AFRICAN TREATMENT LITERACY CONFERENCE 11-14 DEC 2005, DEVONSHIRE HOTEL, JHB

On the 11-14 Dec 2005, the Treatment Action Campaign (TAC) conducted an Africa-wide treatment literacy workshop and strategizing meeting with representatives from 14 countries. The meeting took place at the Devonshire Hotel in Johannesburg. These countries included Botswana, Zimbabwe, Zambia, Malawi, Mozambique, Lesotho, Namibia, Swaziland, Nigeria, Tanzania, Kenya, Ghana, Uganda, Cameroon--representing East Africa, West Africa and Southern Africa. Participants were required to bring an assessment of the state of the epidemic and other health crises in each of their countries. In choosing who to attend, we gave priority to people living with HIV/AIDS and ensured that there was a gender balance to the roster. The other main priority was given to community-based organizations, including many from the religious sector. We were excited to have members from the religious community because of the critical need to address stigma around the virus in churches.

We wish to apologize to the many individuals and organizations that we were unable to sponsor or invite at this time. This event is meant to be part of an ongoing series of exchanges about treatment literacy. Those who we were unable to meet with now will hopefully be part of the next workshop. In particular, we apologize to those who were promised by Bread for the World to attend the workshop.

WORKSHOP OBJECTIVES

The aim of the conference was to share ideas and skills about Treatment Literacy with people engaged in community work around pressing health issues and HIV/AIDS throughout Africa. The plan is to continue sharing approaches with partners systematically. In the first two days, the Treatment Action Campaign presented selections of its own Treatment Literacy training. During the latter half, delegates shared ideas and experiences about useful methodologies on doing community-based and mobilization and education around health.

CONFERENCE REPORT

The workshop commenced with introductions and a short film screening, courtesy of Community Health Media Productions. The following day started with reports by delegates on the situation of the health crisis in each of their countries. The bulk of the conference consisted of workshops led by TAC facilitators on the science of HIV/AIDS and treatment. TAC also discussed the different methodologies it uses to conduct workshops. Participants found the information useful and appreciated the way in which our facilitators led them. Many proclaimed that the programme was unique from others they had attended because it was not heavily dominated by inaccessible scientific language that is often difficult to remit to communities.

During the last day, a discussion was held around the politics of HIV/AIDS and what campaigns should be prioritized. We resolved to hold quarterly workshops with more in-depth trainings and to work on campaigns with partner organizations in different countries. We hope to hold a follow-up conference in April to see how the exchange of ideas and information from this meeting has influenced the creation or progression of treatment literacy programs in other countries. New enterprises by ally organizations will be assisted and monitored by trained treatment literacy facilitators from the TAC.

See below for a more detailed summary of the country situation reports and a list of campaigns that have been discussed.

Note of Appreciation

Thanks very much to the TAC Administrative staff for their support in assisting in organizing the workshop. We would also like to thank the organization for having faith in the project, despite of challenges facing the organizers. Thanks to facilitators for taking time away from their families to assist in the success of the event— Your dedication is appreciated "Mathola`nyongande nje kukudlena". A special thanks to Manmeet Bindra who assisted with administrative and programmatic arrangements from the beginning till the end of the workshop. Despite numerous challenges with passport and visa processing, you never gave up. Thanks very much for that patience. I think TAC will do it better than me in saying thanks to Bread For the World, I need thousand mouths to do it and I do not have them, so thank so much.

COUNTRY OVERVIEWS:

Prevalence of HIV by country

- SADC region

- Swaziland 46%
- Namibia 22-19.7
- Zimbabwe 24.6%
- Zambia 16%
- Mozambique 17%
- Malawi 14.4%
- Botswana 26%

- Lesotho 29%

- S.A 29%
- Kenya 7% (23 million population
- Tanzania 2 million (34.4 million population)
- Cameroon 5% (15 million population)
- Nigeria 5%(130 million population)
- Ghana 3.1 % (18 million population

SITUATION ANALYSIS OF COUNTRIES

ZIMBABWE

- People living with HIV - 2 million
- Government rolls out plan as a result of 3x5 (20 000 people) good infrastructure
- Treatment literacy is spear headed by NGO's
- Social dimension Fund (NAC with NAF)- provides

food pack, orphan care, diagnostic equipment

- Need to declare HIV as an emergency – problems facing advocacy
- Misplaced priorities
- Equity issues in treatment
- Huge brain drain
- Insufficient Access to ARV's
- Political polarization

SWAZILAND

Arv Rollout Site

- 28 000 people in need of ARV`s and only 20 000 have access
- 12 ARV Centres
- Political will, draft policy strategy
- Few skilled persnnel
- Poor management of resources

Poverty

- High food insecurity
- High levels of unemployment

Gender and HIV

- About 300 000 PLWHA & about 56% Female
- About 100 000 Children orphaned to HIV related Deaths
- About 29 000 deaths per year to HIV Related Illnesses

Health System

- Not conducive to people living with HIV/AIDS
- HIV Positive usually neglected when hospitalized in Public hospitals
- Inadequate Health Centres which hinders access to health care
- Paediatrics (Opened 06 December 2005)
- 1 Paediatrics (Local)
- Inadequate CD4 machines approximately 4
- Viral loads still taken in South Africa Laboratories

Poverty

- S.D. is poverty stricken owing to drought for past 3 years
- 66% of Swaziland live below poverty line (less than 1 dollar per day)
- No food security for people Living with HIV

LESOTHO

- NAC commission
- Expansion of ARV programme from 5000-300 000
- Prog depends on donor commission
- Mismanagement of resources

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Health System

HIV Positive usually neglected when hospitalized in Public hospitals

- Inadequate Health Centres which hinders access to health care
- Not enough V.C.T mostly located in urban centres
- National policy still at draft level
- No legislations on HIV/AIDS
- Inadequate access to ARV.

MOZAMBIQUE

- 1.5 infected 200 000 need ART and only 12 000 have access to ARV`s
- Strategic plan and draft HIV policy
- Lack of commitment,poor management of resources
- Treatment to be centralized
- Lack of HIV skilled personnel
- Lack of infrastructure and equipment
- Lack of basic drugs
- There is a national policy on treatment
- There is a law that protects the workers and candidates
- Parliament committee on HIV/ADS in place
- Need to draft and establish a policy to protect PLWHA
- Poverty reduction strategic paper
- Gender and HIV are integrated into PARPA as cross cut issues

MALAWI

- NAC commission disburses funds to NGO's
- Draft HIV Policy
- Free ARV's
- Infected 900 000, 170 000 need ART and 50 000 are on ART
    - inadequate supply of ARV's, OI treatment is limited

Poor community preparedness for ART resulting in poor ART compliance

- HIV national policy is put in place.
- HIV work place policies encouraged in public and private sector.
- Main streaming HIV/AIDS programs/plans in work places.
- In adequate supply of essential drugs including ARV's and equipment.
- Unequal distribution of drugs in district hospitals.
- Shortage of trained personnel in all hospitals

Povery is very rampant

Poverty Reduction Strategy Paper (Paper) put in place through HIPC (Highly Indebted Poor Countries) through Malawi Rural Development Fund (Mardef) ie both men and women

Food security programme through ministry of Agriculture and other NGO`s eg Action for Hunger

ZAMBIA

- Huge resources mobilized and available
- Free ARV's but has challenges – accessibly rural people.

Draft constitutional amendment including HIV 2000 000 infected, 35000 in need of ART, 35 000 on treatment 3x5 target .

  - Lack of commitment (no political will)
    - -Over dependence on donor community
    - -Abuse of people right- constituency

Health System

- Poor infrastructure, lack of human resources
- Equitable ARV services
- Declaration not being implemented example UNGASS, ABUJA

Poverty

- 80% Zambian population live below poverty line.
- People unable to access treatment
- Increase in prostitution
- ARV Centres offer only free ARV no medication for opportunist Infections

Gender and HIV

- Traditional norms/practices
- Unable to negotiate safer sex
- Need permission from partner to take ARV

Problems

- Campaigns for enshrinement of HIV/AIDS Policy in the constitution
- As identified above under health system

NAMIBIA

- Roll out of ARV`s and 9 600 on treatments, 19.6% of 1.8 population
- Inaccessibility of drugs – cost
- Centralization of ART site- difficult to access these sites
- Lack of manpower
- Policies around HIV are in place
- Poverty due to lack of education, employment
- Gender-women and children are the most vulnerable group regarding HIV/AIDS
- Culture and tradition, values and beliefs also play a role in perpetuating Hiv.

- What GVT needs to do is to have watch dogs to monitor corruption and HIV matters

Challenges

Access to treatment for OI`s and AVR`s

No food security

No Treatment Literacy programmes

BOTSWANA

- Good PMTCT program and nutritional support
- Free ARV but the supply is inconsistent
- Poor community preparedness
- Donor dictate programme to Africa e.g. the abstinence discourse that is emerging

Gender and HIV

- Most of woman are getting infected than man, because of ignorance and other socio-economic factors like dependency

What Gvt does?

- Has established AIDS committees
- Free food basket
- Free formula milk

Campaigns

- Disclosure campaigns
- Distigmatise HIV/AIDS
- know about Human Rights campaign
- More VCT campaigns

GHANA

- prevalence is 3.4 million (between ages of 15-40 years)
- Daily infection rate is 210 people, there is $15 billion dollars to fight HIV and for prevention.
- The policies are very good in paper but in reality implementation is very much poor
- Currently the govt has put in place the poverty alleviation but gender equity policy is not in place.
  - There is a negative attitude from govt and they instead are assisting the traditional health medical practitioners to analyze their medication before they are administers
- Campaigning towards HIV is on the lower rate because one life can be saved

TANZANIA

- HEALTH SYSTEM; Under MOH through NACP.
- 96 ARV sites
- Free treatment for people that have CD 4 counts less than 200. [1] WEF OCT/04 for ARV. Aim to reach 44,000 PHA.

- But currently 25,000 people only are on ART.They are using public health centres
    - There is treatment for OI's. But the problem is; some medications are not available at Government hospitals. And some government centres are too far from many communities. At least TB TREATMENT and Fluconazole are available and accessible.

Policies around HIV

- There are national policies; since 2001 there has been TACAIDS.
- Most policies and programs have not been implemented
- Especially programs on care and support for PWA and there is not enough PLWHA mobilisation.

Poverty

- Poverty is the major of the high HIV transmission rate i.e. prostitution. As a result it becomes difficult to afford nutritious food or food at all. As well to afford transport fares to government.

Culture

- Under our culture there is gender imbalance i.e. men are still having too much control over women.
- There is still the issue of wife inheritance
- Women still carry the burden of caring for everyone in the family.

Other Problems

- There is great need for mobilizing people living with HIV/AIDS.

Train people on Treatment Literacy and Advocacy.

CAMEROON

Health System

- 10 provincial hospitals
- 4 govt teaching universities hosp\12 other rx centres for HIV/AIDS
- There are plans to operate 60 ARV's management units.
- -600 HIV new infection daily\71,862 people living with HIV need ARV;s
- -14 000 PLWHA on treatment
- -HIV/AIDS activities operate at the primary, secondary and tertiary levels
- -Policies on HIV/aids= PEP, MTCT
- -No law that protects PLHA
- -ARV rx= 3000 – 7000 to be on treatment every month
- Inadequate supply and distribution system
- Untrained health staff
- Poor infrastructure and more corruption

Poverty

- Cameroon is a regular customer of the highly indebted poor country initiative despite the natural resources at our disposal OIL
- -Majority of Cameroon live under the poverty line= less than 1 dollar a day

Gender and HIV

- Women still need to be empowered
- Cultural beliefs and practises make women more vulnerable to HIV/AIDS.

Campaigns

- Geographical access to free Treatment
- Involvement of all PLWHA in advocacy
- Strengthen access to information campaign especially on policies and Human Right
- Treatment Literacy to be scaled up and target PLWHA.

STRATEGIES FOR THE IDENTIFIED CAMPAIGNS

Country	Campaign	Target Groups	Strategies
Zimb	**Treatment Literacy**	Aids and TB units Minister of Health/Government Zimbabwean National Association of People Living with HIV (ZNNP+) Support groups Community leaders/members AIDS Service Organizations (ASOs)	**Training heads of units of** Provincial training for ZNNP Train community leaders Monitoring ASO`S that have Hold public meetings
	Access to treatment	Government Parliamentary Committees on Health	Hold meetings first and start
Nigeria	Treatment Literacy Access to treatment	Support group members Youth And community at large Orphans and Vulnerable Communities **(**OVC's) PMTCT PLWHA	To train other PLWHA to tra members To give IEC materials to the To do treatment literacy thro To mobilize people in the co with other organizations and
Kenya	Disclosure Campaign	PLWHA	Involve support groups in al Start to do door 2 door Visit churches, schools and
	Treatment Literacy	PLWHA	Hold workshops in clinics ar

		Communities	Hold public meetings
			Workshops for women's anc
Tanzania	Treatment Literacy	PLWHA	
		Communities	
		Health Care Workers	
		Government	
	Know your rights Campaign	PLWHA	
		Affected communities	
		Orphaned and vulnerable groups	
	Disclosure Campaign	500 PLWHA	
	Access to treatment	Donors	
		Government	
Malawi		Government	Public meetings
		PMAs	Pickets and marches
	Treatment literacy	PLWHA	Trainings and meetings
		Counsellors	
		Service Providers	
		Local community leaders	
		Youth groups	
	Stigma /Discrimination	Communities	Workshops
		Youth	
		Churches	
		Work places	
	Prevention Campaigns	Youth at school	Workshops
		Youth outside school	
		Womens organizations	
		Communities	
	VCT Campaign	Youth & communities	
S`d	Treatment Literacy	200 PLWHA	Provide trainings to PLWHA

		100 HCW	Hold w/shops for civil societ
		rural Health motivators	Collaborate with MOH and c
		100 community members	
		Traditional leaders	
	Know your right	200 plwha	Organise workshops with civ
		1000 community members(250 per region)	Incorporate campaign in exi our organizations
	Disclosure campaign	200 PLWHA per region	Sensitise PLWHA about imp group meetings
			Incorporate campaigns into
			Collaborate with MOH and c field to promote disclosure
M`QUE	Access to treatment	MOH	Hold demonstrations
		Parliamentarians	Media campaign
		Communities	Community mobilization
		PLWHA	Door 2 door
			Regular meetings
	Treatment Literacy	PLWHA	Workshops
		Communities	
		Government	
NAMIBIA	Treatment Literacy	PLWHA	Stakeholders meetings
		Teachers	W/shop around condom use
		HCW	Use lifeline to open lines for
		Motivational speakers	W/shops in diff languages
		Regional co-ordinators	
		Partner organizations	
	Prevention Campaign	NRC,CAA,ACT,SMA,NASUMA,	Meet MOH and radio statior
			Train partner organizations a
		IBIS,VSO,GVT,AGS	
			Workshop youth organizatio

		Private Sector	Use media to show importar
		Institutions	.
Cameron	Access to treatment	14 000 PLWHA in need of treatment	Use the universal Declaratic 2010
		Community organizations	
		Traditional leaders	As a tool to advocat Include OI treatmen Need Government t
		Donor organizations	To do door to door (talks in churches
		Government	Will use media to mobilize a
	Treatment literacy	HCW	Organise seminar workshop
		PLWHA	Train communities in clinics
		Community health workers	Increase community mobiliz
			TL trainings to create more

Challenges:

- Self- imposed stigma
- Health workers attitude
- Proximity to health centres
- Disclosure (drug assistance) to family
- No treatment literacy (esp. Cameroon)
- Cost of testing and treatment
- How politics interfere in media – accuracy of prevalence rates e.g. Cameroon from 12% - 5.5%
- Gender issues- Few men willing to join support groups, More women infected e.g. Tanzania more than 55% of 2 million infected are women.

Resolutions:

- Move beyond GIPA and more MIPA (Meaningful Involvement of PWLHA)
- Use treatment literacy (learn about our constitution to use them to demand human rights) to encourage people to make demands on state.
- Use a more accessible language for rural communities, especially in Zimbabwe.
- Call for an African movement for people living with HIV
- Put pressure to out ministers of trade
- Monitoring in countries to report to other countries
- Engage (not to work in isolation) other civil society organs about other services accessibility- health of my community – community health plan
- Better coordination and communication of the Civil society movements in different countries (PATAM, IRASA etc) – to pull more Faith Based Organization's and Community Based Organization's in the movement. PATAM should be institutionalized with a secretariat. Divide the PATAM group according to regions.
- Monitoring and follow- up different countries by the PATAM regional groups

- Work with our government. Improve people's understanding of the way government works in order to better monitor their activities.
- Intensify our community mobilization – for a free access for all basic treatments
- Create a vibrant civil society coalition to put pressure on government to honour the commitment
- Need for regional coordination and adopt a stance that is a regional integration of programmes.
- Treatment preparedness should be part of government roll out plan
- More political commitment from government to allocate more resources for HIV from government
- Develop own human resource capacity to respond to HIV.

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