gauteng and the Western Cape, having higher spending levels than the previously disadvantaged and predominantly rural provinces of Mpumalanga, Limpopo, North West and Eastern Cape. Table 3 demonstrates the range of per capita spending between provinces in 2001/2.

Table 3: Public health sector per capita expenditure for the year 2001/2 by province

| Province | Per capita expenditure 2001/2, SAR (\$) |
|----------------|--|
| Eastern Cape | 610 (77) ⁱⁱⁱ |
| Free State | 849 (106) |
| Gauteng | 1450 (181) |
| KwaZulu-Natal | 902 (113) |
| Limpopo | 511 (64) |
| Mpumalanga | 554 (69) |
| Northern Cape | 745 (93) |
| North West | 548 (68) |
| Western Cape | 1183 (148) |
| Average | 830 (104) |

Source: 2003 Intergovernmental Fiscal Review – National Treasury Republic of South Africa

The figures become even starker when examining dedicated PHC funding. Well resourced provinces estimate a per capita average PHC expenditure of more than R200 (\$25) in contrast with poorer provinces like Limpopo, Eastern Cape and Mpumalanga, which estimate their expenditure to be R70 (\$9), R91 (\$11) and R122 (\$15) respectively.⁵¹ Even in the poorer provinces there are worryingly large *intra-provincial differences* between the PHC per capita spending of the richest and poorest districts. PHC per capita *financing* for 2001/2 ranged from R190 (\$24) to R75 (\$9) in the Northern Cape and R118 (\$106) and R40 (\$5) in the Eastern Cape.⁵²

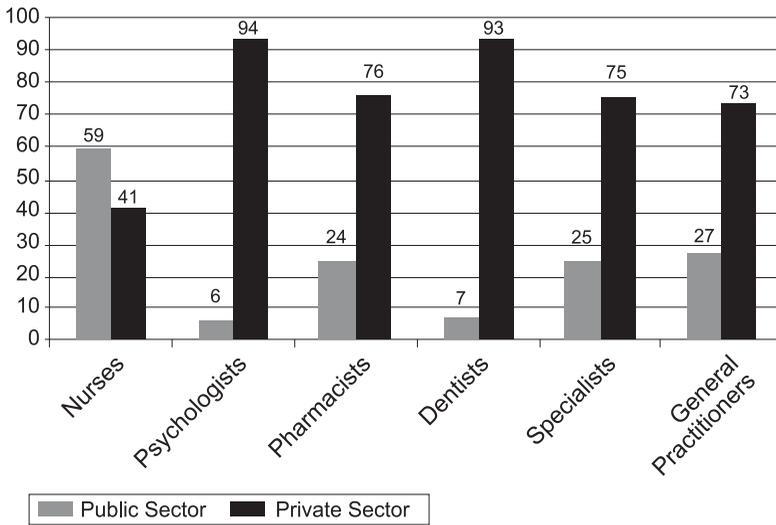
Cost estimates indicate that at least R125 per person per year is needed to provide a basic basket of primary healthcare services, excluding ART and other forms of HIV-related treatment. Per capita health expenditure in the public sector is R830 – five times the amount that has been costed for a basic PHC package. However, the current distribution of resources means that the poorest and most disadvantaged districts cannot fund even the basic PHC package.

3.4 Maldistribution of human resources

Possibly the most challenging inequity is the maldistribution of health personnel. Figure 6 highlights the inequities between the private sector and public sectors. The private sector, which serves less than 20% of the population, employs the majority of psychologists, pharmacists, dentists, GPs and specialists.

ⁱⁱⁱ The South African Rand (SAR)/US Dollar (US\$) exchange rate used throughout is 8 SAR to 1 US\$. All US\$ have been rounded to the nearest whole figure.

Figure 6: Healthcare personnel in the private and public sectors 1999



Source: Cornell J, Gouge J et al. National Health Accounts - Private Sector Report for the SA Department of Health March 2001

Great disparity also exists *within* the public sector. Wealthier provinces like Gauteng and the Western Cape have 8.9 and 7.8 health workers (this includes all categories of health workers) per 1000 public user population respectively, while the more needy provinces (those that are poorer with high rural populations, have less funding for healthcare services and are historically disadvantaged) for example, Mpumalanga, Eastern Cape and Limpopo have 4.1, 4.4 and 4.4 personnel per 1000 public users respectively.

Table 2 illustrates the inequities in the distribution of human resource by province. There is a twofold difference in the distribution of professional nurses between the best and least resourced provinces. The picture is much more extreme where doctors and medical specialists are concerned with a thirty fold difference existing for non-specialists.

South Africa has both an overall scarcity and an inequitable distribution of health personnel resulting in the high concentration of vacant public sector posts in disadvantaged areas. Rural-urban migration is common and is in part a response to poor salaries.⁵³ However, substandard working conditions, professional isolation and lack of supervision, lack of housing and schooling, coupled with poor roads and other infrastructure all play a part in the unpopularity of many rural posts. This has been exacerbated recently with health workers feeling overwhelmed in the face of the HIV/AIDS epidemic.⁵⁴

Table 2: Population served per public sector health worker: February 2003

| Province | Doctor non-specialist | Medical specialist | Professional nurse | Dentist | Pharmacist | Physiotherapist | Occupational therapist | Speech therapist | Dietician | Radiographer |
|----------------|-----------------------|--------------------|--------------------|---------------|---------------|-----------------|------------------------|------------------|---------------|---------------|
| Eastern Cape | 8825 | 47 529 | 1278 | 190 117 | 53 662 | 237 647 | 554 507 | 950 583 | 475 292 | 26616 |
| Free State | 422 | 11 342 | 786 | 71 491 | 31 881 | 45 369 | 3 932 | 157279 | 65 533 | 14 212 |
| Gauteng | 273 | 3398 | 606 | 25 458 | 18 994 | 29 117 | 31 575 | 79 714 | 54 635 | 8104 |
| KwaZulu-Natal | 4362 | 15 641 | 901 | 145 607 | 27 239 | 43 289 | 79 291 | 170 391 | 148 304 | 21 528 |
| Limpopo | 8544 | 92 129 | 1001 | 141 736 | 48 067 | 106 302 | 76 774 | 197 418 | 110 554 | 60 084 |
| Mpumalanga | 5772 | 143 698 | 1124 | 54 605 | 35 003 | 75 841 | 65 006 | 151 681 | 60 672 | 5056 |
| Northern Cape | 823 | 6635 | 1079 | 74 066 | 47 535 | 86 076 | 99 526 | 244 986 | 109 821 | 49 763 |
| North West | 3352 | 39 296 | 776 | 64 303 | 32 151 | 5411 | 101 047 | 235 777 | 70 733 | 24 391 |
| Western Cape | 2979 | 2746 | 796 | 28 074 | 13 789 | 32 126 | 33 152 | 135 489 | 61 103 | 691 |
| Average | 4829 | 10 403 | 910 | 65 406 | 29 578 | 55 689 | 64 722 | 172 793 | 98 282 | 17 878 |

Source: 2003 Intergovernmental Fiscal Review – National Treasury Republic of South Africa

Macroeconomic policy in South Africa, through its focus on formal sector employment, appears to have played a part in concentrating resources more in urban areas and, in keeping with worldwide trends, South Africa is experiencing population movement from rural to urban areas.⁵⁷ Many who move to urban areas are either skilled or semiskilled, and their departure then creates a vacuum that contributes to the further underdevelopment of the rural areas.

Rural urban migration of health workers is compounded by significant levels of migration from the public to the private sector, as well as skilled professionals leaving the country to work overseas, which not only depletes the local pool of personnel but also results in reverse subsidies. The UN Conference on Trade and Development calculated that for each professional recruited from outside the country, US\$184 000 is saved by the recipient country.⁵⁸ The cost of the migration of 600 South African doctors to New Zealand to the taxpayer was estimated to be in the region of R600 million.⁵⁹ Health worker migration from rural to urban facilities, from the public to the private sector, as well international migration has exacerbated existing human resources shortages. In 2002 alone, South Africa supplied 1480 nurses to Britain.

South Africa does not yet have a comprehensive Human Resources strategy. Initiatives designed to redress the shortage of personnel in rural areas – such as Community Service and employment of Cuban doctors –

have been only partially successful. The rates of attrition from the public sector, coupled with the projected numbers of health professionals expected to die as a result of AIDS, and the increased demand for care arising from the epidemic, imply that SA needs to increase the numbers of health professionals it produces. Concurrently, exploration of comprehensive strategies to recruit to and contain migration from the public sector, in particular from rural areas, requires attention.

3.5 Human rights

A range of pro-equity policies have been put in place across all sectors and the South African Constitution has been internationally acclaimed for its inclusion of a range of justiciable (courts may be approached to enforce these rights if they have been violated or not adequately provided for) socio-economic rights. Included in these rights, which are enshrined in the Bill of Rights, is the right to have access to healthcare and if the state is unable to provide for these rights due to insufficient resources, it is required to take reasonable legislative and other measures to making progress in the realisation of these rights. The Constitution does not guarantee the right to health but the right of access to healthcare services.

Human rights is identified as a priority issue and incorporated into the government's National HIV/AIDS and STD Strategic Plan for 2000/05.⁶⁰ Mindful of its duty to provide health services within a rights based framework, the Department of Health has developed the 'Patients' Rights Charter' as a set of norms and standards to govern the relationship between themselves and users. Widely displayed in state healthcare facilities, the contents of the charters are neither known by patients nor practised by healthcare workers. This suggests that there is still a great deal of work to be done before access to healthcare is perceived by both service providers and users as a right and not a privilege.

Anecdotal evidence suggests that some people's experience of the public health system has been an unpleasant one where healthcare workers are brusque or worse do not speak to patients and prescribe treatment without consultation. PLWHA have been subjected to prejudice and, on occasions, abuse. This leaves beneficiaries feeling disempowered, vulnerable and unsure of what steps they need to take to improve/control their health conditions.

3.6 Pro-equity health policies in South Africa

South Africa's Constitution strives to ensure equal access to healthcare facilities provided by third parties; to ensure that privatisation does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties.⁶¹ The DoH has attempted to protect the human right for access to healthcare through initiatives designed to regulate the private sector and by a variety of initiatives designed to increase access to public sector care.



schemes. The 1998 Medical Schemes Act was intended to reduce the burden on the public sector through a range of measures, including increasing the number of people with medical aids, curbing dumping on the public sector and increasing cross subsidisation.

Increased enrolment of the average income earner into medical schemes has been negligible, probably due to steeply escalating costs. Medical inflation – which covers the change in prices of medical goods and services – was consistently higher than headline inflation in the period between 1995 and 2001 and between 2000 and 2001 the price of medical schemes went up by an average of 11%. Rather than there being a lessening burden on the public sector, trends indicate that there has been an increase of ‘dumping’ of medical scheme patients on the public sector when their medical schemes benefits run out.⁶² So the anticipated increase in cross subsidisation from rich to poor and from healthy to sick has failed to materialise. Proposals for the introduction of a social health insurance as a tool for cross subsidisation have been put forward on a number of occasions, although successive proposals have become increasingly regressive. There has so far been no progress with implementation of any version of the Social Health Insurance (SHI) [proposals].⁶³

Internationally healthcare is increasingly considered a new field of economic activity. There has been phenomenal growth in the medico-pharmaceutical industry, which has overtaken the arms industry to become the world’s leading business sector and is therefore seen to have the greatest potential for growth and profit this century.⁶⁴ The private health sector has a strong hold in South Africa, and although the reforms introduced were good, the inability of government to control costs means that they have had limited impact.

In the public sector, the government has attempted to implement a number of pro-equity policies. Primary healthcare is provided free of charge for the entire population and pregnant women and children under seven years are entitled to free care at all levels of the system. In addition, measures have been put in place to improve equity in resource allocation, strengthen primary healthcare systems and improve welfare cover and access.

With a view to moving towards a fairer distribution of resources, the SA Treasury introduced an equitable shares formula for allocating the provincial share of the budget (from which the provincial health budget comes). The formula includes a ‘backlogs’ component intended to assist previously disadvantaged provinces. However, this component constitutes a mere 3% of the formula, and while there has been some redress between well-resourced and poorer provinces, the overall trend has not yet significantly improved the distribution of funds.⁶⁵

The DoH initiated and has supported and sustained a strong commitment to the most equitable level of care, Primary Health Care (PHC). The government embarked upon an ambitious clinic building and upgrading programme, and has had some success in effecting a cut back in tertiary care in favour of primary level care. The DoH has been consistent in its efforts to strengthen the District Health System and an increasing body of skills and knowledge is

being built up to support the effective implementation of the District Health System.^{66, 67} However, the PHC budget comprises only about 15% of the public health budget, and medium-term projections indicate that this is unlikely to grow in the next three years.⁶⁸

Disability grants, old age pensions and child support grants are the bedrock of the government's welfare security net. Unfortunately many children who qualify for a state child support grant are not accessing it either because they have no proper identification document or because their caretakers are ignorant of this right. Recent efforts to highlight problems with the child support grant appear to be bearing fruit. The government has exceeded its target of 3 million children receiving the grant by 2003, and the grant has been extended to cover children up to 14 years (to be phased in over a period of three years).^{69, 70, 71}

3.7 Implications of current inequities for access to treatment and care for HIV/AIDS

HIV/AIDS is deepening existing inequities both in its impact upon the household and in services' ability to respond as they become overburdened by HIV-related illness and depleted by HIV-related morbidity and mortality among health workers. Progress that has been made with transforming the SA public health system is being undone as a result of the epidemic, and services that are currently struggling to provide an acceptable level of care are in danger of becoming almost non-functional unless significant restructuring and redistribution is to happen.

The inequitable distribution of human resources is most extreme between the private and public sectors. However, the ongoing overall scarcity of specialists in the disadvantaged and largely rural provinces presents a particularly intractable problem. The Apartheid regime created a system that actively constructed the underdevelopment of the black population and the areas of the country to which much of the population was forcibly removed. The net effect of this was a severe lack of trained intellectual capital and capacity that haunts us to this day, despite the democratic government seeking to redress this legacy. Some of the basic managerial skills necessary for the effective functioning of the health sector are either very scarce or completely absent in many disadvantaged regions.

Monies are relatively easy to redistribute by comparison. However, even when there is a relatively 'fair' distribution of funds for pilot programmes between the nine provinces, the poorer provinces still struggle with implementation because of poor human capacity at the level of planning, management and leadership.⁷² The inequitable distribution of human resources and skills will impact on this, and is likely to worsen in the short term with the introduction of HIV treatment programmes that require new knowledge and skills, and additional infrastructure and technology.



4. South Africa's response to HIV/AIDS

4.1 The political context

Leadership and direction on HIV/AIDS in South Africa has been inconsistent and divisive and there is no doubt that the absence of strong and committed political leadership has compromised an effective response to the epidemic. A series of events, including a much publicised scandal over Sarafina^{iv}, alleged government involvement with the effective and toxic Virodene which was promoted as a treatment for HIV, and the Minister of Health declaring AIDS to be a notifiable disease without consulting HIV/AIDS organisations, resulted in HIV/AIDS becoming highly politicised in the country.

The damaging effects of these scandals has been compounded by a questioning of the link between HIV and AIDS by individuals at the very highest level of government and the establishment of a Presidential Panel on HIV/AIDS - a forum intended to resolve the debates between the so-called dissidents and orthodox scientists about the cause of HIV/AIDS and whether HIV tests are reliable.⁷³ This panel was unable to reach consensus on these questions, which further compounded the problems and obfuscated the real issue of the need to make treatment available to those with AIDS. In addition to the questioning of the link between HIV and AIDS, some senior members of government were issuing warnings about the toxicity of antiretrovirals, and suggesting that ARVs were more dangerous than AIDS itself.

In contrast, the last decade has seen a groundswell of social and legal activism around the management and treatment of HIV/AIDS. In 1998, the Treatment Action Campaign (TAC) was launched to lobby for better treatment for people with HIV. The Treatment Action Campaign has enjoyed both a cooperative and adversarial relationship with the government in its quest to provide effective treatment for people living with AIDS (PLWAs) and has participated in a number of high profile court cases. Joining with government, as a friend of the court, TAC was successful in mobilising global support for its campaign to secure the provision of affordable medicines and, in April 2001, the Pharmaceutical Manufacturers' Association withdrew a court action challenging the legality of the 1997 Medicines Control Act.⁷⁴ Later that year, exasperated by what appeared to be a series of diversions, TAC resorted to successful legal action against the government in an attempt to force them to provide Nevirapine beyond just the 18 pilot sites.⁷⁵ Advocacy and service organisations together with organised business and labour groupings have collaborated over a variety of initiatives in an effort to advance the struggle for an acceptable treatment regime for people living with AIDS and related illnesses. For example the COSATU/TAC Treatment Conference held in Durban in June 2002 saw a broad civil society grouping endorsing a Treatment Plan proposed by TAC.

^{iv} An HIV prevention project initiated in the mid 90's

Policy conflict and therapeutic activism have combined to make access to ARVs one of the most high profile policy issues in South Africa and brought many of the equity debates around treatment access into the public domain.

4.2 HIV/AIDS financing

There has been considerable debate around the affordability of HIV/AIDS programmes and more specifically, on the costs and affordability of providing ARVs. By 2003 it appeared as if financing was no longer the major obstacle. According to the SA Treasury, Department of Health Funds earmarked for HIV/AIDS are to increase from almost R4.5 billion in 2001/2 to over R7.5 billion in 2005/6.⁷⁶ Nearly R2 billion is provisionally budgeted for 'medically appropriate treatment' (which is assumed to refer to antiretrovirals) for HIV-infected people, pending a decision by a government task team on the possible universal roll-out of medicines to people living with HIV/AIDS. According to the National Treasury and Department of Health Report,⁷⁷ in 2005 R7 billion would be required to provide a total package of HIV/AIDS treatment and care (including basic nutritional support) to cover a 50% uptake (i.e 250 000 of the estimated 500 000 people who could benefit if the programme achieved 100% uptake).

However, increases in HIV/AIDS funds, while necessary, may not be sufficient and rapid increases have already been found to result in some unintended consequences. The absolute shortage of skilled health personnel means that provinces do not always have the necessary skills and resources to discharge their budgets, which resulted in a considerable amount of underspending in priority health programmes and activities.⁷⁸ In some provinces resourcing decisions are divorced from either analysis of the ability to spend or the costs of delivery. Specific problems have been experienced with the HIV/AIDS conditional grant, impacting upon provinces ability to utilise the monies. These problems have included poor timing of the delivery of funds, and poor communication or planning as to provinces' needs.⁷⁹ Already disadvantaged provinces are least able to find the necessary resources to overcome these problems. This indicates that resources need to be matched with wider planning of capacity to benefit and to provide services.

4.3 The National Strategic Plan

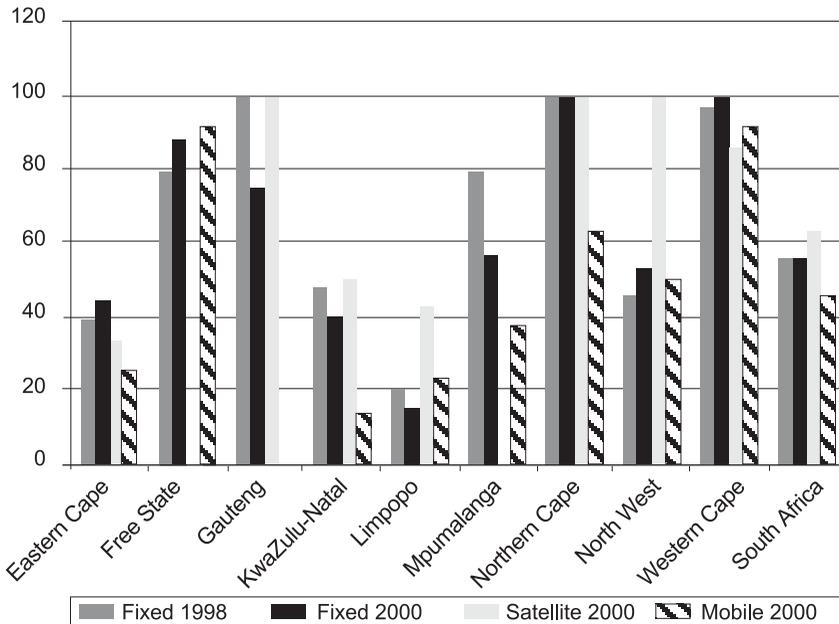
Between 1992 and 2000 South Africa put in place a variety of structures and strategies designed to address the HIV epidemic. The current Strategic HIV/AIDS Plan (which acknowledges the link between HIV and AIDS), covers the years between 2000 and 2005.⁸⁰ The plan outlines a holistic approach to countering the epidemic, involving prevention, treatment and care, backed by national and provincial structures to implement the plan. The DoH has a Directorate responsible for HIV/AIDS and sexually transmitted infections (STIs) and there are HIV/AIDS and STI Directorates at provincial level. At the district level there is an effort for multi-sectoral collaboration between the departments of health, education and social welfare, and civil society in dealing with the epidemic.

4.4 Healthcare services for HIV/AIDS

Prevention is widely recognised as being a more effective and equitable approach in controlling communicable diseases than treatment oriented strategies, and especially so in resource-poor settings. Not only are disadvantaged communities most vulnerable to communicable diseases and likely to become more disadvantaged as a consequence of ill health, but they are also the communities with least access to good quality healthcare. Effective disease prevention is thus equity promoting as it has a relatively greater impact on the poor than the wealthy; whereas treatment oriented approaches can compound and exacerbate existing inequities.

Primary prevention of HIV in South Africa has had limited impact on the spread of the epidemic. Lack of clear leadership and a questioning of the link between HIV and AIDS by some high level members of government are partly responsible for this. Access to secondary prevention such as VCT and PMCT, is currently inequitable and reflects patterns of inequity associated with treatment, benefiting those in mostly urbanised provinces where there is better infrastructure, better distribution of human resources and fewer social and cultural constraints. The 2000 National Primary Health Care Facilities Survey⁸¹ found wide provincial variation in access to VCT (Figure 7) and similar variations have been found in access to PMTCT services.

Figure 7: Availability of HIV testing – fixed (1998, 2000), satellite and mobile (2000) (percentage with test)



4.4.1 Policy context

Although the provision of HIV/AIDS services has been developed within the framework of a strategic plan, the ambivalent and confusing policy context has impacted upon service delivery and affected the efforts of the many individual health service managers and professionals who have striven to provide accessible and high quality care.

Policy inconsistency has weakened the rollout of HIV/AIDS services. For example, in about half of the 75,000 infants born with HIV infection in South Africa in 2000 infection could have been prevented if short-course antiretroviral treatment had been available.⁸² Access to PMTCT has been constrained by confusion and delays in policy making. In 2001 the government launched a limited programme of PMTCT and, when it seemed as if the government had decided to make PMTCT available throughout the public sector, following the presentation of the interim findings of research into these sites, the Minister of Health raised doubts about the safety of Nevirapine. A Constitutional Court ruling in July 2002 resulted in plans for a much more rapid roll out.

The first of 18 national sites comprised 260 access points (clinics and hospitals). The number of access points increased about 600 in December 2002.⁸³ The DoH intended full national roll out to have occurred by March 2003.⁸⁴ However, in July 2003, only the Western Cape, KwaZulu-Natal and Gauteng provinces had achieved substantive roll out. The political will displayed by the premiers and ministers of KwaZulu Natal and Western Cape is thought to have been central to the success of the PMTCT in these two provinces.⁸⁵

4.4.2 Targeting hard to reach populations

There are inadequate services that are specifically biased towards poor, inaccessible, rural populations as exemplified by the TB cure rates and aspects of the VCT and PMTCT programmes. South Africa has a high burden of tuberculosis (TB) and 60% of TB cases are HIV positive. The TB cure rate stands at 64%,⁸⁶ below the national and WHO accepted target of 85%. In 2001, only 7 of the 18 pilot PMTCT sites achieved an HIV testing rate of more than 60% (a site achieving a 60% or above testing rate can be considered to be doing reasonably well) and of these, six are urban or peri-urban and situated in the three historically best resourced provinces (Western Cape, Gauteng and KwaZulu-Natal).

Training heavily influences the quality of counselling, which in turn influences uptake of testing. Provinces with ready and easy access to support from academic and technical experts were at a distinct advantage to those without, particularly as many provinces rely on NGOs and university departments to assist with training. It is the rural, already disadvantaged provinces, that struggle to access technical support.⁸⁷ Counselling and testing require privacy and additional space and there are wide disparities in facilities, with many clinics in under-resourced areas suffering from inadequate infrastructure, including space.

Long distances and the cost of transport to health facilities, which are typical experiences for health service users in rural and underserved provinces, made follow-up visits difficult for some women, and this was exacerbated by long waiting times and queues, which further discourage attendance, and impact negatively on the effectiveness of the PMTCT programme.

4.4.3 Management of services.

Reviews of services have pointed to a number of planning and management deficiencies. The quality of STI management in the public sector is still not optimal.⁸⁸ Although the strategic plan focuses on improving the management and control of STIs in both the public and the private sector, there remain many clinics with staff who are not completely familiar with syndromic treatment protocols, and in which the required drugs are not always available. VCT does not appear to be vigorously promoted amongst STI clients. Proactive clinical screening for signs and symptoms of STI does not seem to be happening, even for family planning (FP) and antenatal clients (ANC). Finally, partner notification does not appear to be a routine aspect of STI case management.

A study of VCT services in one province, Gauteng, found that testing remains largely hospital-based and reserved for those presenting in late stage disease. Counselling services are often poor and queues for services long. Same day results are not universally available and many of those who present for testing never follow-up for results.⁸⁹ Of those clients who are diagnosed HIV positive, a system of ongoing follow up does not generally exist in the public health sector. The notion of a clinic with a cohort of patients who are provided chronic care and support is rare. In addition, while staff attitudes are sympathetic to the plight of HIV-positive patients, there does not seem to be an attitude of being able to promote wellness amongst HIV-positive patients. The absence of an effective referral system and linkage between PHC nurses at the clinic level and medical doctors with HIV clinical expertise also contributes to a lack of adequate follow up.⁹⁰

In the PMTCT pilot sites the correct administration to both mother and child was only given in slightly under one third of pregnant HIV-positive women.⁹¹ The approach to crucial issues such as infant feeding, drug dosages and the following up of babies and mothers requires improved coordination.

There is a lack of clarity with regard to the role of health professionals in supporting the lay counsellors, which in turn impacts on the services offered. The lack of standardisation of management, training and remuneration of lay counsellors; and persistent stigma and discrimination on the part of many health workers are challenges yet to be overcome.⁹²

4.4.4 Integration of services

Increasing service provision through vertical approaches undermines the horizontal integration of services. VCT services could be used to integrate HIV/AIDS and TB services and improve comprehensive HIV/AIDS and TB management and referral services to ensure continuum of care. However,

there is a concern that the VCT programme is run vertically, taking away the opportunity of using it as an entry point for STI and TB prevention, treatment and care services.⁹³ Perpetuation of vertical services reinforces inequity given the actual and time costs involved in attending clinics for many clients, especially those in rural areas.

4.4.5 Resources for HIV/AIDS services and programmes

There has been an inadequacy of human and other resources with which to provide high quality services. Services have often been 'added on' to health professionals' existing responsibilities and to a system that is already highly inequitable in its resourcing and delivery. The absence of complementary resource inputs means providing HIV/AIDS services over and above other PHC services and overloads facilities and staff.

In some of the PMTCT pilot sites, no additional staff were employed despite PMTCT meaning an increase in workload and responsibilities for staff. Provinces differed widely in how they recruited, trained, managed and paid lay counsellors to work alongside professional staff and there has been an overall lack of adequate numbers of lay counsellors. In some provinces key provincial posts have been unfilled over a period of time.⁹⁴

The DoH has yet to establish the staffing needs of each province, district and health facility required to make PMTCT accessible to all who need it. This is not a simple task, given the fine judgement required; for example, in advocating formula feeding in communities where stigma and discrimination of HIV-positive mothers who choose not to breastfeed is seen daily.⁹⁵

4.4.6 Impact of stigma

The backdrop of South African society is critical in influencing vital portals to HIV/AIDS prevention and treatment. The Department of Health estimates that only between 10% and 25% of infected people know their HIV status.^{96, 97} Where VCT services are available there is no optimal utilisation, due to lack of understanding of the benefits of VCT and because denial and stigma within communities also negatively impact on the success of the programme.⁹⁸ It has been mooted that more people would utilise VCT if it was coupled with access to ARVs.⁹⁹

One study¹⁰⁰ reports that the actual uptake of testing is low. On average, 13 HIV tests per month were done in clinics, out of which only 9 clients returned for their results. This amounts to about 2 patients being tested and post-test counselled for HIV per week per clinic and it appears that some of these patients are being tested primarily for clinical reasons. In addition, a high proportion of the HIV test results were positive, indicating that testing is being demanded by or offered to clients with a high clinical suspicion of being HIV positive. A higher proportion of HIV negative results would signify a greater demand for testing amongst healthy clients.

The level and degree of stigma and ignorance amongst health workers may be a reason for the relatively low uptake of VCT. A large majority of PHC workers also feel that 'confidentiality' is hampering the country's ability to get on top of the HIV/AIDS epidemic, suggesting a possible over-emphasis on secrecy that reinforces stigma rather than encouraging openness and disclosure.

4.4.7 Community care

Acknowledging the limited resources of the public sector, focus has been placed on developing home-based care programmes to cater for the needs of those sick with AIDS, and to support the growing numbers of orphans being created as a result of the epidemic. By March 2003 a total of 466 home/community based programmes were in place providing services to 370,172 people through 9533 volunteers.¹⁰¹

Inadequate links between health services and community programmes, particularly home-based care, places an additional burden on families already struggling to survive. Many families are caring for the sick without any guidance from health workers¹⁰² and there is lack of palliative, psychological and spiritual care for many people sick with AIDS.¹⁰³ The situation is likely to worsen as many HIV-infected people succumb to AIDS. The poorest of the poor, already most affected by the epidemic, shoulder a double burden as they attempt to care for dying loved ones.

Health workers, and particularly those at primary healthcare facilities are expressing the helplessness they face daily in dealing with HIV/AIDS patients, and while many health professionals in western countries are well informed on new developments in HIV/AIDS interventions, the majority of South African health professionals thirst for accurate and reliable information on HIV/AIDS, particularly regarding the use of ARVs.¹⁰⁴

4.5 Business response

Although South African companies have much to lose by not factoring the impact of HIV/AIDS into their planning, many listed companies do not take AIDS seriously.¹⁰⁵ Research indicated that 49% of 428 companies surveyed said AIDS had not affected them and only 78% of companies consider themselves to be exposed to HIV/AIDS. The survey also found out that 50% of companies had no official AIDS policy, 68% did not offer voluntary testing or counselling, while 73% had implemented no healthcare provision for AIDS.

Many companies were also not factoring in the indirect costs of AIDS, including increased absenteeism, 25% lower productivity in those with clinical AIDS and a scenario in which 10 people would need to be trained to fill eight jobs.

Nonetheless, as the economic burden of HIV/AIDS increases the business sector appears to be systematically shifting the burden of the epidemic away from the private sector through:

- pre-employment screening (which although illegal is thought to still continue)
- reduction in employment benefits
- restructuring employment contracts
- outsourcing low skilled jobs
- selective retrenchments
- changes in production technologies.

For example between 1997 and 1999 more than 66% of large South African employers reduced the level of care benefits or increased employee contributions.¹⁰⁶

5. Access to treatment

*'Highly active antiretroviral therapy (HAART) has the potential to reduce the increasingly devastating impact of HIV on households, communities, workplaces and the entire society. It would allow infected parents to live long enough to care for their children until they reach adulthood and may diminish stigma associated with HIV/AIDS and also greater acceptance of prevention efforts. In particular it may allow more people to present for HIV testing at an earlier stage in their illness. The provision of HAART may have an impact on the infectiousness of individuals thereby reducing transmission as well as alleviating the enormous burden due to HIV-related illnesses in hospitals.'*¹⁰⁷

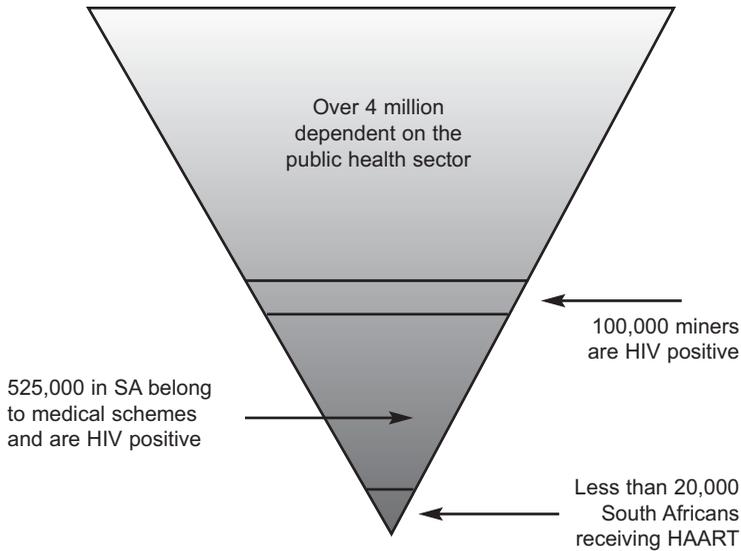
A separate focus is given here to the provision of HAART because of the significant and substantial implications for the health system in undertaking to provide antiretroviral treatment for AIDS. Provision of HAART is costly, requires sustained technical capacity and represents a major challenge to under-resourced and under-served areas.

Where it has succeeded, antiretroviral therapy has altered the nature of HIV disease, transforming an almost uniformly fatal illness into a chronic but apparently stable condition. Research has shown that HAART can be successfully provided in resource-poor settings, including in Haiti, Thailand and Brazil.¹⁰⁸ For South Africa, now that the Department of Health has undertaken to provide HAART in public sector facilities, the challenge is in finding ways to deliver HAART that will not exacerbate existing inequities in access to healthcare.

5.1 ARV coverage

Of approximately 5 million South Africans infected with HIV, and out of more than 500,000 who could benefit from HAART, less than 20,000 are receiving it. The majority of these are accessing the drugs through the private sector¹⁰⁹ (see Figure 8).

Figure 8 ACCESS TO ARVS IN SOUTH AFRICA



Source: Patrick Connelly, ARVs in South Africa: Who knows who cares? 2002

5.2 Sources of of ARVs

ARVs are currently accessed through a range of routes:

Medical schemes

Although there is variation between medical schemes as to the extent of treatment and care that can be accessed by someone who is infected with the HI virus, it is generally the case that at least some treatment and care is provided by all private medical schemes, often through a 'Disease Management Programme'. Most beneficiaries have access to dual or triple therapy and the use of ARVs is accompanied by other services including treatment of side effects, drug monitoring, and diagnostic measures.

This, however, does not mean that medical scheme provision for HIV/AIDS is without caveats. Most medical schemes have a ceiling on how much HIV/AIDS-related treatment they will cover, which invariably means that people who have exhausted their medical aids will either have to pay out of pocket or once again become the responsibility of the public health sector, thereby increasing the strain on an already overburdened system. Ironically, given the concerns that have in the past been expressed in government about the toxicity of ARVs, Medical Aid schemes available to Members of Parliament and civil servants (paid for by the government) provide for access to ARVs.



Workplace schemes

Some of the large companies in South Africa have started providing antiretrovirals to their employees as part of broader HIV/AIDS prevention and care programmes. Daimler-Chrysler South Africa, Coca-Cola, McCord's Hospital and Anglo-American all have programmes. Anglo estimates that 23% of its 134,000 employees are affected and it expects about 10% of those to take up the treatment in the first year. Anglo's move suggests it has grown impatient with the broader Chamber of Mines initiative announced in April 2002 to explore ways of embarking on a collective feasibility study on the provision of the drugs to miners. Metropolitan Life is marketing an insurance product to large employers, in which HAART is paid for as part of group life cover. The rationale for introducing such a product is the belief that the costs of HAART would be more than offset by reductions in death benefit payouts and other direct and indirect costs related to HIV/AIDS in the absence of HAART.¹¹⁰

Public sector services

The main thrust of the government's treatment initiative in the public sector has been directed towards improving the quality of life of people with the HI virus through the treatment of opportunistic infections. The DoH has developed and distributed a number of guidelines to assist healthcare workers in addressing HIV/AIDS, STIs and opportunistic infections.

In 2002 the government indicated that expanded coverage of ARVs in the public sector would be introduced. Post-exposure prophylaxis was expanded to include post sexual assault as well as needle stick injuries, and universal access to Nevirapine for the prevention of mother-to-child transmission was to be provided. For people living with AIDS, the government accepted that ARVs could help improve their condition but decided that they were still too expensive to be provided in the public healthcare system. However, by the end of 2002 a treatment plan developed by TAC was being reviewed by a working group including the Treasury and the DoH. In May 2003, in her budget speech, the Minister of Health hinted that an ARVs treatment plan, developed by the Treasury and DoH, was awaiting ratification by government¹¹¹, and on 8 August Cabinet announced that ARVs would be made available in the public sector, giving the Minister of Health until the end of September to develop a plan for implementation.

Although in the past public sector doctors have been unable to provide antiretrovirals, they have offered clinical support, including monitoring laboratory tests to patients who make out of pocket payments for ARVs.¹¹²

NGO services

HAART is available to patients without medical aid through a small number of privately funded sites that have been established to provide this treatment. The Generic Antiretroviral Procurement Project (GARPP) has 18 projects involving 980 persons on HAART in the public sector. They aim to have 2295 additional persons receiving HAART in these projects by end of 2003.

The current projects are situated in Gauteng, KwaZulu-Natal and Western Cape and all but one are based in urban or peri-urban settings. An additional 13 projects are expected to commence during 2003. These 13 projects have the capacity to provide HAART to a further 12,680 people. Three of these projects will be based in rural provinces (Eastern Cape and Mpumalanga).¹¹³

5.3 Health personnel capacity

New demands posed by AIDS care call for greater skills levels and training in health personnel. At the same time many healthcare professionals are already intimidated by their workload and constantly pass on the opportunities of upgrading their skills.¹¹⁴ In some facilities nursing shortages are so dire that managers do not allow their staff time off to attend advanced training courses.¹¹⁵

According to Dr Gustaaf Wolvaardt, executive director of the Foundation for Professional Development (FPD), 'relatively few' of the estimated 31,480 doctors and 202,000 nurses in southern Africa have received training in the clinical management of the disease, or in counselling and testing their patients and families.¹¹⁶ The majority of professional nurses, who are also charged with supervision of PHC facilities, are not trained in clinical use of ARVs.¹¹⁷ A total of 11,000 health workers have been trained in the management of opportunistic infections. The government plans to train 100 health workers per province annually for 3 years on HIV/AIDS/TB and management of patients on ARVs starting 2003.¹¹⁸ This number is quite small given the extent of the epidemic.

As one response, Eskom, Africa's largest electric utility company, has joined forces with the FPD, the Southern African HIV Clinicians Society (SAHCS) and Development Communication Associates (DCA), a US-based development organisation, to train doctors and nurses in the southern African region. Unfortunately shortage of human resources in many of South African PHC facilities may prevent many from taking up this opportunity.

5.4 Costs of ARVs

The costs and financing of ARVs is a highly contested area. It is difficult to get a precise and uniform estimate of the treatment costs of HIV/AIDS as the treatment regimens and drugs costs of the regimens vary substantially. Allegations that pharmaceutical companies are capitalising on the epidemic for maximum profit and indulging in cartel-like behaviour appear to have some merit as there has been seismic fluctuation in prices of ARVs. The Full Report of the Joint Health and Treasury Task Team documents varying drug prices over the period between October 2001 and April 2003.¹¹⁹

Table 4: Prices of selected ARVs in US\$ between October 2001 and April 2003

| \$US Cost per patient/year | October 2001 | June 2002 | April 2003 |
|--|---------------------|------------------|-------------------|
| Zidovudine 300mg Glaxo SmithKline | 584 | 584 | 274 |
| Best Priced Generic | 193 | 140 | 140 |
| Nevirapine 200mg Boehringer Ingelheim | 438 | 438 | 438 |
| Best Priced Generic | 150 | 112 | 105 |
| Combavir Glaxo SmithKline | 730 | 730 | 329 |
| Best Priced Generic | 270 | 204 | 204 |

Source: Joint Health and Treasury Task Team Full Report, August 2003

In light of the South African government's reservations about the cost of antiretrovirals, it is disappointing to note that they have failed to explore alternative means and mechanisms for procuring the required drugs. Compulsory licensing of (generic) ARVs for example could drastically reduce the costs of providing the medication. There are currently two ways of obtaining generic ARVs: by obtaining a compulsory or voluntary licence to manufacture them in South Africa or by applying a 'section 21' exemption to import and use an unlicensed drug. Medecins Sans Frontieres (MSF) has reported that by importing generic ARVs – manufactured by the Brazilian National STD/AIDS programme, under a section 21 permit – prices of triple therapy used in Khayelitsha were halved and that a triple regimen can be provided for R10 per patient per day.¹²⁰

In April 2003, Glaxo SmithKline (GSK) one of the six manufacturers of antiretrovirals announced that it was halving the price of some of its drugs in its anti HIV portfolio for 63 nations (including all African nations)¹²¹ The company cited reduced manufacturing costs and economies of scale as reasons for the price cut. A daily dose of Combivir would cost roughly R7 (\$1) per day and a monthly treatment regimen approximately R220 (\$28) – a sum that is out of the reach of many poor and unemployed South Africans, and still more expensive than the AZT/3TC regimen manufacture in India by Ranbaxy and Aurobindo.

More recently GARPP has compared the pharmacy retailing pricing for a month of 3TC/d4T/NVP adult dosages of approximately R1312 (\$164) with the generic price that is available to GARPP member projects of R205 (\$26) (co-formulated), only 15% of pharmacy retail price.

Though drug prices have fallen, most tests considered routine for HIV management in the West are simply out of reach elsewhere. Viral load tests cost an average of \$100, excluding equipment and laboratory facilities. The cheapest flow cytometers for measuring CD4 T-cell counts cost \$75,000 to \$100,000, while other machines are for sale in the \$40,000 to \$80,000 range. Added to this expense is money needed to train and hire technical staff, maintain and repair broken equipment, ship and store samples. WHO recommend a number of minimum tests, which are required for the implementation of an ARV programme and many of these are simply not available in most public sector primary healthcare facilities.¹²²

At the household level, even if ARVs are marketed at the generic price of \$26 per month this is still out of reach of many households in SA given that 46% of the total population are surviving on below R353 (\$55) per month.¹²³ In addition to the costs of drugs, accessing HAART may be impossible for some, in that patient-related costs of travel are considerable and may be unaffordable even if medicines were to be provided completely free.

5.5 Financing of ARVs

A review of the cost of AIDS treatment options, jointly undertaken by the South African Health and Treasury Departments, found that widespread ARV provision could be cheaper than previously thought. After reviewing a number of scenarios, it suggests that 500,000 people could be provided with a full package of healthcare and nutrition support including antiretroviral treatment by 2008 for between R13.4 and 15.7 billion as opposed to an estimated cost of R6.7 billion for HIV services and care excluding ARVs¹²⁴ (see Table 5).

Table 5: service delivery costs: billions of rands per year

| Scenario | 2003 | 2005 | 2008 | 2010 |
|------------|---------|---------|-----------|-----------|
| No ARV | 5.4 | 6.3 | 6.7 | 6.7 |
| 50% cover | 5.5 | 7.0 | 9.6–10.5 | 10.8–12.9 |
| 100% cover | 5.6–5.7 | 7.9–8.3 | 13.4–15.7 | 16.9–21.4 |

Source: Joint Health and Treasury Task Team Full Report, August 2003

The Disease Management programmes (DMPs) have documented annual costs ranging from \$1200 to \$4810 per treated person year for the few who are receiving HAART under their management in South Africa. However, the level of treatment and care provided varies between these programmes and this per-patient data is not entirely transferable to the public sector.¹²⁶

With a vast network of clinics and hospitals, the mining industry is in a unique position to deal with HIV/AIDS and a number of industry leaders have recently undertaken cost analyses to estimate the feasibility of providing HAART to employees. The Chamber of Mines has been conducting an analysis of the costs of HAART for infected mining employees and projects that cost of treating an HIV infected employee for a period of ten years is between \$8,750–10,000. This study assumes the onset of AIDS after six or seven years and ARV costs to be \$1862 a year.¹²⁷

Compounding the difficulties associated with the costs of providing ARVs, is a lack of firm commitment to fair and adequate financing. At the African Heads of State meeting in Abuja Nigeria in April 2001, heads of state declared their intention to commit at least 15% of their annual budgets to health sector development.¹²⁸ To date, South Africa has not honoured this commitment. In addition there has been confusion around the in-country processes that the DoH requires for accessing funding from the Global Fund for AIDS, TB and Malaria (GFATM), and this has resulted in delays in the GFTAM monies due to come to South Africa.

5.6 Equity issues in relation to antiretrovirals

Those sites that are struggling to provide good PMTCT services tend to be those that are implemented within the context of poor healthcare delivery in general and poorly functioning healthcare systems. At the core of the differences between sites and provinces are the large inequities in healthcare infrastructure within the country.'

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There are powerful pro-equity arguments that support the need to alleviate the misery and suffering of millions of South Africans, especially given the racial, gender and economic bias in the burden of disease. The challenge is in devising and implementing a strategy that can do so most equitably, and in finding a balance between preventative programmes (despite the high levels of infection the majority of South Africans are not infected) and treatment programmes. In planning for and reviewing HIV/AIDS programmes, not only should the immediate goals of the effectiveness of treatment be taken into consideration, but also their contribution to improving the overall health status of the population.

The provision of HAART in itself, is not sufficient as there are a variety of other socio-economic variables that impact on successful treatment of HIV/AIDS.

The WHO protocol for the use of ARVs includes: HIV counselling and testing and follow-up counselling services to ensure psychosocial support and adherence to treatment; capacity to appropriately manage HIV-related illness and opportunistic infections; a laboratory that provides tests for monitoring treatment; a continuous supply of antiretrovirals and medicines for the treatment of opportunistic infections and other HIV-related illnesses; reliable regulatory mechanisms. Countries implementing HAART programmes are also required to concurrently implement an HIV drug resistance sentinel surveillance system. This implies the availability of adequately trained doctors, clinical officers, nurses, laboratory technicians, pharmacists, counsellors and clerks to provide the services required.

As these requirements are variably available a HAART treatment programme will encounter challenges in less resourced areas, and indeed the pilot PMTCT programme has demonstrated the difficulties. Unfortunately there is no reason why the inverse care law will not apply to ARV programmes, especially given the current levels of inequity in access to services.

Stigma within communities has still to be overcome and it is difficult to gauge the extent to which this will constrain uptake of services. Poor communities with least exposure to IEC and with little NGO activity are likely to have most difficulty in overcoming stigma, thus creating another hurdle for equitable provision of HAART.

It seems inevitable that, at least initially, provision of ARVs will exacerbate existing inequities. This is probably true of any new treatment intervention, and has never been used in the past as a reason to delay interventions.

What is less easy to judge is the longer term impact on equity of the intellectual, human and financial resources that will be absorbed as the HAART programme is implemented. Ideally the strengthening of services that will be necessary to provide HAART can happen in such a way as to benefit disadvantaged areas, and strengthen PHC services generally. This will require restructuring, reorganisation and redistribution of existing resources to facilitate reform of the underlying issues of the health system, and will need to be supported by increased financial, infrastructural and human resources.

What is unclear as yet is the extent to which health workers, struggling to keep their morale high, despite having no means of treating unprecedented numbers of desperately sick and dying patients, will be encouraged by being able to administer HAART, as opposed to becoming overwhelmed in the face of the demands made on them by yet one more programme. It is possible that the availability of HAART may contribute to stemming the exodus of health professionals from the public sector.

There is the potential for destabilisation of society as a result of large numbers of state employees (teachers, health workers, community workers, social workers, police, etc) and community leaders dying from AIDS, and the accompanying expected increases in the numbers of orphans. It is always the poorest who are hardest hit in time of societal turmoil, and while a public sector AIDS treatment programme is likely to be regressive from an access perspective, the importance of protecting essential services for vulnerable communities needs to be factored in.

6. Conclusions and issues for follow up

The political controversy and conflict around the cause of AIDS and the introduction of ARVs has impinged negatively on rational debate about equitable and sustainable access to treatment in South Africa. Now that the government has made a commitment to a public sector ARV programme, there will hopefully be more space in which to constructively discuss the best way of expanding access to treatment.

As mentioned earlier, South Africa represents a highly symbolic case because of its ability to reflect the social and economic inequities that exist at the global level. If it is able to buck the trend of widening health disparities in-country, it may also point to the solutions required to reduce widening global disparities, some of which are related to the current form of economic globalisation. To curb the increasing disparities, civil society and educational institutions will have a significant role to play in fostering understanding and action that can counter this debilitating global trend.

One of the key challenges for South Africa will be to ensure that interventions to provide access to ART are appropriately balanced with broader social and economic interventions to alleviate poverty and malnutrition. The vicious cycle of HIV, poverty and malnutrition will not be adequately broken by a medical intervention. This is especially important from an equity perspective because it will be the poor who will stand to benefit least from any expansion of treatment. The poor will find it more difficult to access treatment (even if the medicines are free), maintain treatment adherence; and to tolerate its side effects. Although well-run and managed projects have shown that it is possible for the health system to provide support in a way that will mitigate the effects of poverty, evidence has shown that the poor find it more difficult to manage a chronic disease requiring long-term treatment.

In addition to poverty, stigma continues to represent a barrier to equitable access to treatment. Communities (and women in general) with lower levels of information, understanding and social capital will result in lower levels of voluntary HIV testing, disclosure and access to treatment. Leaders and role models could make a difference by choosing to speak publicly and frequently about HIV/AIDS. Strengthening of IEC campaigns that target particularly disempowered groups with appropriate language and cultural references will therefore continue to be an important intervention that should not be neglected.

A further key challenge will be to expand access to treatment in ways that will not reinforce or accentuate the already existing health systems inequities. In South Africa, the experience with VCT and PMTCT services, and the limited uptake of ARVs amongst those with Medical Aids, indicates that ensuring access for the most disadvantaged communities will be a particular challenge. This will require reforms to reduce the public-private divide, as well as a more equal distribution of available health resources geographically. Strengthening the

health system in under-resourced areas and those that are serving disadvantaged communities, will require addressing the human resource capacity shortfalls of the health system described in this paper.

Finally, the expansion of ART services must be managed in such a way that does not undermine other key and vital health services. These include HIV prevention efforts, but also key maternal and child health services, TB control programmes and STI services. The opportunity costs of expanding treatment must be kept to a minimum, and should be determined on the basis of transparent, public health principles.

6.1 Key recommendations

Improve the coordination of HIV and health systems development interventions

South Africa now has a comprehensive and ambitious HIV strategic plan, which includes the rapid expansion of ART. The challenge in government is to ensure that its health management structures are able to implement the plan in a way that is coordinated, effective and appropriate. Many activities remain vertical and need to become better integrated with other services. The low management capacity and lack of public health leadership in the poorer provinces are especially important challenges. In addition, the lack of authority and capacity at the district level will tend towards the adoption of vertical systems to implement ART, which could in turn undermine local capacity development.

One of the solutions to more effective implementation of the national HIV strategy that is appropriate to the local context is the establishment of a functional and effective DHS. This would in theory result in strong and effective decentralised management structures that are able to plan and implement activities in a way that is appropriate, sustainable and efficient. However, in order for this to happen, the central management structures of the DoH must be prepared to invest in developing capacity at the periphery.

Provide a meaningful social welfare benefit in the context of AIDS

It has been argued that the absence of a comprehensive social security system and a social net to 'catch' people in times of lifetime crises has exacerbated the effect of HIV/AIDS, especially in poor households. The introduction of a basic income grant could play a significant role in injecting cash into impoverished households and could provide a small but meaningful lifeline to people with no other means of survival. At present, the state provided disability grant is only available to people who are in stage four of AIDS and considered terminal. This withholding of state assistance to people who are unable to provide for themselves might possibly not stand up to constitutional scrutiny and a reassessment of the eligibility criteria for receipt of a disability grant also needs to be undertaken. The growing phenomena of child-headed households also need to be addressed from a legal and social security perspective.

Promote a more equitable distribution of public resources

The current resource allocation formula does not take adequate account of inherited backlogs that continue to disadvantage some provinces. A more equitable formula, which will increase the resources available to underserved provinces and facilitate improved quality of care is required. There is also need to shift the balance between spending on PHC and other levels of care in such a way as to increase the resources that are available at the primary level.

Develop an appropriate long-term human resource plan

Health personnel are the lifeblood of any health system. South Africa needs to urgently develop a comprehensive human resource strategy for meeting not just the challenges of ART but also the delivery of a comprehensive package of PHC services. This would include determining the appropriate mix of health staff, calculating attrition rates and modifying production rates accordingly. In addition, it would need to develop strategies to overcome the current maldistribution of staff.

Prioritise the development of healthcare infrastructure in the under-resourced and rural areas

Despite a substantial clinic-building and upgrading programme many facilities in under-resourced and rural areas remain inadequate and without the necessary space for privacy that is required especially for HIV/AIDS care and services. This serves as a barrier in access to care that is exacerbated by poor roads and lack of water, sanitation and electricity, all of which discourage staff as well as patients. Remedying this weak infrastructure should be prioritised.

Monitor expenditure on HIV/AIDS

The 2003/04 Budget allocates increased funding for the appropriate treatment of HIV/AIDS and indicates that funding will increase over the coming two years. Strategies to monitor that these funds are being used fairly are required. Interrogation of provincial spending patterns and differing capacity, needs and existing impediments of provinces to provide effective treatment, must be given individual and specific attention, if not inequities will remain but manifest at another level.

Clarify criteria for access to treatment

There are an estimated 500,000 South Africans who could benefit from ARVs and this number is expected to grow. Clear guidelines need to be developed as to at what stage of the illness people will be entitled to access treatment. Questions around whether a means test will be administered to determine eligibility for treatment or whether fees will be implemented on a sliding scale must also be answered. Current thinking suggests that a means tested access to treatment is not the most appropriate eligibility mechanism due to the bureaucratic and cumbersome nature of the instrument and the tendency of people to lie about their financial status to access treatment.

Widen business and private sector cover of HIV prevention and care

The reforms to the private sector already in place are a good start. There is a need to go further in terms of reducing the costs of, and increasing access to, private care. Business and the private health sector need to be encouraged to put in place mechanisms for minimising the impact of the epidemic on the public sector. The mechanisms that can be adopted for shifting the burden of the disease to the public sector should become the subject of public debate and discussion with a view to encouraging big business to take responsibility for providing treatment to all levels and categories of staff. Government should encourage the private sector to provide adequate employment assistance programmes as well as disability, death and sickness benefits that take into account the devastating impact of the epidemic; new ways of stimulating corporate social responsibility must be explored. More vigilant and effective monitoring of labour and equity promoting laws is required to ensure that people who are HIV positive are not being discriminated against when applying for and maintaining their employment.

Empower communities to engage with the health system

Stigma continues to dog efforts to inform and empower communities to combat the epidemic and engage with healthcare providers for their rightful care. Strategies to improve HIV/AIDS literacy and strengthen the notion of the basic right to health need to be put in place at the community level.



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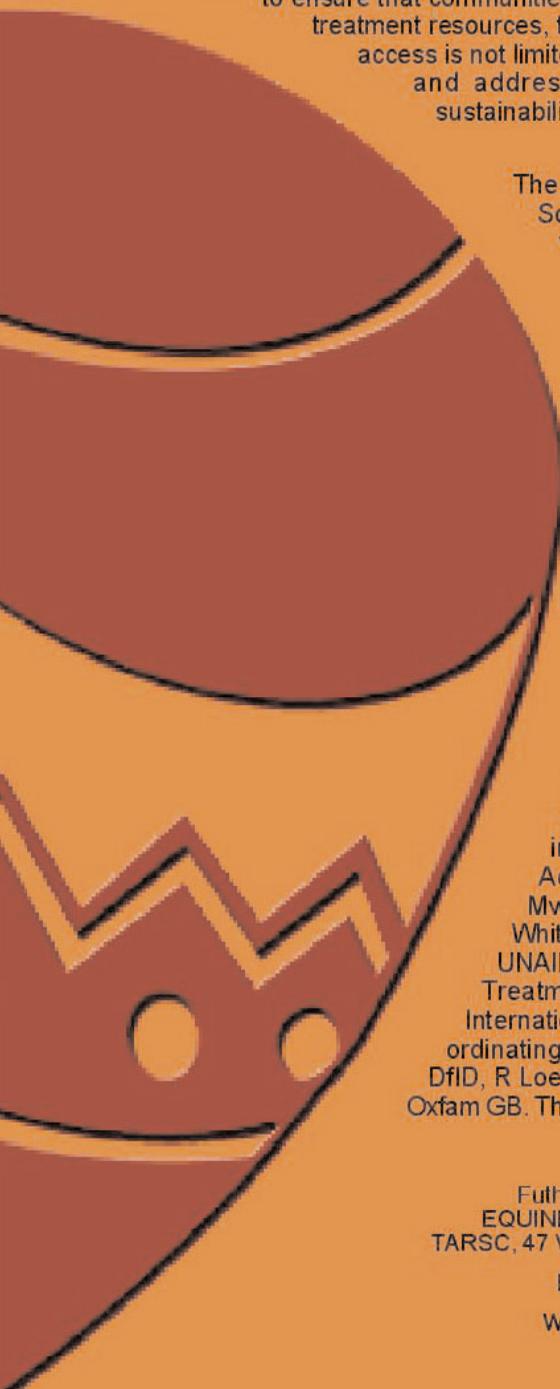
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HIV/AIDS has had a deep impact on health and health equity issues in Southern Africa. Health services in southern Africa have faced a significant challenge to ensure that communities access prevention and care. With new treatment resources, this now includes ensuring that treatment access is not limited to the wealthiest globally or nationally, and addresses wider health system needs for sustainability and equity.

The Regional Network for Equity in Health in Southern Africa (EQUINET) and Oxfam GB with government and civil society partners have initiated a programme of research, policy analysis and intervention on equity in health sector responses to HIV/AIDS. The programme has reviewed policy issues relevant to equitable health care responses to HIV/AIDS in Malawi, South Africa, Tanzania and Zimbabwe and in relation to health personnel and nutrition. The discussion papers in this series arise out of this work. They are also available on the EQUINET and Oxfam Websites.

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