The recently concluded 15th African Union (AU) Summit in Kampala, Uganda, deliberated on maternal, infant and child health and development in Africa. This, according to the AU Commission’s Director of Social Affairs, Advocate Bience Gawanas, was a historic first for the continental body.

A woman in Africa is estimated to have one out of 16 chances of dying of pregnancy-related complications or during childbirth. This figure is glaringly disproportionate compared to the fact that one out of 4,000 women are at risk in a developed country.

The main causes of maternal deaths on the continent are a result of haemorrhage, septic infections, hypertensive disorders, anaemia, obstructed labour, and complications from unsafe abortions and increasingly, HIV and AIDS complications in expectant mothers. These are compounded by inadequate food security and malnutrition, tuberculosis, malaria and other communicable and non-communicable diseases, as well as neglected tropical diseases.

At an institutional level – that is at health facilities – it was found that the absence of skilled health personnel during births is the strongest contributing factor to maternal deaths.

The health situation for pregnant and child-bearing mothers and their children is dire in Africa. It is estimated that 12,000 children die daily in Africa. Every minute, eight children die from preventable diseases or treatable conditions. Two of these children are infants.
Child mortality figures show:
• 167 to 220 deaths per 1,000 live births occur in countries with the highest maternal mortality
• HIV is a growing threat to mother and child health and welfare in 36 out of 54 countries, where 58% to 65% of HIV-positive adults are women
• average maternal mortality across Africa for the last five years was about 260,000 per year

In the five most affected African countries, only 18% to 47% of births had skilled attendants present. This is compared to 79% to 99% in least affected countries. Access to reproductive and sexual health advice and commodities is vital to progress, said the Africa Public Health Information Service. It stated that in five most affected countries, a mere 2.8% to 14.6% of couples have reported the use of family planning. In the five least affected countries, 55.1% to 75.8% of couples have gone through family planning.

As far as child mortality goes, 167 to 220 deaths per 1,000 live births occur in countries with the highest maternal mortality. HIV is a growing threat to mother and child health and welfare in 36 out of 54 countries, where 58% to 65% of HIV-positive adults are women. The information service stated that overall progress remains minimal. The average maternal mortality across Africa for the last five years was about 260,000 per year, claiming the lives of about two million African women since the Millennium Development Goals were adopted in 2000.

According to the AU Commission’s Department of Social Affairs, this critical situation is as a result of weak health systems in African states, delays at different levels in assessing health services and lack of emergency neonatal obstetric care and family services. There is no quick fix, suggested the African Public Health Information Service, explaining that the poor ratio of health workforce to population means most countries will need to double, triple or even quadruple the health workforce to make long-term and sustainable progress in maternal health and other health needs. Equally, it said, there is a need for rapid changes in long-term education and labour practices, including integration with health planning.


This AU Summit’s theme was maternal, infant and child health and development in Africa. And in response to the dire trend, the Summit adopted the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). So far, 16 of the AU Member States – including Namibia – have launched CARMMA. AU Commission Chairperson, Jean Ping, said the plan is that an additional seven countries will adopt CARMMA by the end of 2010.

CARMMA is derived from key priority areas enshrined in the 2005 AU Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa and the 2006 Maputo Plan of Action. The 2005 framework calls for mainstreaming of sexual and reproductive health and rights in primary healthcare to accelerate the achievement of health-related Millennium Development Goals (MDGs), and in particular the fourth, fifth and sixth MDGs.

MDG 4 deals with promised made to reduce the under-five mortality rate; MDG 5 calls for the reduction of maternal deaths by three-quarters; and MDG 6 calls for the halting and reversal of the spread of HIV and AIDS; for the achievement of universal access to treatment for HIV by 2010, and the halting of the incidence of malaria and other major diseases.

The AU Department of Social Affairs said 10 African countries are on track with MDG 4. Algeria, Cape Verde, Egypt, Eritrea, Libya, Mauritius, Morocco, Seychelles, Tunisia, and recently Malawi, have made strides. Others that have made some progress are Ethiopia, Ghana and Tanzania.

With respect to MDG 5, most countries could not give dependable statistics, but 40 are estimated to have very high maternal mortalities. Countries that have made progress on this score are Benin, Burkina Faso and Ghana.

On the other hand, one of the main pillars of the Maputo Plan of Action is the prevention of maternal and child morbidity and mortality. It calls for a redoubling of efforts to attain universal access to sexual and reproductive health in all African countries by 2015. This is considered one of the most robust collective responses to the alarming rate of deaths among women and children in Africa – a sensitive indicator of the inequality between men and women on the continent.

CARMMA focuses on three key areas: positive messaging, encouraging the achievement and strides made by countries to reduce maternal mortality and seeking to replicate them, and to intensify actions aimed at reducing maternal and infant mortality. Important at this summit, said Gawanas, was that under the CARMMA programme, Heads of State committed themselves to key actions – and not a declaration likely to gather dust.

“This is a historic first in the sense that the debate [of the summit] focused on the lives of women and children on the continent,” said Gawanas, who added that she has no doubt that Africa’s leaders have shown the political will to promote the health and well-being of women and children.
These actions include the launch of CARMMA with the hope that its mandate would be broadened and the strengthening of a comprehensive and integrated health system across Africa. Gawanas said national activities fall under the stewardship of national governments.

Action steps include the scaling up of good practices; sustainable financing to start with domestic resource mobilisation with a look at public-private partnerships and other possibilities, such as the waiving of user fees and the introduction of national health insurance; mechanisms to be pursued by the AU to see how member states can access pledges for funding from the G8 and Global Fund; a call to global partners to replenish the Global Fund; and a commitment to a functional and strong monitoring and evaluation system for accurate and timely information on the situation. There was also a commitment that maternal, infant and child health matters will feature permanently on the yearly agenda of the AU Assembly, which is the highest decision-making body of the AU.

Civil society groups that were at the summit felt that the outcome on the theme was positive, but expressed reservations over how fast and steadily African states will respond to the commitments. Before the key activities were adopted, at least 117 civil society organisations expressed concern that some Heads of State have been advised to repudiate crucial commitments on health and social development.

One particular commitment by Heads of State is contained in the 2001 Abuja Declaration – that every African government will commit at least 15% of the national budget to the health sector. According to the World Trade Organisation’s (WTO’s) World Health Statistics for 2010, only three countries’ health budgets exceeded the 15% mark. These are Rwanda (19.5%), Tanzania (18.4%), and Liberia (16.6%). Namibia’s health budget constituted 11.1% of the national budget.

Civil society organisations complained that at present, 34 African countries are investing less than the WHO recommended minimum package of USD40 per capita on health. These include 27 African countries investing less than USD20 per capita on health and 15 countries investing as little as USD2 to USD10 per capita on health. “Clearly, per capita investment in health needs to improve alongside percentage allocation for Africa and its citizens to have a chance to fulfill potential and aspirations,” the organisations said.

Executive Director of the International Community of Women Living with AIDS East Africa, Lilian Mworeko, felt not enough emphasis was put on HIV and AIDS, which shows a clear linkage between the disease and maternal and child deaths.

“It is naive of presidents and governments not to mention HIV,” said Mworeko, adding that it was equally disappointing that African leaders did not address the criminalisation of HIV that is increasingly seen across the continent. Uganda, for example, is considering a draft Bill to criminalise the spread of HIV, and includes provisions for forced disclosure of HIV status, as well as mandatory testing.

Gawanas felt that mention of HIV would be superfluous. “The intention was not to make the key action points disease-specific; we know the causes of maternal and child mortality. We must move away from vertical approaches and look at the totality. We want an integrated approach,” countered Gawanas.

Africa Advocacy Advisor of Save the Children, Chikezie Anyanwu, was more upbeat in his comments on the commitments made by the summit. “The maternal and child health principles African leaders have committed to are excellent. Now they must follow through. If they dedicate the resources promised and employ the strategies outlined here, African leaders could save the lives of millions of children and mothers and dramatically boost the development of their nations and the continent. We are prepared to work with the leaders to make their decisions a reality for African people,” said Anyanwu.

Save the Children also commended African leaders for pledging to reduce out-of-pocket health expenses through initiatives like waiving fees for pregnant women and children under the age of five years. “Most importantly of all,” said Anyanwu, “African leaders have acknowledged what is in fact the silver bullet needed to end maternal and child deaths – political will. The solutions to ending these preventable deaths annually are well known. If the leaders exercise the will to take concrete actions as they have said here (at Kampala), there is no reason Africa cannot save the lives of millions of its mothers, new-borns and children.”

Universal access too expensive?

In the years since the landmark International AIDS (IAC) Conference in Durban in 2000, many things changed for the better. Remarkably, ARVs were rolled-out to resource-limited settings, a feat made possible by increased political will, cheaper drugs, stronger scientific research, and more comprehensive national and international policies1. But now the attitude towards universal access is distinctly chilly.

As economist Nicoli Nattrass, from the University of Cape Town, explained at IAC Vienna, HIV funding increased massively, from less than US$1 billion in 1999, to about $10 billion in 2007. She argued that there were three reasons for this: the focus on HIV as an issue of human security; the mobilisation of a transnational activist alliance; and the Bush administration’s co-option of HIV treatment as part of its ‘conservative care agenda’. Nattrass believes that donors were willing to make considerable commitments to HIV funding because of the longest boom in capitalism since World War II. She noted that “it’s amazing that we’ve managed to keep AIDS funding at where it is, because the boom has burst”.

This is the real cause of the current ‘AIDS backlash’ and why past arguments concerning the cost-effectiveness of ART are resurfacing despite significant evidence for ART as a vital weapon in the prevention armory: “We are beginning to hear... once more, that universal access is too expensive and that we can’t do it,” said Peter Mugyenyi, Director of Uganda’s Joint Clinical Research Centre.

Trade and aid have always been intimately connected, with assistance in the guise of aid’ often benefiting the donor country as much as the recipient. HIV medication is a case in point. It is naïve to talk about funding for universal access without also looking at the cost of HIV medications, and their availability and affordability in high-burden countries. It is also very important to consider some of the less discussed reasons for this high cost.

One of these is intellectual property rights (IPR). Today, these have acquired unprecedented importance. In the 1980s, the United States expanded the boundaries of trade laws to include intellectual property and now regards protection of intellectual property as an investment activity. The trade-related aspects of intellectual property rights (TRIPS) agreements purports to contribute towards the enhancement of knowledge by incentivising innovators through international property rights (IPR) protection. However, in the long run, it undermines access to knowledge and innovation and has stifled the generic competition that drove the price of first generation antiretrovirals down, causing huge disparities in the price of first, and second-line ARVs.

The reality of compulsory licensing for developing countries

In theory at least, a country can get around TRIPS patent enforcement by issuing a compulsory licence which enables someone other than the patent holder to copy patented drugs without fear of prosecution. Since the 2001 Doha Agreement, a compulsory licence can be issued for a drug that treats a disease causing a severe health emergency in a country without paying royalties, but this option allows only pre-defined quantities to be

It is naïve to talk about funding for universal access without also looking at the cost of HIV medications, and their availability and affordability to high-burden countries and without considering some of the less discussed reasons for this cost.
manufactured, limiting the economies of scale from large-scale production. Such licences are also granted to supply domestic markets only, so poor countries without technological capability cannot access generic drugs from elsewhere.

And there are other barriers. In February 2009, a shipment of second-line generic ARV drugs bound for Nigeria was confiscated by Dutch customs authorities. It was eventually released, indicating that the European Union (EU) is also unhappy with the relaxing of the TRIPS rules for developing countries.

The cost-significance of using generics is evident: from 2005 to 2008 President’s Emergency Plan for AIDS Relief (PEPFAR) saved an estimated USD323,343,256 through the use of generic ARVs - money which can be used to support other areas. Nonetheless, the United States (US) is intent on defending the patent rights of pharmaceutical companies (Big Pharma) - so much so that AIDS activists from the United States (US), Africa, Asia, and Latin America have filed a complaint against it with the United Nations Special Rapporteur on the Right to Health. They maintain that the US is working with Big Pharma and using its trade policies to coerce countries to adopt IPR policies that increase the costs of medicines and violate the human rights of their citizens.

The allegation is that the US threatens countries with trade sanctions for making use of legal, WTO-compliant measures that bring down the cost of AIDS drugs and other essential medicines, by listing them on “watch lists” under “Special 301”, which threatens sanctions against foreign countries for their IP laws.

Thailand, India, and Brazil – the latter two by no coincidence the key manufacturers of AIDS drugs for African and other developing nations – were placed on these lists in 2010, for their failure to adopt IP laws that maximise profits for Big Pharma.

The implications of the US behaviour for the cost of universal access have not been openly discussed, but the Journal of the International AIDS Society has recently published a new study demonstrating the central role Indian generic manufacturers play in the supply of ARVs to developing countries. This is of particular importance, the authors say, given ongoing negotiations for bilateral or regional trade agreements that may introduce new IP obligations that could constrain or restrict generic supply.

The Anti-Counterfeiting Trade Agreement

Not content with the power they already wield through TRIPS, the world’s wealthiest governments are currently negotiating a deal that could cut off poor people from life-saving medicines. The so-called Anti-Counterfeiting Trade Agreement (ACTA) has been kept out of the public spotlight but China, India, and the European Parliament have all spoken out against it recently. The most worrying provision of the proposed deal is its treatment of essential medicines. The ACTA would treat many generic and “counterfeit” drugs in the same way, making cheap competition for name-brands subject to the ‘seize-and-destroy’ tactics applied to fake medicines. Big Pharma claims this is needed to protect consumer safety - but they themselves sell generic versions of medicines whose patents have expired. The real issue is drug company profits.

The AIDS Backlash

The current AIDS backlash is driven by “financially driven political hostility, but [now] it’s being presented under pseudo-scientific arguments” argues Paula Akugizibwe of AIDS and Rights Alliance of Southern Africa (ARASA). Michel Kazatchkine, Executive Director of the Global Fund agrees. “What we’re hearing is AIDS has enough, it’s not sustainable… let’s do more with less… this is very dangerous.”

The argument seems to be that HIV has taken money away from primary health care, but an opposite argument can be, and is made. “The bar should be raised in relation to all health conditions, not pulled back down again so that HIV can be as equally neglected as other diseases”, says Mark Heywood, Executive Director of Section 27, a social justice organisation. He says that universal access should be seen as having cut a new path and establishing a set of principles that should apply to all diseases.

It is even more important, in this atmosphere, that African governments honour their commitment to the Abuja Declaration to spend 15% of GDP on health, to show the world that Africa is doing something for her own people. All said and done, it remains to be seen whether the ‘huge funding gap’ in Global Fund Round 10 will in fact be filled. As Michel Sidibé says, “This is the moment that we need to scale-up, rather than flat-line or step down”.

---

1 The report was published jointly by Health & Development Networks and the Medical Research Council of South Africa – for further information, please write to: info@hdnet.org
2 http://www.avert.org/generic.htm
3 Press release: UN asked to investigate US trade policies by AIDS activists from health gap (global access project)
4 A lifeline to treatment: the role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries. Brenda Waning, Ellen Diedrichsen and Suerie Moon
Indigenous knowledge saves lives

By Carol Thompson

As visitors to a rural health clinic, supported by Community Technology Development Trust (CTDT) in Murehwa District, we asked a question during our introduction to the community: how did they know that increased nutrition in the daily diet prolonged lives of persons living with HIV?

“Take a look at me!” The young man was emphatic, and confident of his ability to sustain his health using indigenous knowledge related to local foods.

The rate of incidence of HIV in Zimbabwe plummeted from 29.3% in 1998 to 15.3% in 2007, the sharpest decline in southern Africa. When I worked in Zimbabwe in the late 1980s, and again in the 1990s, those who were diagnosed kept it a secret and families reported that a member had died “after a long illness”. This denial from upper classes and pop stars to the most penurious street person created misery for people living with HIV and for those who loved them. Families were torn apart. The incidence rose so quickly and so high that those trying to educate the young about it could claim that “every Zimbabwean family is either infected or affected” by the AIDS epidemic. Southern Africa HIV and AIDS Information Dissemination Service (SAF AIDS) has well documented the behavioural changes (e.g. delay of first sexual encounters and increased condom use) which account for the decline in the incidence rate.

A success story less told narrates behavioural changes occurring among those living with the virus. The availability of antiretroviral drugs from international donors offers hope for a longer and more vigorous life, but for that hope to be realised, behaviour must also change. And it has changed across Zimbabwe, demonstrating that indigenous knowledge is as important as the advanced technology of antiretrovirals in prolonging lives.

The home village (kumusha) defines a Zimbabwean, and during the last century of rural-urban mobility, the very sick and aged often go home to be cared for. Many in the community assist, providing sustenance and concern, in contrast to urban anonymity. As the HIV epidemic spread however, many families were overwhelmed, with grandmothers finding themselves raising four to eight grandchildren, since both parents had died. AIDS created orphanages where they had never been needed.

Providing much more than solace, communities are now mobilising to change production and consumption of local foods. Antiretroviral drugs alone are not sufficient for communities to sustain lives and livelihoods; indigenous knowledge of foods and nutrition is equally vital. For example, as nutritious as maize is for carbohydrates and vitamin B6, sorghum is more nutritious in protein, calcium, copper, iron, phosphorus, ash, pantothenic acid (vitamin B5), isoleucine and leucine (amino acids). Finger millet (rapoko), traditionally cooked in delicious porridge for pregnant women, is also rich in the B vitamins, potassium, iron, phosphorous, magnesium and zinc. Highly versatile foods, sorghums and millets can be boiled like rice, or cracked open like oats for porridge; or they can be baked like wheat into flatbreads, or popped like popcorn for snacks. Locally bred varieties of soya, ground nuts and indigenous cow peas are excellent sources of protein, and very necessary to persons living with HIV, who need 50% more protein than the average.

Important for climate change, small grains (e.g. sorghum, pearl millet and finger millet) are highly drought tolerant because strains have been bred for early flowering to occur, not when adequate rains have come, but according to daylight length.
Pearl millet varieties bred in Zimbabwe sport longer spines to deter the quelea birds; others flower into grain only after other crops, equally enticing to the birds, are readily available.

In Tsholotsho, Murehwa, and Uzumba-Maramba - very different parts of Zimbabwe where we visited - farmer field schools meet as often as once a week, to exchange knowledge about best practices. They exchange seeds and save seeds. The local farmers share indigenous knowledge about intercropping diverse plants. One farmer grows as many as 15 to 20 different crops – a profusion of nutrition. They are practicing conservation agriculture which diminishes fertiliser use to one-third, reducing the cost of production and enhancing environmentally friendly farming.

More than one farmer field school we saw was about 90% female; many of these women are widows and their farmer field schools provide a support group and assist them in using land productively, increasing its value. They themselves become community leaders, fully rejecting the role of desolate widow. Many of the changes take time; for example, it takes about three seasons for conservation agriculture to show its dramatic effects for lower costs with higher production. Local seed banks take several seasons to collect the amounts and varieties needed for sustainable supplies. In the field schools (some established over a decade ago with assistance from Community Technology Development Trust, women support each other as their production techniques gradually advance.

These changes in production are so vital that the Murehwa District health clinic cultivates a “nutrition garden” as a demonstration plot, to show the variety of crops and to teach agronomy of those crops. The garden also feeds all the patients staying at the clinic as well as the health workers. People living with HIV (PLHIV) can learn first-hand over a few days, that careful nutrition can make a difference in how they feel; as their health improves, they also learn how to prepare the foods at home.

With the rich variety of foods available, PLHIV can avoid highly refined, packaged foods; a way of changing behaviour and prolonging health and life. The consumption of many varieties of foods provides the vitamins and minerals necessary, in complex interactions more beneficial than any assortment of vitamin pills. Baked sweet potato slices are a much more nutritious snack (rich in vitamins A, C and potassium) than Irish potato crisps or chips. Lightly fermented sorghum (mahewu) is more delicious and nutritious than any Coke or Fanta. One does not need to spend precious cash at the local tuck shop as consumption habits change. One young man, so proud of his dietary choices, helped to bring a peanut butter-making machine to the local shop; instead of buying peanut butter overloaded with salt, growers of groundnuts come to the shop to make their own.

Community volunteer care-givers organise themselves and work from the clinics as their base. They visit families, caring for those who have become ill and helping out in various ways. Often the volunteer is also HIV-positive and acts as a role model, especially for changing consumption habits. They bring advice about increasing and improving nutrition. These leaders, working with the farmers, and complementarily with CTDT field officers, fulfil the goal of sustenance.

Food production and consumption define communities. Improving the production of indigenous crops and promoting the consumption of bio-diverse foods, helps communities to realise the hope of prolonging the lives of people living with HIV. Affirming local culture and knowledge sustains community life and lives.

Carol Thompson, PhD, works with the Policy Analysis Unit, Community Technology Development Trust (CTDT), Zimbabwe Northern Arizona University, USA

Editor: This article shows that information about nutrition and health, particularly in relation to HIV, has trickled down to communities and is empowering community members to look after themselves, even in areas of severe economic and climate hardship. It also shows the importance of biodiversity and the need for small-scale farmers and consumers to think local, especially in the light of climate change and the need to improve the nutrition of communities.
New technologies: male circumcision and microbicides potentially provide an important new HIV prevention tool for men and women. Key highlight of the XVIII International AIDS Conference, 2010

By: Maserame Mojapele and Tafadzwa Madondo

One of the key highlights of the 2010 International AIDS Conference was the introduction of the experimental intervention of a microbicide gel which provided evidence that this gel has the partial effect of preventing HIV infections among women. On the other hand male circumcision has been observed to reduce HIV infection among males. However, if both the microbicide and male circumcision are used together, this could produce modest reductions in HIV incidence. Microbicides and male circumcision could potentially be powerful prevention tools when used alongside existing prevention strategies such as male and female condoms, risk reduction counselling, and diagnosis and treatment of sexually transmitted infections. A realistic level of microbicide and male circumcision adoption would produce reductions in new HIV infections within 15 to 20 years.

However, the effect of these individual therapies, if combined, could produce massive reductions in new infections. Inevitably, male circumcision would benefit men more and microbicides would be of greater benefit to women.

If male circumcision was the only intervention used, the reduction in infections seen would be amongst men and if microbicides alone were used, the reduction would be in women; but if used together, the sexes would share the benefit equally.

The efficacy of male circumcision is best seen when it is supported by voluntary counselling and testing (VCT) and consistent condom use; while antiretroviral therapy (ART) used alone continues to show a decrease in the number of HIV infections between the partners. Microbicides, of course, offer the first proven prevention method to come completely under the control of individual women and the results of the CAPRISA 004 trial announced at the 2010 conference caused a huge swell of much-needed optimism in the halls and by-ways.

This shows that there is no ‘magic bullet’ in HIV prevention and those impressive reductions in the infection rate between couples can only be achieved by using the range of interventions available in combination. It is important that this is taken into account in future programming.

Maserame Mojapele is a Programme Manager at SAfAIDS and Tafadzwa Madondo is a Programme Assistant, also with SAfAIDS

Editor: See also the detailed article on the CAPRISA 004 trial elsewhere in this issue
The 2010 XVIII International AIDS conference (IAC) was hosted in Vienna following regional conferences conducted on each continent during 2009. This conference occurred at a critical juncture in the global response, with infection rates still high, whilst the global recession has affected funding of programmes for prevention, treatment, care and support, especially in the poorer regions such as sub-Saharan Africa. With a global economic crisis threatening to undermine public investments, the conference helped to put HIV on the international agenda and to demonstrate the importance of continued HIV investments to broaden health and development goals.

With the theme ‘Rights Here Right Now’, IAC 2010 aimed to underscore the fact that the protection of human rights is a fundamental pre-requisite to an effective response to HIV, continuing the dialogue that began in Mexico in 2008. The 2010 AIDS Conference programme also sought to promote scientific excellence and inquiry; encourage individual and collective action; foster multi-sectoral dialogue and constructive debate, and reinforce accountability amongst all stakeholders.

The new HIV epidemic is located in eastern Europe and the host city, Vienna, bridges eastern and western Europe. This allowed an examination of the epidemic in eastern Europe where it is driven by serious obstacles to HIV prevention, treatment and care services, among them injecting drug users, sex work and prisoners – who constitute the most-at-risk populations.

The Vienna Experience:
Sharing on children and HIV family support first conference

By Lillian Chikara

The 2010 XVIII International AIDS conference (IAC) was hosted in Vienna following regional conferences conducted on each continent during 2009. This conference occurred at a critical juncture in the global response, with infection rates still high, whilst the global recession has affected funding of programmes for prevention, treatment, care and support, especially in the poorer regions such as sub-Saharan Africa. With a global economic crisis threatening to undermine public investments, the conference helped to put HIV on the international agenda and to demonstrate the importance of continued HIV investments to broaden health and development goals.

With the theme ‘Rights Here Right Now’, IAC 2010 aimed to underscore the fact that the protection of human rights is a fundamental pre-requisite to an effective response to HIV, continuing the dialogue that began in Mexico in 2008. The 2010 AIDS Conference programme also sought to promote scientific excellence and inquiry; encourage individual and collective action; foster multi-sectoral dialogue and constructive debate, and reinforce accountability amongst all stakeholders.

The new HIV epidemic is located in eastern Europe and the host city, Vienna, bridges eastern and western Europe. This allowed an examination of the epidemic in eastern Europe where it is driven by serious obstacles to HIV prevention, treatment and care services, among them injecting drug users, sex work and prisoners – who constitute the most-at-risk populations. Since 2010 had been set by world leaders as the deadline for universal access to treatment, IAC 2010 provided the opportunity for reflection on progress, gaps and charting a way forward, bearing in mind what has worked and what has not. However, this article will focus on the issues specific to paediatric HIV; on the face of it, one of the easiest epidemics to eradicate.

Dr Michel Sidibe, UNAIDS Director, spoke passionately about this and reiterated that there should be zero infections, zero deaths and zero stigma, resulting in the virtual elimination of paediatric HIV by 2015. This will only be possible if all sectors unite and work together. This alone marks notable progress since Mexico 2008 when paediatric HIV was not even on the conference agenda. The family centered approach needs to be taken up as it improves the quality of life of children with HIV.

As part of IAC 2010, a two-day symposium entitled ‘Children and HIV: Family Support First - Working Together to Achieve Universal Support and Access to Treatment’, was attended by participants from all over the world with an interest in paediatric HIV and AIDS. The symposium was jointly hosted by The Teresa Group, the Coalition on Children Affected by AIDS (CCABA), and World Vision Austria; leaders of a consortium that seeks to end paediatric HIV and AIDS. The focus was on providing evidence and sharing the latest models on family-centered care and services for children affected by HIV. Close to 600 service providers, donors, researchers, advocates and policy leaders from developed and developing countries working within affected communities on national, regional and global platforms attended. The symposium promoted opportunities for stronger linkages between programme design and implementation, policy, research and advocacy.

Highlights from the symposium

Plenary presentations were held in the morning with key presentations setting the tone for the conference. Mrs Elizabeth Mwenye from Zambia highlighted the role of civil society in the fight against paediatric AIDS. The need to support children is being recognised, as is the importance of targeting both men and women through antenatal care, labour, post-natal care, infant feeding, adolescent health programmes and family-based approaches that provide holistic care to the infected and affected.

Simultaneous sessions discussed a range of topics. Presentations included topics such as care and support programmes, service delivery by governments, international policies and initiatives, research and skills building and knowledge exchange. Some of the issues
raised that are of interest for future programming in children’s issues include:
- ART coverage for children can be increased by building on services that already exist
- In some areas, grants are being given to families to improve the quality of life of children living with HIV. This has been shown to be successful
- Identifying chronically ill children rather than just focusing on children living with HIV helps to reduce stigma
- All children in high burden countries under five years of age should be tested for HIV
- Linking programmes for orphans and vulnerable children with prevention of mother-to-child transmission (PMTCT) programmes improves outcomes for both parents and children
- Indigenous knowledge systems should be harnessed so that communities can manage and run programmes
- Due to cultural dynamics in some countries, infant feeding is a delicate issue and there is need to handle messages regarding HIV transmission via breast milk with great care
- Integration of services provides a more holistic approach to care compared with vertical programmes

Improved health systems will enable the successful implementation of PMTCT programmes using the four-pronged approach to care. The Four-Pronged Approach to PMTCT Strategy is a programme model developed by the United Nations in 2001. Each of the four “prongs” represents a stage at which programme services work to:

- prevent HIV in women of reproductive age,
- prevent unintended pregnancy in women with HIV,
- prevent HIV transmission from mother to child, and
- provide ongoing care and support to mothers, their children, and families

Within the third stage — preventing HIV transmission from mother to child — the PMTCT Continuum of Care Services include critical antenatal, intrapartum, and postpartum/postnatal health services to mothers and infants.

Implications for Children’s Programming
For children’s HIV programmes to run well, it is essential to continue fundraising, even though the global financial crunch is affecting many donors and partners. In addition, the evidence base for programming must be expanded and monitoring and evaluation of both qualitative and quantitative aspects of programmes needs to be increased.

Co-ordination for efficient and effective implementation of programmes at all levels must also be promoted.

Key programmatic issues include:
- Children with advanced HIV disease experience challenges to their mental and physical development, hence the need to start treatment early
- Adolescent girls and boys need to be given life skills information on HIV, prevention of unwanted pregnancies as well as on the benefits of delaying the age of sexual debut, to ensure safe motherhood
- Programmes should focus on ending all forms of violence against women, as violence heightens rates of HIV transmission
- The role of family and primary care givers, secondary care givers and community-based volunteers was commended and needs support as they are the back-bone of the family-centred approach to HIV
- Media has an important role to play in educating and advocating for children’s programmes.

Lillian Chikara is a Programme Officer at SAfAIDS

More information on these issues may be found on the conference website http://www.teresagroup.ca/vienna/program.html
Barriers to accessing highly active antiretroviral therapy by HIV-positive women attending an antenatal clinic in a regional hospital in western Uganda

Puta Duff1, Walter Kipp1,2, J Cameron WHD1, Tom Rubak6 and Joa Okoch-Ogony1

Abstract
Background: The aim of this study was to describe barriers to accessing and accepting highly active antiretroviral therapy (HAART) by HIV-positive mothers in the Ugandan Kabarole District’s Programme for the Prevention of Mother to Child Transmission-Plus (PMTCT-Plus).

Methods
Our study was a qualitative descriptive exploratory study using thematic analysis. Individual in-depth interviews (n = 45) were conducted with randomly selected HIV-positive mothers who attended this programme, and who: (a) never enrolled in HAART (n = 17); (b) enrolled but did not come back to receive HAART (n = 2); (c) defaulted/interrupted HAART (n = 14); and (d) are currently adhering to HAART (n = 12). A focus group was also conducted to verify the results from the interviews.

Results
Results indicated that economic concerns, particularly transport costs from residences to the clinics, represented the greatest barrier to accessing treatment. In addition, HIV-related stigma and non-disclosure of HIV status to clients’ sexual partners, long waiting times at the clinic and suboptimal provider-patient interactions at the hospital emerged as significant barriers.

Conclusions
These barriers to antiretroviral treatment for pregnant and post-natal women need to be addressed in order to improve HAART uptake and adherence for this group of the population. This would improve their survival and, at the same time, drastically reduce HIV transmission from mother to child.

Background
Sub-Saharan Africa has been devastated by the HIV and AIDS epidemic, having more infections and deaths than any other region globally [1]. Uganda is among those countries in the sub-Saharan region that is hit hard by HIV and AIDS: the latest national HIV prevalence is estimated to be 5.4% among adults, and higher among women (7.5%) than among men (5.0%) [2]. Since there are currently an estimated 940,000 people living with HIV in Uganda, there is potentially a high demand for highly active antiretroviral therapy (HAART) in this population: Hladik et al estimate that 111,100 HIV patients will require HAART in Uganda by the end of 2010 [3].

Unfortunately, only a small portion of HIV patients actually receive HAART. This is in spite of the strong efforts of the Ugandan Government to scale-up HAART programmes, including an extensive information and education campaign. Hladik et al also stated that universal access to HAART may not be achievable in Uganda at all [4]. Efforts to increase access to HAART are therefore crucially important and it is paramount to assess all factors currently restricting access to HAART. With this as a first step, HAART programmes can be modified to facilitate easier access and attempts to provide universal HAART as a fundamental service to all HIV and AIDS populations.

Previous studies in resource-poor countries have identified a number of factors that hinder access to HAART for both men and women in sub-Saharan Africa. Factors identified and ranked high as serious obstacles to accessing HAART were transportation costs in Uganda and Tanzania [5,6]. In Benin, Malawi and South Africa, restricted access was due to complicated dosing in HAART regimes, language barriers for patients
communicating with staff, and economic reasons [7–9]. Similar findings were reported from Zambia, where high costs of treatment (e.g. laboratory tests), adverse reactions to HAART, an overcrowded health care system, overworked clinic staff and language problems were reported to hinder the uptake of HAART [10]. In a comprehensive review of barriers to HAART access, the most cited barriers were lack of information about HAART, including knowledge about treatment procedures, and a lack of coordination between HAART services and other health care services [11].

Regarding access to HAART for women and specifically for pregnant or post-natal women, much less information is published. A multi-centre study with 33,164 individuals from 13 countries, including participants from sub-Saharan Africa, concluded that enrolment in HAART was higher for all women compared with men, and that enrolment had increased in the past years to 68% [12]. In contrast to this review, several studies reported that pregnant and post-natal women had less access to HAART or did not want to utilize it. One study from Zambia included breastfeeding women and found that (as in other studies) stigma, adverse reactions to HAART and lack of food were barriers to accessing HAART. Other factors not previously described in the literature were the presence of mental disorder (e.g., depression), hopelessness and the potentially damaging effect of HAART on personal relationships, particularly between wife and husband [13]. A study from Malawi reported that pregnant women (among other groups, such as TB patients and children) accessed HAART less often than other HIV patients [9]. In Wakiso District, Uganda, prevention of mother to child transmission (PMTCT) programme coverage for pregnant and/or post-natal women was reported to be as low as 28% [14].

In order to address gaps in knowledge for understanding barriers to HAART among pregnant and breastfeeding women, we conducted our study in Kabarole District, western Uganda, with a sample of pregnant and post-natal women attending the Prevention of Mother to Child Transmission-Plus (PMTCT-Plus) programme run by the regional government hospital in Fort Portal. We focused on pregnant and post-natal women because they are especially vulnerable and have generally received less attention than other populations.

The Ugandan PMTCT-Plus programme is an initiative to scale up HAART uptake by pregnant and post-natal women and to reduce mother to child transmission of HIV. It consists of provision of free HIV counselling and testing, single-dose nevirapine and/or combination HAART to eligible HIV-positive mothers and family members, using eligibility criteria according to the national guidelines for HAART [15]. Despite the Ugandan Government’s efforts to scale up the PMTCT-Plus programme from 2003 to 2006, 22,000 new paediatric HIV infections due to mother to child transmission were recorded in recent years [16].

It is crucial to the success of the Kabarole PMTCT-Plus programme that locally perceived barriers to accessing and accepting HAART are comprehensively described, understood and addressed. This study explores PMTCT-Plus clients’ barriers to enrolling in the programme, as well as obstacles faced by those who have enrolled and want to continue with HAART. The specific objectives of our study were to:

(1) explore and describe barriers to accessing free HAART among women in Kabarole’s PMTCT-Plus programme at a regional hospital;
(2) analyze women’s positive and negative HAART experiences within the context of the delivery of the existing PMTCT-Plus programme; and
(3) use the study findings to make recommendations to improve the uptake of HAART by women attending this programme.

Methods
This was an exploratory, descriptive qualitative study using thematic analysis. Data were collected through in-depth interviews and one focus-group discussion. We chose this approach because using a qualitative methodology could elicit extensive discussions that revealed women’s perceived barriers to HAART in a way that may not have been obtained from solely quantitative methodologies.

Study setting
Kabarole’s PMTCT-Plus programme was first launched in 2003 in five hospitals. These hospitals are attended by 13,000 women, 8% of whom are HIV infected. Kabarole District’s PMTCT-Plus programme at the regional hospital experiences a low uptake of HAART among eligible PMTCT-Plus clients, with approximately one-quarter of the clients on HAART lost to follow-up in 2006 (personal communications, J. Okech, Kabarole District Health Officer, Fort Portal, Uganda). Kabarole District has an estimated population of just under 400,000, approximately 20,000 of whom are pregnant women at any given point in time [17]. The district’s population is characterised as low income, with subsistence farming representing the main source of income. Approximately 74% of the population resides in rural areas, far from hospitals and health clinics that are located in the urban centres [18].

Study sample
Study participants were identified using the PMTCT-Plus client register at the government-run referral clinic for the district, based at the regional hospital. All programme registrants were categorized into four groups: (1) clients who were eligible for HAART but never enrolled in the programme; (2) clients who formally enrolled in HAART but never returned to start HAART; (3) clients who enrolled and defaulted on HAART; and (4) clients taking HAART medication during the time of the interviews without reported
interruption. Women were eligible to participate in the study if they had attended antenatal care and received pre-test HIV counselling and were found to be HIV positive, and were 18 years and older. Each registrant was assigned a number. Study participants were chosen via simple random sampling in each group separately (see Table 1).

<table>
<thead>
<tr>
<th>Group classification of study participants</th>
<th>Interviews (45)</th>
<th>Focus group discussion (one)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Never enrolled for HAART</td>
<td>17</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>2) Enrolled but never began HAART</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3) Defaulted HAART</td>
<td>14</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>4) Taking HAART</td>
<td>12</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>8</td>
<td>53</td>
</tr>
</tbody>
</table>


Table 1. Group classification of study participants

Potential study participants were contacted by a research assistant in a discreet manner, informed about the study, and were given an information letter describing the purpose of the research, confidentiality and the right to refuse to participate. There was a high acceptance rate, with only two women out of 53 declining to be interviewed. Respondents were questioned via in-depth interviews, and another eight randomly selected respondents were included in one focus group discussion (FGD). The FGD was conducted following the interviews and was designed to enhance trustworthiness of the findings by validating results obtained from the interviews.

Data collection and analysis
In-depth, face-to-face interviews and the FGD were conducted using an interview guide with open-ended questions. The topics were derived from findings on barriers to HAART access in the literature, along with advice provided by health professionals and experts in the field (in Uganda and in Canada). The interview and FGD guides included such topics as: personal views about the PMTCT-Plus programme; HAART knowledge; perceived impact of HAART on patients and family members; social support for patients; experiences of HIV and AIDS stigma; issues related to HIV serostatus disclosure to participants’ partners; patient and health care delivery factors; perceived barriers to accessing HAART services (e.g., geographical distance, economic and time constraints); fear of HIV and AIDS stigma; and perceived barriers to adhering to HAART regimen (e.g., forgetfulness, tablets not refilled, tablets out of stock, adverse reactions to tablets). In addition, those participants who were on HAART but who defaulted later from treatment were asked about their experiences while taking HAART, including what led to their decisions to discontinue treatment.

Interviews and the FGD were carried out in quiet and discreet locations, often a vacant room in the hospital’s outpatient department, where the interview could be carried out privately and without interruption. The interviews were conducted and audio-taped in the local language, Rutooro, and lasted about 80 minutes each. The FGD was approximately 90 minutes in duration. Tapes were transcribed verbatim in Rutooro and then back-translated into English. Spot checks of interview and FGD transcripts and translations were regularly conducted to ensure the completeness of the transcription and the accuracy of the translation. Data collection was carried out from September to December 2006.

Data analysis for both the interviews and the FGD was conducted using principles of thematic analysis [19,20]. This included multiple readings of the transcripts to capture context and meaning, followed by coding and categorisation of recurring concepts and ideas. A master list of all categories was assembled and examined for common themes. Categories of codes were then organised into overarching themes. Data verification was done by a second researcher, who also coded all transcripts. Codes were compared and added or removed based on the agreement between analysts. The results of our interviews were also compared with the literature and verified with participants who were contacted again after the results became available.

Following coding, a frequency distribution list was developed, and the number of responses for each category of participants was recorded and tallied. This allowed us to identify the most frequently mentioned barriers and the proportion of participants who identified an issue as a barrier to treatment. Relative frequency of each thematic issue identified during analysis was calculated and expressed as percentages or in such statements as “most of the participants” or “all of the participants”. Similar to the in-depth interviews, the FGD transcript was analyzed using the principles of thematic analysis and compared to the interviews. Recurring topics emerging from the FGD were noted and served to validate data obtained from the interviews. The quotations selected were those that best represented the ideas voiced by participants and were also chosen based on the frequency with which they were mentioned.

Ethical considerations
Ethical and administrative approval of the study methodology was granted by the Health Research Ethics Board (Panel B) at the University of Alberta, Edmonton, Canada, the Uganda Council for Science and Technology, Kampala, Uganda, and the District Health Officer of Kabarole District. Written, informed consent was obtained from each participant prior to the interviews.

Results
Most (70.6%) of the participants had very little formal education, were married and were rural dwellers living in economically deprived environments (Table 2).
Other financial constraints expressed by participants were the cost of food while waiting to see health care providers and the cost of nutritious foods that HAART patients are recommended to eat while taking the medication. Although these factors represented challenges to taking HAART, they were not cited as reasons for not starting or continuing HAART.

In addition, many respondents indicated that they were economically dependent on their husbands, who either provided or controlled the household finances:

“I don’t earn anything. We are all looking to my husband. Sometimes he sells a bunch or two of matooke and from that little money we can buy salt and any other needs.” (defaulted HAART)

“The man cannot give me money; he would rather use it to drink. He says that he doesn’t have money, even when you are sick.” (never enrolled in HAART)

This was found to limit some women’s control over treatment-seeking decisions and their ability to begin and adhere to HAART. Economic dependence on spouses was a particular barrier among those women who had not disclosed their HIV-positive status to their partners:

“If I told my husband I were HIV positive he would stop buying food and drinks and that is why I decided to keep quiet and I used to take my drugs secretly. If I told him he would have stopped all forms of assistance...” (defaulted HAART)

**HIV-related stigma**

Most patients acknowledged that HIV and AIDS stigma was prevalent within their communities and that people living with HIV and AIDS were discriminated against due to their positive HIV status. One of the 53 women interviewed claimed that she never enrolled in HAART in order to hide her positive HIV status from her community. Despite this, many (58%) respondents claimed that the community’s view of HIV-infected persons had no bearing on their decision to begin or continue treatment:

“What people think does not hinder me because this life is mine. Let them talk. I’m not the first one to have HIV.” (taking HAART)

**Non-disclosure of HIV serostatus**

Non-disclosure of a client’s HIV-positive status was the second most cited barrier to enrolling in the programme and continuing treatment. Ten of the 53 respondents

---

**Table 2. Demographic characteristics of study participants**

<table>
<thead>
<tr>
<th>Demographic characteristics of study participants</th>
<th>Group 1 (n = 17)</th>
<th>Group 2 (n = 2)</th>
<th>Group 3 (n = 14)</th>
<th>Group 4 (n = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age</td>
<td>30</td>
<td>36</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (%)</td>
<td>70.6</td>
<td>100</td>
<td>42.9</td>
<td>41.7</td>
</tr>
<tr>
<td>Single (%)</td>
<td>5.9</td>
<td>NA</td>
<td>35.8</td>
<td>16.7</td>
</tr>
<tr>
<td>Widowed, separated (%)</td>
<td>23.5</td>
<td>NA</td>
<td>21.3</td>
<td>58.4</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>29.4</td>
<td>0</td>
<td>7.1</td>
<td>83.3</td>
</tr>
<tr>
<td>Rural</td>
<td>70.6</td>
<td>100</td>
<td>92.9</td>
<td>16.7</td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>23.5</td>
<td>100</td>
<td>28.6</td>
<td>8.3</td>
</tr>
<tr>
<td>Some primary</td>
<td>52.9</td>
<td>NA</td>
<td>57.1</td>
<td>50.1</td>
</tr>
<tr>
<td>Complete primary</td>
<td>11.8</td>
<td>NA</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>Some secondary</td>
<td>11.8</td>
<td>NA</td>
<td>14.3</td>
<td>8.3</td>
</tr>
</tbody>
</table>

said they had withheld their HIV status from their sexual partners. The challenge of disclosure was reported to stem from their partners’ reluctance to test for HIV:

“I did not tell my husband because he refused to go for a check up with me, so I decided to wait to start these drugs because when I tell him he will say I am the one who brought the disease.” (never enrolled in HAART)

The women explained that they withheld their status from their partners out of fear of blame, domestic violence, abandonment, divorce and loss of economic support that might ensue:

“The reason why I did not tell my husband is that I thought that when he sees me taking the drugs he will say that I am the one who has brought the disease and he will beat me. I was taking the drugs secretly and thereafter said to myself, how long will I keep hiding the drugs, and I decided to leave the drugs.” (never enrolled in HAART)

“My child was very young and I knew that if I told [my husband] he would run away from me and leave me suffering with the child. So that is why I fear to tell him.” (never enrolled in HAART)

Several participants disclosed that hiding their HIV status made avoiding unprotected sex with their partners a challenge. Despite knowing that practicing safe sex may be important to prevent re-infection and viral resistance to HAART, several participants stated that suggesting safe sex might give rise to suspicion in their spouses. Fear of exposing their status through the suggestion of safe sex was cited as a barrier to beginning and continuing HAART:

“He might find out about my HIV status if I want to use a condom. I haven’t decided yet since I haven’t yet started on treatment. I still fear him.” (enrolled but never began HAART)

“I realized that I was wasting my time because I was taking HAART and having unprotected sex. It was a waste of time because I am not supposed to be having unprotected sex while on HAART.”
(defaulted HAART)

Health care service factors
HAART health care service factors, such as long waiting times and negative interactions with the staff, represented barriers to continuing HAART, as expressed by Group 3 and 4 participants. Waiting times were reported on average to be at least four hours, but ranged from one hour to longer than a day:

“The reason why I stopped taking my drugs is because I would sometimes come and the services at the clinic wouldn’t be good. We would spend the whole day at the clinic and you don’t even see the nurse and you even end up not getting the drugs and you go back home empty handed. I waited so long and no one was giving me the drugs. I decided to go home.” (defaulted HAART)

Eight of the 24 clients (33% of participants) reported very negative interactions with programme staff, such as rude comments and unacceptable behaviour, such as shouting. Almost all of the remainder cited suboptimal interactions with the staff as a barrier to continuing HAART:

“The staff shout at you in the midst of other patients and they say “Did I give you AIDS?” It is so hurting.” (taking HAART)

Staff’s favouritism of some patients was cited as a barrier and contributed to long waiting times and failure to receive the drugs during the monthly visits. Patients who were not familiar with the clinic staff or were new on treatment were especially neglected:

“There is one problem I have noticed. When you come here and you are not known to anybody, you can end up going home without receiving drugs.” (defaulted HAART)

HIV and AIDS and HAART knowledge
Participants who had enrolled for HAART (Group 3 and 4) articulated a level of HIV and AIDS and HAART knowledge sufficient to make an informed decision to continue or terminate their treatment. Counsellors and health providers were identified as the most common source of reliable information:

“The doctor taught me again and again and every time we come back for drugs they again told us about the drugs. So we understand.” (defaulted HAART)

Respondents who had not enrolled for HAART demonstrated a markedly lower level of HIV and AIDS and HAART knowledge compared with those who had enrolled in the PMTCT-Plus programme. Patients explained that instead of one-on-one counselling, they were provided with pamphlets about HAART, which many didn’t read because they were illiterate or were embarrassed to take them home where others might find and read them:

“I didn’t go back to enrol so I haven’t been counselled about HAART yet. So how can I know about HAART?” (never enrolled in HAART)
“I won't lie. I haven't kept those books for fear that someone will come and read them. They will find out what I am. The information was there but I didn't read it.” (never enrolled in HAART)

Many patients referred to radio shows and casual village conversation/gossip as their main sources of information about HIV and AIDS and HAART. This can be problematic, as village conversation, in particular, has proved to be fraught with fallacies. The most common misconception was that HAART makes the patient weak and actually kills those ingesting it:

“People say that drugs make you lose energy, and then you die. That's what people say.” (never enrolled in HAART)

“Now you see that if you are taking drugs you can die there and then. I have to control myself and look after my kids to see that they’ve grown, work for them and build for them. Now you see my land is not progressing, we want to build. Do you want to kill me there and then?” (never enrolled in HAART)

Patient's physical health and HIV disease progression
More than half of the patients who had not enrolled in HAART claimed that they were deferring treatment until their health deteriorated significantly. Many participants (60%) perceived that the expected time to be receiving HAART was when they became bedridden:

“How can I start on the drugs and yet I am not yet bedridden and I have not felt anything and not seen any symptoms...”
(never enrolled in HAART)

A number of respondents explained weighing one’s physical state against the availability of finances when making the decision to start HAART:

“It depends on how I feel in my life. What can force me to start HAART is money because when I have money and feel that I'm not OK, then I can start.” (never enrolled in HAART)

Discussion
This study described the cultural context and locally perceived barriers to accessing HAART among HIV-positive women attending the PMTCT-Plus programme at the main regional hospital in Kabarole District. As the perception of pregnant and post-natal women regarding access to HAART has not been well documented previously, we believe that the information in our article contributes to improving access for treatment of this vulnerable group. Because pregnant and post-natal women who are successful on HAART have little risk of transmitting their HIV infection to their babies, this programme has huge relevance for the wellbeing of the women being treated, their infants and their entire families. In contrast to other studies from sub-Saharan Africa, this study included participants who were lost to follow up by the health care providers in the Kabarole PMTCT-Plus programme, and therefore we were able to capture barriers to HAART among an understudied group.

Consistent with other studies of groups other than pregnant women, financial constraints, such as high transportation costs represented the major barrier to starting and adhering to HAART [21,22]. High transportation costs were found to be the most formidable barrier to treatment by the authors of these studies and also by us. Therefore, proximity to the clinic emerged as a strong determinant of access, with the majority of participants not taking HAART residing in rural areas, too distant from the clinics providing HAART. This is a problem for the majority of Kabarole’s population, including pregnant women who reside in rural areas, where only 26.1% of them are within a five kilometre distance of health care facilities [23]. Efforts to reduce or eliminate this barrier would likely substantially increase HAART acceptance and adherence. As it is not feasible to increase access to HAART by building new clinic facilities in poor countries such as Uganda, or by providing universal access through formally trained health care workers alone, as suggested by Barnighausen (2007), the only option is to bring HAART services closer to the population through community resources and community premises [24].

In three Ugandan studies, it has been shown that this is possible. Two HAART studies come from eastern Uganda (one from Jinja, run by the Medical Research Council, United Kingdom and The Ugandan Support Organisation [22], and one from Tororo, run by the Centres for Disease Control and Prevention, United States of America), where home-based HAART services were offered and excellent treatment outcomes were achieved [25]. Treatment success was measured by the HIV-1 RNA viral load (VL) in patients: in both studies, more than 90% of patients had suppressed VL. A third study was run in Mbuya, a suburb of Kampala, by the Anglican Church of Uganda, where lay persons were involved in community-based HAART services, providing an outreach treatment, monitoring and adherence support programme [26]: treatment success as measured by VL was similar to that found in the other two studies.

These three examples of programmes show that community/home care-based approaches to HAART are feasible and bring HAART services closer to the population. One other potentially useful option for expanding HAART services in Uganda, recently suggested by Mbonye et al, was to use private midwives as the delivery point for HAART services to pregnant and post-natal women [27].
Social factors were identified as the second most cited and important barrier to HAART access. The study participants revealed non-disclosure of their HIV status to their partners, and directly attributed this to HIV-related stigma; most asserted that this was a substantial barrier to treatment. Non-disclosure to partners as an impediment to treatment has been recognized in other African studies, particularly pertaining to adherence [4,28,29]. Nachega et al and Olley et al found the rate of partner non-disclosure to be 22% and 38% respectively, in their South African studies [38,29]. Similar to findings from other studies, non-disclosure by our participants arose from fear of blame, violence, abandonment, divorce and loss of economic support [30-32]. Our data demonstrated this fear to be legitimate: several respondents described that such incidences occurred following disclosure to their partners.

Health care delivery issues were the third most frequently cited barrier to access to HAART. This reflects the underlying issue of human resource constraints, pervasive in busy HAART clinics in sub-Saharan Africa. This issue has been identified as an important health system limitation to scaling up HAART [33,34]. An inadequate supply of health care personnel to meet rising demand leads to long waiting times, and overburdened and overworked health care workers who take their frustrations out on their patients. Studies have shown that women, especially, are more likely to participate in programmes if health care workers have positive attitudes [35,36].

Respondents’ knowledge about HIV and AIDS and HAART was generally high. There were no significant discrepancies in HAART knowledge among those taking HAART and defaulters. These results are contrary to conventional views, which often hold that knowledge of treatment effectiveness and procedures to be followed is associated with better HAART uptake or adherence. Our data suggest that financial constraints may be so overwhelming that they prevent access to HAART, regardless of patients’ HAART knowledge and intentions to take the drugs. Participants who had not enrolled for HAART did demonstrate a suboptimal knowledge of HIV and AIDS and HAART, which acted as a barrier for some. Several respondents exhibited deficits in HAART knowledge in that they felt HAART was required only after clinical symptoms due to HIV had developed. Early start of HAART has been found to be associated with better survival [37].

There were several limitations associated with this study. First, as this was a qualitative study, the results are not intended to be generalized to the population at large. Second, social desirability bias cannot be excluded, as the study topic dealt with sensitive issues. This could potentially alter participants’ responses, causing them to provide answers that conform to socially accepted norms. To reduce this bias, highly trained interviewers familiar with qualitative interview techniques were used. Third, the study was carried out in 2006, and how pregnant women access HAART now may be different to what we described. Generally, we think that these limitations do not significantly compromise the validity of our study.

We provide the following recommendations to the Kabarole Health Department to mitigate the four most important barriers to HAART access, as found in this study:

**Develop and expand community-based HAART services**

Economic costs associated with HAART, such as transport to the nearest HAART clinic, food requirements during long waiting times, and loss of time, can only be realistically reduced by moving HAART services closer to the people in need. It also needs a community-based approach, where routine tasks, such as monitoring HAART and supporting adherence, is shifted to lay persons in the community. Barnighausen reported that formally trained health care workers will not be able to provide universal access to HAART in the next decade [34]. A few successful models already exist in Uganda, as we have mentioned.

**Strengthen a programmatic approach to HIV-related stigma**

It is possible to promote HIV/HAART counselling to both male and female partners in joint counselling sessions. Health care workers and/or counsellors could be better prepared to provide this partner-based service more effectively, which would address HIV-related stigma at the most personal level. Programme guidelines would have to be established. It would also require some resources, motivation and persistence from staff to make it happen. In general, men have been very willing to participate in reproductive health/HIV and AIDS education.

**Improve HAART services management**

Overburdened HAART clinics and burned-out HAART workers are understandable as the demand for HAART far outweighs what the infrastructure can provide. However, better management of HAART clinics could ease the situation, e.g., for those patients who said that they had to stay overnight near the hospital as they were asked to come back the next morning, or for those who reported having to wait for a long time because their files were “lost”. Negative staff attitudes and behaviour expectations should be monitored by the staff supervisors and embedded in a “no tolerance policy for patient abuse”.

**Educate widely for early HAART initiation**

The misconception of some study participants that HAART is required only after clinical signs of HIV infection have begun is dangerous. It can lead to a delay in treatment with less favourable survival outcomes. To correct this misconception, a simple education component could be inserted into all of the existing HIV and AIDS treatment and counselling services, as this applies to all HIV-positive persons, not only to women.
While these four recommendations are key to the success of all HIV and AIDS-related programmes, not only for HAART, they reinforce the urgency that should exist in addressing this specific target population attending PMTCT programs. With all the gender issues known to be important for women with HIV and AIDS, treating these women effectively would improve their own individual health, the health of their children and the health of other family members. The final three recommendations could be implemented in the existing service delivery model of clinic-based HAART, and need only a stronger quality-improvement, client-focused approach. A community-based district HAART programme, with government support for improved HAART access requires a major shift in service delivery for rural communities, for which successful models already exist.

Competing interests

The authors declare that they have no competing interests.

Authors’ contributions

PD was involved in study design, field work execution, data analysis, interpretation and writing the first draft of the article. WK helped with study design, data analysis and interpretation and wrote the final version of the manuscript. CW was involved in the study design, data analysis, interpretation and gave input into the final version of the article. TR provided input into the study design, supervised the field work and commented on the study results and their interpretation as well as the first draft of the article. JO-O supervised the field work and provided comments on the study results and their relevance to the health care services as well as commented on the first draft of the article. All authors have read and approved the final manuscript.

Acknowledgements

We thank Jean Kipp for her very useful comments on the first drafts of the manuscript. The study was financed by a research grant from the Canadian Institutes of Health Research, grant no. MOP-74586, and the Fund for Support of International Development Activities, University of Alberta.

References

5. Muller DM, Bangsberg DR, Semanki J, Ware NC, Emenyuny N, Weiser SD. Transportation costs impede sustained adherence and access to HAART in a clinic population in southwestern Uganda: a qualitative study. AIDS Behav. 2010, 14(4):778-784

© 2010 Du Rebecca J, Biase LM, Biase N. Open Access Article distributed under the terms of the Creative Commons Attribution License. The electronic version of this article is the complete one and can be found online at: http://www.josoc.org/content/13/1/33

Published: 23 September 2010
CAMELIA: Timing of Antiretroviral Therapy in HIV/Tuberculosis Co-infected Patients

By David A. Cooper, MD, DSc.

The current World Health Organization recommendations for resource-limited settings state that for patients co-infected with tuberculosis (TB) and HIV, TB therapy should be initiated first, followed by antiretroviral therapy as soon as possible afterwards and within the first eight weeks of TB treatment; but precisely when during those eight weeks has not been clear.[46]

The Cambodian CAMELIA trial was designed as a randomised, superiority trial to compare initiation of antiretroviral therapy at Week Two (early; n = 332) versus Week Eight (late; n = 329) of TB therapy in patients with newly diagnosed, acid-fast bacilli-positive TB and CD4+ cell counts ≤ 200 cells/mm3). [47] The primary endpoint was survival according to an intent-to-treat analysis.

The antiretroviral regimen comprised stavudine, lamivudine, and efavirenz, which is standard of care in Cambodia. At Week 58, patients were permitted to switch from stavudine to zidovudine on the basis that stavudine is a very tolerable drug at the beginning of therapy and it avoids the anaemia associated with zidovudine, in such a severely immunodeficient population. The median baseline CD4+ cell count was 25 cells/mm3 and the median baseline HIV-1 RNA was very high at approximately 5.6 log10 copies/mL. The patients were clearly experiencing wasting, with a very low median body mass index of 16.7-16.8. Most of the TB cases were pulmonary (68% to 69%) or both pulmonary and extrapulmonary (22%). Most patients were confirmed to have Mycobacterium TB by culture (early arm: n = 282; late arm: n = 294); however, cultures from 16 of the 661 randomised patients demonstrated nontuberculous mycobacteria, and 69 patients were culture negative but smear positive. Approximately 2% of patients had multidrug-resistant TB.

During the study, 59 deaths occurred in the early antiretroviral therapy arm (mortality per 100 person-months: 1.44 per 100 person-months in the late initiation arm (P < .0001). The relationship between IRIS and early antiretroviral therapy initiation in HIV/TB co-infected patients has always been a concern of clinicians because of the difficulties associated with managing IRIS as well as the concomitant toxicities. The investigators stated that the cases of IRIS were relatively easy to manage and were not terribly aggressive.

The results of this study provide a major advance in the field of HIV/TB co-infection. The results of the randomised SAPIT trial in South Africa comparing integrated TB and antiretroviral therapy with sequential therapy (antiretroviral therapy initiated within four weeks after completing standard TB therapy) showed that antiretroviral therapy initiation clearly cannot be delayed until the completion of TB treatment ).[48] The SAPIT study is continuing to examine earlier antiretroviral therapy initiation, either within four weeks of initiating TB therapy or within four weeks following completion of the intensive phase of TB therapy at Week Eight, but the analysis of that randomization has not been completed yet.

The findings of the CAMELIA trial will become just as important, in my opinion, as the CHER study has become in the developing world for early diagnosis and treatment of infants [49] because it demonstrates an approach that prevents death. I think these data will be very influential in changing World Health Organization guidelines because patients in developing regions of the world such as Cambodia and sub-Saharan Africa who present with TB and HIV are generally in very late stages of HIV infection, and this strategy is clearly a life-saving approach that, in my opinion, will change practice.

Reproduced from CCO in practice

**Integrated TB/HIV therapy was associated with a 56% reduction in the risk of death, relative to sequential therapy in the SAPIT trial**
New research could bolster arguments for a controversial approach that could eradicate HIV transmission in South Africa within five years, said Dr Brian Williams of the South African Centre for Epidemiological Modelling and Analysis (SACEMA).

The ‘test and treat’ approach is based on mathematical modelling and pairs aggressive HIV testing campaigns with almost immediately putting people found to be HIV positive on treatment. In theory, this model would use early treatment to lower viral load (the amount of virus in the blood), and lower the likelihood of transmission, eventually cutting HIV prevalence rates.

A report published in the current issue of *AIDS*, the Journal of the International AIDS Society, is based on a study that followed about 14,000 new mothers in Zimbabwe for about two years from 1997 to 2000 after the birth of their children.

The research showed that HIV-positive new mothers were at much greater risk of dying than their HIV-negative peers, even when the positive women had a CD4 count (which measures immune system strength) of 600 to 1,000 and was equal to or higher than that of HIV-negative women. Although the research was conducted before antiretrovirals were available in the public sector, the data may have answered a crucial question in the test and treat debate.

“One of the questions around doing [the test and treat model] has been that even if you accept that there is public health benefit of testing and treating everyone, what does that do for the individual?” Williams told IRIN/PlusNews.

“The study’s authors showed that even at CD4 counts of up to 1,000, mortality among the HIV-positive women was about 50 times higher...”

The study’s authors showed that even at CD4 counts of up to 1,000, mortality among the HIV-positive women was about 50 times higher, [and] it’s in the patient’s interest too, to start treatment early,” said Williams, who spoke in favour of test and treat at the Conference on Retroviruses and Opportunistic Infections (CROI), and the annual meeting of the American Association for the Advancement of Science, both in the United States.

John Hargrove, co-author of the report, said the study was one of a very few that had compared the mortality rate of untreated HIV-positive adults to their HIV-negative peers and had tied this to CD4 counts - the research could never be ethically replicated in today’s expanded treatment environment.

However, there are concerns that the approach is unrealistic, given low testing uptake globally, and that putting more people on treatment earlier may lead to poor adherence and contribute to drug resistance.

The approach is being implemented on a trial basis in high HIV prevalence areas of the United States, including the District of Columbia and New York City. The US infection rate is about 0.6 percent, according to UNAIDS.

**Test and treat - do models match reality?**

“...it’s in the patient’s interest too, to start treatment early,” said Williams, who spoke in favour of test and treat at the Conference on Retroviruses and Opportunistic Infections (CROI), and the annual meeting of the American Association for the Advancement of Science, both in the United States.

“...it’s in the patient’s interest too, to start treatment early,” said Williams, who spoke in favour of test and treat at the Conference on Retroviruses and Opportunistic Infections (CROI), and the annual meeting of the American Association for the Advancement of Science, both in the United States.

The study’s authors showed that even at CD4 counts of up to 1,000, mortality among the HIV-positive women was about 50 times higher, [and] it’s in the patient’s interest too, to start treatment early,” said Williams, who spoke in favour of test and treat at the Conference on Retroviruses and Opportunistic Infections (CROI), and the annual meeting of the American Association for the Advancement of Science, both in the United States.

The study’s authors showed that even at CD4 counts of up to 1,000, mortality among the HIV-positive women was about 50 times higher, [and] it’s in the patient’s interest too, to start treatment early,” said Williams, who spoke in favour of test and treat at the Conference on Retroviruses and Opportunistic Infections (CROI), and the annual meeting of the American Association for the Advancement of Science, both in the United States.

The approach is being implemented on a trial basis in high HIV prevalence areas of the United States, including the District of Columbia and New York City. The US infection rate is about 0.6 percent, according to UNAIDS.

**Testing and treating, funding and debating**

Williams said doing away with specific requirements like the need to verify CD4 counts would reduce costs, but estimated that it would still cost a country like South Africa at least USD2 billion a year to implement the test and treat strategy nationally.
“Costings show that the cost of providing ARVs will be roughly balanced by the costs saved in connection to opportunistic infections and hospitalisations,” he said. “We need a big investment initially, but in the long term we are going to be saving money. It’s the only real prospect for actually stopping the epidemic.”

However, in a debate about test and treat in late 2009, Dr Francesca Conradie, Deputy Director of the University of Witwatersrand Clinical HIV Research Unit, argued that money was not the only issue, and that test and treat models ignored current realities, including low testing uptake.

According to the 2008 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, only about half of people 15 years and older had been tested for HIV.

Conradie also argued that the US had low HIV prevalence, whereas South Africa’s HIV population was simply too big to meet the treatment targets cited by current test and treat models; to make the approach effective - the country would have to reach more than eight times the number currently on treatment to meet the targets.

With an HIV prevalence rate of about 18% and more than half a million people on treatment, South Africa runs the world’s largest ARV treatment programme.

Research showed that HIV-positive new mothers were at much greater risk of dying than their HIV-negative peers, even when they had a CD4 count of 600 to 1,000 - equal to or higher than that of HIV-negative women.
Study of microbicide gel shows reduced risk of HIV & herpes infection in women CAPRISA/FHI/CONRAD

Researchers have achieved an important scientific breakthrough in the fight against HIV and genital herpes with a vaginal gel that significantly reduces a woman’s risk of being infected with these viruses. The results of the ground-breaking safety and effectiveness study of an antiretroviral microbicide gel study were reported by the Centre for the AIDS Programme of Research in South Africa (CAPRISA) at the XVIII International AIDS Conference in Vienna, Austria.

The microbicide gel could fill an important HIV prevention gap by empowering women who are unable to successfully negotiate mutual faithfulness or condom use with their male partners results, widespread use of the gel, at this level of protection, could prevent over half a million new HIV infections in South Africa alone over the next decade,” said study co-principal investigator, Dr. Qurraisha Abdool Karim, Associate Director of CAPRISA and Associate Professor of Epidemiology at Columbia University. “This new technology has the potential to alter the course of the HIV epidemic, especially in southern Africa where young women bear the brunt of this devastating disease.”

Tenofovir works by preventing HIV from growing inside human cells. Taken in pill form, tenofovir is a common component of various three-drug cocktails that are used to treat HIV infections. The new results now indicate that tenofovir formulated as a topical gel and inserted into the female genital tract also has great promise for use in HIV and herpes simplex virus type-2 (HSV-2) prevention.

The CAPRISA 004 trial of tenofovir gel involved 889 women at high risk of HIV infection at an urban and a rural site in KwaZulu-Natal, South Africa. Overall, 98 women out of the 889 became HIV positive during the trial - with 38 in the tenofovir gel group and 60 in the placebo gel group. Out of the 434 women who tested negative for herpes at the start of the trial, 29 became infected in the tenofovir group and 58 became infected in the placebo group. The reduced rates of HIV and herpes infections among the women who used the tenofovir gel are statistically significant.

Microbicides will help by giving women the choice and ability to protect themselves from HIV.
“Tenofovir gel has a potential dual effect in preventing HIV. Since women with genital herpes are much more likely to become infected with HIV, the additional protection of tenofovir gel against herpes creates a second mechanism whereby the gel may have a bigger impact in preventing HIV,” said study co-principal investigator, Dr Salim S. Abdool Karim, Director of CAPRISA and Pro Vice-Chancellor (Research) at the University of KwaZulu-Natal, South Africa. “The trial results are a significant first step toward establishing the effectiveness of antiretroviral drugs for HIV and genital herpes prevention; confirmatory studies are now urgently needed.”

During monthly visits, all participants were provided with HIV risk-reduction counselling, condoms and treatment for sexually transmitted infections, and each was clinically examined for potential side effects and tested for HIV infection. The study was double-blinded and neither the researchers nor the participating women knew whether a woman in the study received tenofovir gel or placebo gel.

Women in the study were advised to use the gel up to 12 hours before sex and soon after having sex for a maximum of two doses in 24 hours - a dosing strategy referred to as BAT24. Participants used the gel for a minimum of one year and a maximum of two and a half years. The trial team observed no substantive safety concerns from use of the gel. Further, no increase in risky behaviour was observed in the women.

The CAPRISA researchers also found that the protective effect against HIV and genital herpes increased as use of the tenofovir gel increased. Women who used the gel in more than 80% of their sex acts had a 54% reduction in HIV infections, whereas those who used the gel in less than half of their sex acts had a 28% reduction in HIV infections. Among those women who became infected, tenofovir gel had no effect on the amount of HIV in their bloodstream at the time of infection. Also, none of the women who became infected with HIV showed resistance to tenofovir.

All volunteers to the study who tested HIV positive were provided with care, including ARV treatment at the CAPRISA clinics and women who became infected during the study were enrolled into CAPRISA studies and/or the CAPRISA AIDS treatment programme at their respective sites for ongoing care and support. This study was jointly funded by the Governments of South Africa and the United States, through the Technology Innovation Agency (TIA) and the US Agency for International Development (USAID), respectively. USAID provided USD16.5M and TIA provided USD1.1 for the study. “USAID is proud to be the major donor of this first-ever proof of concept that a vaginal microbicide can effectively and safely reduce the risk of HIV transmission from men to vulnerable women. The success of the CAPRISA 004 trial perfectly complements the Global Health Initiative and our focus on women’s health, both in prevention and sustainable health delivery systems,” stated USAID Administrator Raj Shah.

The promising findings of the CAPRISA 004 study are only a first step in determining if tenofovir gel is effective in preventing HIV and herpes infection; additional studies are urgently needed to confirm and extend the findings of the CAPRISA study. Important information is expected from current studies such as the Microbicide Trials Network’s VOICE study, which is currently assessing daily tenofovir gel as well as daily tenofovir and Truvada tablets in women in several African countries. Studies of daily Truvada tablets are underway in intravenous drug users, young high-risk women and men who have sex with men. “We are proud to have partnered with CAPRISA and CONRAD on this important study. We see it as a major victory in the field of HIV prevention research. This is the first evidence that an antiretroviral drug in a gel form - a microbicide - can reduce HIV and genital herpes infection in women,” said Ward Cates, President of FHI. “The next step is to see whether other studies underway confirm these exciting results.”

Only after drug regulatory authorities determine that tenofovir gel is safe and effective for HIV prevention can the gel be made available to the public for HIV prevention. Since this process can take several years, TIA and United States-based CONRAD are working together to address the challenges to making the gel available first to women in South Africa. “CONRAD has given the rights to manufacture this gel to the Government of South Africa to get
this much needed product to women in South Africa as rapidly as possible,” said Dr. Henry Gabelnick, Executive Director of CONRAD, who provided the gel for the study. “The Technology Innovation Agency (TIA) is working closely with the South African Government, CAPRISA and CONRAD to ensure that this important innovation makes an impact in preventing the spread of HIV,” said Dr. Mamphela Ramphele, Chairperson of TIA.

Ambassador Eric Goosby, United States Global AIDS Co-ordinator said, “The results of the CAPRISA trial provide new hope and direction for not only HIV prevention, but also broader efforts under the Global Health Initiative. We recognise that microbicides will be a great asset to HIV prevention efforts, and the United States Government is pleased to support this important research.”

Professor Malegapuru Makgoba, Vice-Chancellor of the University of KwaZulu-Natal stated, “This piece of research is a significant milestone for women in the thirty year history of the HIV epidemic, microbicides and antiretroviral research. The research represents that which is best in science with direct translation into prevention policy, bringing a message of hope and empowerment to women, policymakers and scientists. These research findings will not only significantly alter the shape and form but also the future direction of this devastating epidemic.”

“The trial’s findings create a new vision for the opportunity for prevention of HIV and to re-define the public health approach to HIV control,” added Dr Linda Fried, Dean of the Mailman School of Public Health of Columbia University, New York.

The trial was conducted by CAPRISA in partnership with the United States-based organisations Family Health International (FHI) and CONRAD, with funding from United States Agency for International Development. Gilead Sciences donated the active ingredient for the manufacture of the tenofovir gel.

Detailed information on the trial results can be accessed on the following websites: www.caprisa.org www.fhi.org www.conrad.org

A posting from Partners Zambia (partnerszambia@eforums.healthdev.org)
The UNAIDS Regional Support Team for Eastern and Southern Africa (RST ESA) has launched a series of documentaries, feature stories and photographs documenting activities and interventions that have had some level of success or innovation in integrating HIV in humanitarian responses.

The first in the series is a documentary produced by UNAIDS in partnership with FAO entitled “Empowered over their fields, empowered over their lives: food security response to HIV and gender-based violence.” The documentary focuses on the innovative methodology of the Junior and Adult Farmer Field Schools, which have been successful in addressing and reducing HIV and gender-based violence (GBV) through improving food security. The documentary is set in post-conflict Northern Uganda.

The documentary is accompanied by a feature story and a collection of photographs which can be accessed at http://www.unaidsrstesa.org/thematic-security-humanitarian-response

‘AIDS and MDGs’ Approach: What is it, why does it matter and how do we take it forward?

The publication highlights changes in the health and development landscape resulting in a need to re-think the relationship between HIV and the MDGs. This approach effectively addresses both the short- and long-term challenges and impacts of the HIV epidemic while promoting the attainment of wider health and development goals.

Drawing on recent research, programme experience, and country progress reports, the paper outlines three important elements: understanding how HIV and the other MDGs impact one another; exchanging programmatic lessons across HIV and the other MDGs; and creating synergy and increasing cost-effectiveness through strategies that simultaneously address HIV and other MDGs.

The report highlights case studies of how cross-MDG synergy can be promoted. For example, in Malawi’s Zomba district, the World Bank implemented a cash-transfer programme to encourage girls’ school attendance. A recent study showed a 60% decrease in HIV and other STI risk among participants. The girls were also more likely to stay in school, have a smaller age gap with male partners, and delay marriage.

The project demonstrates how leveraging the links between HIV and a range of other development issues can spur significant and accelerated progress towards multiple MDGs at once.


Making the law work for the HIV response.

Making the law work for the HIV response aims to:

- provide at a glance the current situation in countries, territories and entities regarding certain laws that either support or hinder the attainment of universal access to HIV prevention, treatment, care and support;
- serve as a baseline against which progress toward an enabling legal environment can be measured;
- support positive engagement and consultations at national level among government, civil society and other stakeholders to identify the legal and policy barriers to the HIV response and devise ways to address them; and
- highlight efforts by civil society partners to monitor this important aspect of national responses to HIV - the law.
The Snapshot provides data from various sources (updated as of July 2010) on the following laws:

1. Laws and regulations that protect people living with HIV against discrimination;
2. Non-discrimination laws or regulations that specify protections for vulnerable sub-populations;
3. Laws, regulations or policies that present obstacles to access to HIV prevention, treatment, care and support for vulnerable sub-populations;
4. HIV-specific restrictions on entry, stay or residence;
5. HIV-specific laws that criminalise HIV transmission or exposure;
6. Laws that criminalise same-sex sexual activities between consenting adults;
7. Laws deeming sex work to be illegal; and
8. Laws that impose compulsory treatment for people who use drugs and/or provide for the death penalty for drug offences.

Key data in the Snapshot of selected protective and punitive laws relating to HIV show, among others, that:

- One hundred and twenty-three (123) countries reported having laws and regulations that protect people living with HIV against discrimination.
- One hundred and six (106) countries reported having laws, regulations or policies that present obstacles to access to HIV prevention, treatment, care and support for vulnerable sub-populations.
- Fifty-one (51) countries, territories and entities are reported to impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status.
- Seventy-nine (79) countries criminalise same-sex sexual relations between consenting adults. Six (6) countries apply the death penalty for offences related to same-sex sexual relations between consenting adults.

Downloadable documents

- A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support (July 2010)
- Eastern and Southern Africa: a snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support (July 2010)

MDG 6: Six things you need to know about the HIV response

This new report provides an overview of six key aspects of the AIDS response today:

1. New HIV infections are falling
2. More than five million people are on HIV treatment
3. HIV prevention works
4. Virtual elimination of mother-to-child transmission is possible by 2015
5. Criminalization is challenging the AIDS response
6. Investing for AIDS is a shared responsibility

Global HIV and AIDS news and Analysis.

PlusNews (2010).
PlusNews is a global online HIV and AIDS news service of the United Nations Integrated Regional Information Networks (IRIN). It is the most compressive source of original reporting on the epidemic, providing a professionally produced, one-stop information service for cutting-edge, but jargon-free news and analysis on HIV and AIDS in four languages – English, French, Portuguese and Arabic.

Don’t Let Children Fall Off The Map: Children in Eastern & Southern Africa Affected by AIDS.

This report highlights that whilst there has been some progress made in HIV prevention and mitigation; and in protecting children from the impact of the HIV epidemic, countries in eastern and southern Africa still have a long way to go in terms of fulfilling the many commitments and goals to which they are party to. In these regions, children, their families and their communities continue to live with the harsh impacts of HIV and AIDS.


Save the Children: Johannesburg (2010).
From 25th to 27th May 2009, Save the Children UK, in collaboration with the forced migration studies programme (FMSP) of the University of Witwaterand hosted a seminar on children who cross borders. The seminar was prompted by the urgent need to bring together key stakeholders in the region to share and exchange knowledge, experiences and learning on children on the move.


This situation analysis is part of a broader review and assessment of agricultural and livelihood-based social protection for orphans and other vulnerable children (OVC) programmes in Malawi that are deemed to have potential for replication and scaling up.

Traditional Leaders as Agents of Change in the HIV and AIDS Era:

A Case Study Of The Combined Oxfam Gender, HIV And AIDS Programme In Zimbabwe.
The report highlights six key case studies that show the important role played by traditional leaders in HIV prevention programmes.

Antibodies: Beyond Neutralisation – Nipping HIV in the Bud.
International AIDS Vaccine Initiative.
www.iavireport.org 2010
Report tracing the history of HIV vaccine research, what has been happening in the field of HIV research over the past two decades, the successes and challenges that were faced by researchers. The authors point out that the next decade must focus on a permanent solution to the scourge of HIV.

National Psychosocial Support Guidelines for Children Living With HIV and AIDS.

Guidelines for families, communities and volunteers living and working with children who are living with HIV. The guidelines provide for a common understanding and purpose on the provision of psychosocial support among organisations working with children living with HIV.

Making Care Work Count: A Policy Development.

The value of unpaid care to communities is beyond doubt, but it exacts a high, often hidden cost, particularly to women and girls who are expected to be care providers. Care providers have a key role to play in the provision of care to people living with HIV and AIDS in poor and marginalized communities, filling in serious public health delivery gaps in many SADC countries.
In any country, the news media - print and broadcast - play a critical role in setting the public agenda on HIV. Yet, it is important to recognise that media both shapes and is shaped by public perception of HIV. The publication, "What is Left Unsaid - Reporting the South African HIV Epidemic", is a compilation of news stories published between 2004 and 2010, and interwoven with an analysis of the overall news media's coverage of HIV in South Africa.

The publication is a compendium of analyses produced by fellows of the HIV/AIDS and Media Project - an initiative aiming to explore ways to improve the reporting of HIV in South African media, as well as the relationship between journalists and policy makers and HIV researchers. The first section of the book explores how the media has covered HIV, the quality of reporting and challenges experienced by journalists in doing their work. The second section features articles on various HIV-related themes, including prevention of mother-to-child transmission (PMTCT), children affected by HIV, abstinence and faithfulness, stigma, denial and disclosure, and traditional healers.

When it comes to HIV, the history of South Africa's national response is fraught with political controversy; principally created by conflict between Government and civil society. Memories of HIV denialism and limited ART rollout are still fresh in the minds of South Africans. While the news media has led on debates around scientific and health approaches to HIV, the HIV story in South African news media was more frequently linked to power and politics. With the changing of characters in the news media was more frequently linked to power and politics. With the changing of characters in the political landscape, the coverage of news stories on HIV has also shifted.

In the first chapter, Catherine Duncan reports that the amount of media coverage on HIV has decreased in the past five years - a period coinciding with the shift in the political agenda with regard to HIV. Without the political controversy, she argues, the HIV story is less newsworthy, and with increasing commercial tendencies, new media relies less on media advocacy, instead focusing on what sells. Her conclusion is optimistic but calls for a re-defining of HIV media reporting.

Recommendations on how HIV reporting can be improved are provided throughout the book. In a chapter written by Kylie Thomas, the potential for HIV reporting in tabloid magazines was explored. She argues that currently, tabloids are a missed opportunity for reaching mass audiences with HIV messages. Other authors argue that newsrooms tend to assign HIV and health reporting to junior journalists, who have limited capacity and experience. Senior journalists are rarely provided the opportunity to develop a specialty in HIV reporting and as a result, HIV reporting was found to have poor analysis and on occasion, to be unethical, and stigmatising towards people living with HIV.

Exploring feedback on media consumers themselves, Ida Jooste's analysis highlights that people in South Africa want news stories that offer a "more authentic reflection of their lived experiences in the community" (p. 79), and that they value credible, ethical, accurate and sensitive stories. In South Africa, the media is expected to play an 'advocacy' role and HIV coverage should be scaled-up to match the level of the epidemic.

This publication provides a springboard for debate on the state of HIV reporting. Through the documentation and analysis of the coverage of the media, media professionals, academics and HIV and health researchers can have some insight into shifts in public opinion, analyse the impact of the national response to HIV and related health issues, as well as explore the role of the media in setting the agenda.