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## FUND THE FIGHT AGAINST HIV AND TB: TAC'S RESOURCES FOR HEALTH MEMORANDUM\*

This memorandum is structured as follows:

- *Introduction*
- *Main objectives of the campaign*
- *How TAC aims to achieve these objectives and campaign demands*
- *Results of research on resources for health and the failure of NSP targets in TAC's six Model Districts*
- *Campaign timeline*
- *Slogans*
- *Campaign background*

### Introduction

Every day in South Africa, there are approximately 1,000 deaths from AIDS and 1,450 new HIV infections. Due to the social vulnerability of young women and the lack of adequate services for PMTCT, about 45% of new infections occur in women under 25 years of age, and their babies.<sup>1</sup>

It is government's responsibility to make antiretroviral therapy (ART) accessible and sustainable, as stated in the National Strategic Plan (NSP), to which government has committed. The NSP aims to treat 80% of people who need ART by 2011, and to reduce HIV transmission by 50%. But there is a crisis in the NSP's implementation, proven by recent research in TAC's six model districts and outlined further below.

As of June 2009, about 700,000 people have been initiated onto ART in South Africa's public health sector. About 560,000 of these patients remain – as approximately 140,000 have either died, been lost to follow-up, or moved into the private sector. **But at least double the current number of people who are on ART need treatment urgently to survive.**

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\* PCR thanks everyone who commented on earlier drafts of this memo.

<sup>1</sup> 'A Roadmap for the Reform of the South African Health System: draft final report', convened by the Development Bank of South Africa, 8 November 2008, p. 43.

In the last few months, the ART roll-out has lost momentum. Tens of thousands of people remain on waiting lists, and most patients have CD4 counts just above 100 by the time they are finally initiated onto ART.<sup>2</sup> Francois Venter, the head of the HIV Clinicians Society, has stated that in South Africa, most patients have a CD4 count of *below* 100 when they finally gain access to ART. This means that many patients have already suffered from severe symptoms and have stage 3 or 4 AIDS by the time they start ARVs.

### **Health Rights, Human Rights, HAART Rights**

This is both a moral outrage and a waste of precious health resources. The Constitution guarantees the progressive realisation of access to comprehensive health care. Long ART waiting lists and stock-outs of ARVs and other essential medicines violate this right and sacrifice the lives and wellbeing of HIV-positive South Africans.

Late ART initiation is also costly because treating opportunistic infections requires more clinical care and is therefore expensive and time consuming. Earlier initiation of ART would prevent both TB and HIV transmission by reducing the viral load and strengthening the immunity of people living with HIV.<sup>3</sup> Public understandings that HIV prevention and HIV treatment are separate must therefore be changed. Making ART more accessible is a vital part HIV and TB prevention.

The ARV 'moratorium' in the Free State, which started in November 2008 and lasted for four months, showed that provincial roll-outs were badly flawed – particularly in terms of their budget planning and oversight. Since then, sporadic ARV stock-outs have arisen in areas in the Eastern Cape, Mpumalanga, Limpopo, KwaZulu Natal and Gauteng (the richest province) and shortages of other essential medical supplies are occurring with greater frequency. The main causes for this are:

- A. Improper, inefficient budgeting, and a lack of civil society monitoring of government budgeting.
- B. A lack of health system capacity, especially human resources and infrastructure.

TAC's Resources for Health campaign will fight for access to ART through the fulfillment of the NSP targets.

### **Main objectives of the campaign:**

1. **To demand early treatment of infants, dual protocols and essential medical supplies for PMTCT.** The NSP target for 2009 is to have 85% of facilities meeting the quality standards for infant

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<sup>2</sup> N. Ford, E. Mills and A. Calmy, 'Rationing Antiretroviral Therapy in Africa – Treating Too Few, Too Late', *New England Journal of Medicine* Volume 360:1808 – 1810, 30 April 2009.

<sup>3</sup> N. Ford et al., 'Rationing ART in Africa'.

feeding.<sup>4</sup> As research from districts proves – this target is failing outright. The CHER study found that initiating infants onto treatment as soon as they are diagnosed HIV-positive will substantially reduce mortality.<sup>5</sup> Demanding PCR tests and earlier treatment for infants will save thousands of lives, and increase the number of children on ART, bringing us closer to the NSP target. Infants and children should be tested at vaccine sites. Mothers who need it must be given full HAART.

2. **To treat at a CD4 count of 350, not 200, and to eradicate ARV waiting lists:** The main reasons why people die from AIDS is that ART is not available to those in need, and that treatment is started too late.<sup>6</sup>
3. **To fight for integration of TB/HIV treatments:** All people with TB must be tested for HIV. Treatment must be offered at the same clinic to ensure that people can adhere.

#### **TAC aims to accomplish these campaign goals by:**

1. Demanding needs-based budgeting, strict financial oversight and accountability at both national and provincial level.
2. Demanding a solution to the human resources crisis in the health sector.
3. Educating TAC members and the public about the current crisis in healthcare and the suffering and death it is causing.
4. Campaigning for resources for health on a global scale.
5. Ensuring that government leads to solve the crisis in the health sector.

#### **Campaign Goal One: Demanding needs-based budgeting, strict financial oversight and accountability at both national and provincial level**

Evaluations of the health system show weaknesses at almost every level. Both hospitals and district services have shown poor service delivery and have failed to meet the health needs of communities.<sup>7</sup> South Africa performs much worse than many other countries which spend less on health.

Following cutbacks of health expenditure relating to the policy of Growth, Employment and Redistribution (GEAR), from 2005 more money has been spent on the public health system, especially on the district system. But increases in the cost of staff and services mean that the public hospital system likely experienced a real decline in budget.<sup>8</sup> This was during the time

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<sup>4</sup> M. Heywood, 'Key Targets of the NSP for 2009', 1 June 2009.

<sup>5</sup> A. Violari et al., 'Early Antiretroviral Therapy and Mortality among HIV-Infected Infants', *New England Journal of Medicine*, 359: 2233 – 2244 (2008).

<sup>6</sup> 'A Roadmap for the Reform of the South African Health System', p. 43.

<sup>7</sup> 'A Roadmap for the Reform of the South African Health System' p. 20.

<sup>8</sup> *Ibid.*, p. 18

of massive increases in South Africa's burden of disease as a result of the co-epidemics of TB/HIV.

### *Resource Allocation in the Public Health System*

There are two broad categories of public health funding by the state:

- i. Nationally allocated funds specifically tied to national priorities.
- ii. Unallocated funds given to provinces to spend however they see fit.

This way of allocating resources has been wasteful and ineffective, and has allowed a lack of financial accountability and transparency in provinces. The ART moratorium in the Free State resulted from budgetary mismanagement and a lack of financial accountability related to the misallocation of funds.

While the Free State ART moratorium was in place, R30 million was dedicated to campaigning for the elections in the province. Only about R700,000 would have been enough to initiate the targeted 1,200 people onto ART in the Free State per month during this time.

In his speech outlining his priorities, Health Minister Motsoaledi acknowledged that 'financial management' was the greatest weakness facing the Department of Health. But he also outlined plans for further 'cost containment' – potentially meaning further decreases in financial resources for health.

South Africa has the skills and the capacity to achieve the NSP targets and to mobilize adequate resources for health, but it must use these in the **right** way. In October 2009, budgetary adjustments are made. There is currently a R1 billion shortfall to initiate the NSP's targeted number of people onto ART for 2009, and District Health Authorities are failing. TAC's model districts must advocate for more money to be made available by monitoring and engaging with the budget by:

Organising attendance at provincial budget planning meetings.

Holding direct actions to highlight the necessity of sufficient resources to achieve the NSP targets. Mechanisms must be introduced to link national priorities to provincial delivery e.g. national norms and standards, national policy frameworks, and M&E bodies to track performance and ensure that officials who are failing to deliver are held accountable.

Using the Public Finance Management Act to quickly eradicate potential stock-outs of essential medicines, and to hold provincial government officials accountable for implementing nationally determined priorities.

TAC is drafting materials around the PFMA and planning trainings on budgetary monitoring. These trainings will take place around October 2009.

**Campaign Goal Two: Demanding a solution to the human resources crisis in the health sector**

The public health sector has suffered staff reductions since the late 1990s and there are currently 11,000 vacancies for doctors in the public health sector.<sup>9</sup> In the last eleven years, no increases in numbers of staff in the public health sector have occurred, despite a massive increase in the demand for services, together with the burden of disease from TB/HIV.<sup>10</sup>

There is a severe lack of competent managers in the health sector. Many senior and middle management posts have been filled by inexperienced or unqualified people, with detrimental effects on the functioning of hospitals and of care for sick people.<sup>11</sup>

Studies have shown that women usually arrive early at antenatal clinics (in one study the majority had arrived by 7:30 am) to ensure that they are seen. They often spend several hours in the clinic and had very little contact with the health provider. Nurses had poor motivation and low morale due to poor promotion prospects, bad management and staff shortages.<sup>12</sup>

The nurse population is ageing. In 2007, 74% of South Africa's registered nurses were over 40 years of age, while only 3% were younger than 30.<sup>13</sup> Health sciences faculties have also deteriorated, compromising South Africa's ability to produce new health professionals.<sup>14</sup> But the numbers of staff leaving the health sector in the last 11 years have correlated with periods in which less money was spent on the health sector. This shows that improved budgets can attract staff back to the public sector.

#### **Demands:<sup>15</sup>**

- Urgent implementation of a human resources policy framework to arrest the human resources crisis in the health sector – seen recently in the doctor's strike.
- Improvements in education and training enrolments levels.
- Retention strategies including performance-based promotions and training programmes.
- Task-shifting and vastly improved use of community health workers.

#### **Campaign Goal Three: Educating TAC members and the public about the current crisis in healthcare and the suffering and death it is causing**

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<sup>9</sup> Ibid., p. 19

<sup>10</sup> Ibid., p. 20

<sup>11</sup> Ibid., p. 21.

<sup>12</sup> Ibid., pp. 23 – 24.

<sup>13</sup> J. Lewis presentation, presentation on 'Human Resource Challenges' for the TAC Partners' Meeting on the Resource for Health Campaign, 1 June 2009.

<sup>14</sup> 'A Roadmap for the Reform of the South African Health System', p. 39.

<sup>15</sup> Ibid., p. 39 – 40.

Through the Resources for Health Campaign - through workshops, trainings, meetings, protests, pickets and marches.

#### **Campaign Goal Four: Campaigning for resources for health on a global scale**

TAC is participating in ARASA's regional campaign for financial accountability and greater access to TB/HIV treatments. A press conference was held on Wednesday 11 June 2009 about this campaign and the statement is available on the TAC website.

#### **Campaign Goal Five: Ensuring that government leads to solve the crisis in the health sector**

President Zuma was elected on a platform of promises for service delivery. For over ten years, provincial governments have failed to plan and render health services.<sup>16</sup> Government officials, from the President to the Health Minister and heads of provincial Departments of Health, must now focus on policy implementation and oversight. Many districts are dysfunctional and a revised model for the district system is urgently needed.

#### **Demands:**

- Government's promises must translate into action.
- Policy development and a system of resource allocation must be centralized at national level. But mechanisms must be transparent, consultative and inclusive of civil society.
- Minimum norms and standards for health delivery must be determined at national level and then implemented in districts with strict oversight.<sup>17</sup>

#### **Results of Research in TAC's Six Model Districts**

Research conducted in TAC's six model districts proves that there is a crisis in the provincial health sector.

#### **Waiting lists and diagnostics delays:**

- In KZN, there is a waiting list of over 60,000. In Pietermaritzburg, many people who need ART immediately to survive are being turned away from clinics. There is a 'huge problem with waiting lists' at Edendale Hospital, according to direct observation by TAC staff.
- At the Cindi Clinic in Mpumalanga, people on the waiting list have been unable to access CD4 count tests since January 2009.

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<sup>16</sup> Ibid., p. 35

<sup>17</sup> Ibid., p. 32.

- The Western Cape has the highest ART coverage in South Africa, but in Khayelitsha (regarded as a national model of ART access), many clinics still have waiting lists well over a hundred. There was a significant decrease of enrolment of new patients in quarter 4 of 2008 – evidence of the slowing down of the roll-out.
- In the Eastern Cape, the official ART waiting list is 14,970 people long.<sup>18</sup>
- In Mopani (Limpopo), there were delays in results for PCR, CD4, viral load and side-effects tests at all health facilities. At the Khujwana Clinic, there has been no treatment for sexually transmitted infections since February 2009. At Nkhensani Hospital there was no test available for lactic acidosis, and CD4 counts, viral loads and PCR results take about three months to arrive. At the Dzumeri Clinic, results for pap smears are almost never returned. The Lenyenye Health Centre has been accredited for ARVs but has not yet started initiating patients.

#### **Low CD4 counts:**

- In Khayelitsha, many people are initiated onto ART with a CD4 count less than fifty. When peripheral sites or decentralised facilities are opened, people with severe AIDS present for care.
- In Ekurhuleni, a patient on the waiting list at Emthonjeni Clinic had a CD4 count of just 25.

#### **Stock-outs:**

- In Ekurhuleni, numerous clinics had stock-outs of D4t, disrupting the ARV regimens of many patients.
- In uMgungundlovu, about 90% of clinics have shortages of formula milk. At the Secunda Municipality Clinic, dual therapy for PMTCT is not available and no formula milk was available for the month of February. In KwaZulu Natal, the Health Department has stopped providing nutritional porridge to over 100,000 patients.
- Many of the clinics in Mpumalanga have frequent stock-outs of formula milk. There were also shortages of drugs for pain relief, Bactrim, vaccines for babies, Streptomycin (unavailable for three months at the VukuZakhe Clinic), pneumococcal vaccine (never available at the VukuZakhe Clinic), Amoxicillin, Co-trimoxazole and Co-trimoxazole syrup, and medicines for chronic illnesses including Insulin for diabetes and hypertension drugs. Vitamins like Folic Acid and B-Complex were out of stock or in short supply at all clinics. At the Winifred Maboja

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<sup>18</sup> Eastern Cape Department of Health, 'Provincial Overview: HIV and AIDS Directorate', 29 May 2009.

Clinic, the long list of stock-outs included cough mixture, Panado, and Ethambutol and Pyridoxine (essential drugs for treating TB).

- In Mopani, stock-outs of formula milk and chronic illness medication were also common. Formula milk was unavailable from most clinics from January 2009. The Lulekani Health Centre had no AZT syrup from March until the end of May 2009. The Nkhensani Hospital had no condoms since September 2008. Most clinics had shortages of Bactrim, pain relief medication, vaccines for children and cough medication.
- There are ongoing condoms shortages in Khayelitsha.

### **TB Treatment:**

- At the Standerton TB Specialised Hospital in Mpumalanga, only about 10% of TB patients were tested for HIV between February and April.
- At Ekurhuleni there is no integration of TB and HIV treatment. Ekurhuleni clinics have shortages of masks and poor infection control practices. Nurses fear that they will contract MDR and XDR TB.

### **Human Resources:**

- The Impilwenhle Clinic in uMgungundlovu usually has only one nurse who operates the clinic, resulting in long queues for patients.
- Research in Mpumalanga showed that the clinic service delivery was hampered by 'working conditions, overburden and low wages'. At Embhuleni Hospital's Wellness Clinic, shortages of health professionals mean that many patients who arrive at 8 am are only attended to many hours later – as late as 5 pm. There is only one full-time doctor at the clinic. At the Sead Clinic – there is only one doctor who is available once a week.
- None of the clinics in Lusikisiki have pharmacists.
- In Khayelitsha, lay counselors have not been paid since November 2008. Many have left the clinics, meaning that patients who go to test for HIV are turned away.
- In Ekurhuleni, the Phola Park clinic has 8,549 patients, two nurses and one doctor.

### **Campaign Timeline**

<b>15 May – 1 June:</b>	District PCR staff collect information on the NSP targets in districts by consulting with CHAs, PTLs and district staff.
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	This information is fed back to national PCR for inclusion in the national campaign materials.
<b>1 June:</b>	Consultative partners meeting on the campaign.
<b>10 June:</b>	Campaign materials finalized with inputs from secretariat, provinces and districts.
<b>11 – 30 June:</b>	District and provincial briefings held to discuss the Resources for Health campaign memorandum. District campaign plans and actions begin. Western Cape march plans begin
<b>Mid-July:</b>	Translated campaign materials including posters, pamphlets and t-shirts are distributed to districts.
<b>19 July:</b>	TAC march for Resources for Health at the July International AIDS Conference held in Cape Town.
<b>July onwards:</b>	Follow-up actions in districts on failure of NSP targets, budgeting oversight and human resources.

### Slogans

Districts should invent their own slogans based on their most important demands and translate these into local languages for maximum understanding. Here are some suggestions:

- **Needs based Budgeting = Lives saved!**
- **Universal Access to Treatment NOW!**
- **Treatment is Prevention! Meet the NSP targets for treatment and prevention!**
- **Our struggle continues: human resources for health!**
- **Waiting list = death row.**
- **HIV/TB is not in recession!**
- **Economic recovery must include health recovery.**
- **Knock-out the stock-out!**
- **If targets are missed - we die!**
- **Decent work for community healthcare workers.**
- **President Zuma/Minister Motsoaledi - save our lives!**
- **Fund the fight against HIV/TB.**
- **Government - protect our lives! increase public health spending**
- **The nation is watching - Deliver on promises for child and maternal health now!**
- **We still have rights in a recession!**
- **No more BROKEN promises, no more BROKEN lives, FIX our healthcare system.**
- **Public health is a global public good.**

### Background to the campaign

Sub Saharan Africa is home to 22% of the global burden of disease and 68% of people living with HIV/AIDS. But the region only accounts for 2% of the global health workforce and only 1% of global health expenditure. The economic crisis and the backlash against AIDS specific funding are further threatening available financing for health and a recent report by the World Bank stated that 70% of people on ART in Southern Africa are threatened by treatment interruptions relating to potential decreases in funding for HIV programmes.<sup>19</sup>

South Africa is the only country out of 30 'peer countries' with similar income levels to have suffered worsening maternal and infant mortality rates between 1990 – 2006.<sup>20</sup> South Africa also performs much worse than many other countries which spend less on health.<sup>21</sup>

The *Roadmap for the Reform of the South African Health System* – which outlines the most pressing problems facing the health sector and gives possible solutions – argues that the health system is performing poorly because of factors under government control. These factors include a lack of political will, the absence of sound policies on human resources, and financial mismanagement and inefficiency. The *Roadmap* shows that vastly improved financial planning and oversight, sound human resources policies and strong political will are essential to improve the quality and accessibility of health services for all who live in South Africa (one of TAC's primary objectives).

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<sup>19</sup> World Bank's Human Development Network, 'Averting a Human Crisis During the Global Downturn – Policy Options' (2009).

<sup>20</sup> 'A Roadmap for the Reform of the South African Health System', p. 15

<sup>21</sup> Ibid., p. 18