TAC Electronic Newsletter

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TAC NEC commends progress in national response to AIDS - Now for implementation

The National Executive Committee (NEC) of the Treatment Action Campaign (TAC) met in Booysens, Johannesburg on 18 and 19 May 2007.

The National Strategic Plan - a great step forward

The NEC discussed the current state of the HIV epidemic in South Africa. It agreed that the adoption of the National Strategic Plan for HIV and AIDS and STIs 2007-2011 (NSP) by Cabinet marks
a watershed in the policy response to the AIDS epidemic.

The TAC NEC believes that the NSP marks a genuine commitment by government to ambitious but achievable targets for the treatment and prevention of HIV, to monitor the epidemic appropriately and to ensure the rights of people affected by HIV are protected. The scale of the plan is reflected in its costing of R45 billion.

TAC believes the NSP is a decisive break with AIDS denialism. It is an opportunity to save lives. But it is also an opportunity to combat gender based violence, improve access to legal services for poor people, raise knowledge of human rights, and alleviate poverty. In this regard we appeal to our allies to see it not just as an AIDS plan, but as a Cabinet sanctioned policy to challenge and overcome many of the inequalities that still beset and bedevil our society.

The TAC NEC calls on its branches, community organisations, NGOs,
unions and activist organisations to implement the NSP, particularly at local and provincial government level, and to deliver better services for people with HIV.

The district health crisis - getting worse

The NEC also heard reports from several TAC districts. Many TAC branches continue doing excellent but unpublicised work in their communities to improve health service delivery, challenge gender violence, prevent HIV and draw attention to aspects of the AIDS crisis. From these reports we remain extremely concerned about the state of health-care in provinces such as Limpopo and Mpumalanga. The NEC resolved to address this, if necessary by protest action, in the coming period.

Another common theme of all the district reports is that our health
service is facing a severe crises, and that two of the worst aspects of this crisis, the Tuberculosis/MDR/XDR epidemics and human resource shortages, are not being properly managed and are getting worse.

TAC's Organisation

Both the adoption of the NSP and the discussion on TAC's district work demonstrated to the NEC that TAC is now operating in a different political and policy environment to the period 1998-2006. We agreed that it is time to assess the organizational forms and methods of TAC.

Previously, progress on the HIV epidemic depended heavily on TAC's ability to highlight the shortcomings and immorality of national policy - and change it. But now progress depends decisively on how well provincial and local governments understand and implement the NSP.

TAC also noted its much closer relationship with government. In particular, the election of Mark Heywood as the Deputy Chair of SANAC, and better working relationships with a range of government departments at national, provincial and local level, means that we must do our utmost at this point to make the official structures of government work effectively on AIDS

TAC's affirms that its district and branch structures will need to be the focus of TAC's work. This may mean that national and provincial structures may need to be restructured to support local treatment literacy programmes and policy implementation.

An organisatonal re-assessment is also necessary because of the massive growth of TAC, both in staff and membership.

The NEC therefore established a commission that will consult with TAC's volunteers, staff and partners on why and how the organisation needs to restructure. This will be a priority activity to be completed by August.

In August, the NEC will reconvene to consider recommendations from this commission. The NEC will then adopt a proposal for restructuring the organisation. Thereafter, a the biannual TAC Congress will be held to look at the aims and objectives of TAC in the next period, and to amend the TAC Constitution - should this be necessary. The organisation will then be restructured as decided.

For further information or comment contact Sipho Mthathi or Linda Mafu on 021 788 3507.

[END OF NEC STATEMENT]

Find the money, reverse the cuts, stop the closures!

On 9 May in Cape Town, doctors, nurses and TAC members held a protest against the provincial health budget cuts. Dr. Lydia Cairncross made the following presentation to the Western Cape Parliament's budget hearings.

Submission to Provincial Parliamentary Public Budget Hearings

By Dr. Lydia Cairncross, Department of Surgery and Health Crisis Committee, Groote Schuur Hospital
Contact: 0827867014

9 May 2007

Good morning parliamentarians, health administrators, health workers and community members.

I am a doctor at Groote Schuur in the department of surgery and a member of the Groote Schuur Health Crisis

Committee.

I am driven to make this submission not because I have looked at the numbers on the budget spreadsheet, not because of an understanding of fiscal discipline or the projected inflation and growth of particular budget grants but because every day I battle against increasing odds to deliver a service of which I can feel proud.

As a surgical registrar I work on average 80 Đ 90 hours per week. I work 30 hour calls at least once a week and often have to operate in theatre at three or four in the morning without having slept. I work long, hard hours every day with other health workers but my submission today is not about our difficult working conditions.

Despite our efforts, we as health workers, go home every day knowing that we have not been able to provide adequate care or a safe and dignified environment for many of our patients. Worse still, we work knowing that we are only treating a fraction of those who desperately need our help.

Let me tell you a little bit about this ongoing health crisis. A crisis that will only be worsened by the proposed budget cuts.

Patients wait months for life saving surgery

One of the indicators of this crisis is that patients wait months for life saving surgery. As a result of previous budget cuts, operating time has been cut by fifty percent in the last few years. This has caused an explosion in surgical waiting times. Because we prioritise the more urgent cases, some patients are booked and cancelled several times before coming to surgery. Some literally wait for years with little hope of ever being done.

There are one thousand patients waiting for hernia surgery at Groote Schuur Hospital. At the current rate, clearing this waiting list will take more than twenty years. I have been involved in the care of patients who had been waiting on this list for years. They have only been operated on after first developed the life threatening complication of intestinal obstruction and rupture. This turns a simple operation into one requiring several hours of surgery and often intensive care treatment.

Patients diagnosed with breast cancer and colon cancer wait up to three months for their life saving surgery. Untreated the cancer cells in these tumours continue to grow with every day of delay. As the cancer grows, the chance for cure diminishes.

Diabetes and hypertension are epidemic in this city together with the complication of poor circulation requiring surgery. Patients who wait too long develop gangrene leaving us with no option but to amputate their legs as an emergency. Even those who make it to surgery sometimes still need a more limited amputation. At times, patients who are delayed for too long lose their lives due to uncontrolled infection.

These delays also affect emergency surgery. At night we usually have only one theatre for all emergencies at Groote Schuur. This is shared with surgeons in orthopaedics, neurosurgery, trauma, ENT, ophthalmology, gynaecology, plastics and cardiothoracics. It is not uncommon for a patient with a surgical emergency such as appendicitis or gangrene to wait 24 Đ 48 hours for their operations.

Cutting back on specialist clinics

Part of our work includes seeing patients in out patient clinics. This is where we follow up patients after their operations, or see patients referred for specialist care. The out patients department is always overflowing with patients who have been up at four in the morning to arrive at the hospital for a six, seven or eight hours' wait. Many have been waiting for several months for their appointments. Sometimes, we see them too late to help with what was otherwise a potentially curable disease.

What does "cutting beds" mean?

Every doctor at Groote Schuur spends hours when on call finding beds for our patients. It is not unusual for the wait for a bed to be as long 24 -48 hours, sometimes days. This means that casualty overflows with patients lying on hard trolleys. These are desperately ill people who are require a drip with drugs and fluids, who are unable to go to the toilet without assistance, who are often frail and elderly and who may have gastrointestinal problems like vomiting or diarrhoea. They have to lie in casualty tightly packed in rows, attended to by only one or two nurses. These few nurses have to administer medication, turn patients regularly, bring bed pans, keep patients clean and monitor acutely ill patients for deterioration. These conditions, suffered while waiting for beds in the ward, are humiliating for patients and extremely stressful for health workers.

The reason patients languish in casualty for hours and days is because our severely downsized wards (medical, surgical, paediatric, obstetric etc) are already overflowing with patients who are also desperately sick and in need of hospital care. The pressure on beds from a full casualty means no patient is kept a minute longer than is absolutely necessary. Sometimes their discharge, when judged against best medical practice, would even be considered premature.

So how do we admit new patients? We "make a bed". This is a euphemism for the process of scouring the hospital, looking for the most stable patients to move, those who have transport to go home, those who live nearby or can return easily. This complex juggling act can takes hours of precious time that should be spent caring for patients. It is a striking paradox that, while desperately looking for beds, we have to walk past the dark, empty rooms that a short while ago were fully equipped surgical and medical wards.

It is against this backdrop that health workers responded to the budget cut announcements with outrage and disbelief. In the face of an increase in national health expenditure we are not being given more beds but are told 60 more will be cut, that there will not be more clinics opening, but that out patient visits must decrease by 50 000. We are not offered extra resources to lighten the load on health services but are asked to do less, save more money, operate on fewer patients.

We ask, when you cut the beds, where should we send our patients? To overflowing Jooste Hospital, to Somerset Hospital which is also losing beds, to Victoria Hospital which is losing it's orthopaedic department. Or perhaps we should tell patients who present acutely ill to casualty to wait for 2010 when the rumoured new hospital in Khayelitsha will be ready.

For the patients waiting for specialist appointments at the soon to be closed out patient clinics, should we send them back to the same clinics and day hospitals that referred them, knowing these centres cannot help?

Who are our patients?

The patients we are treating are among the poorest of the poor. They are not affluent patients receiving luxury treatment at a tertiary hospital. Our patients are from the impoverished areas of our city, from Khayelitsha, Langa, Manenburg, Athlone, but also from the surrounding towns such as Vredenberg, Oudtshoorn, Worcester, George and from as far afield as the villages of the Eastern and Northern Cape.
These patients place their trust and faith in a public health system that is failing them. And when it fails them, they have no recourse to private medicine.

At the same time that we tell a woman from Khayelitsha that she will have to wait three months for her breast cancer surgery or 10 years for her hernia repair, just across the hospital corridor in the world of private medicine, we serve up the very best that modern medicine can offer with no delay. I the very same building, often the same health workers. Where is the justice in this?! This great country of ours held the promise of life and dignity for all. I was not aware that that depended on whether or not you could pay for it. The administrators, economists and health bureaucrats that decide that budget cuts are rational and realistic usually don't have to use these "rationalised", realistic services. They access the protected and growing private sector.

Many of the cuts in services have been justified in the name of Primary Health Care and the Comprehensive Services Plan. This is a distortion of the vision of comprehensive, holistic and appropriate care that was encapsulated in the

Alma Ata Declaration of the WHO in 1978. What is happening here is the construction of a system of cheap, minimal and inadequate medicine for poor people. This, in the same country where the wealthy have access to the very best that modern medicine can provide.

I have spoken about Groote Schuur because it is my immediate personal experience.
But this description is true, to a greater or lesser extent, for any public hospital in Province.

When the reality of the cuts to Groote Schuur became public, the Director-General of Health Professor Craig Household informed us that these cuts were due to a Provincial budgetary shortfall of R400 million. We are hearing many anecdotal reports of cuts at hospitals such as Somerset, Victoria, George and even some district hospitals. We are becoming concerned at the growing evidence that this R400 shortfall will affect almost every public health institution in the Province.

We as health workers have a very simple perspective. We have huge health needs in this Province, if we do not meet them, people die. People are dying right now because we cannot provide an adequate service. In this context, we cannot afford to close a single hospital bed at any institution, we cannot close a single out patients clinic, we cannot lose a single health worker be they permanent, contract or agency.

We believe that there is money to stop the health cuts. Certainly the National Treasury increase in the health budget contradicts the Provincial cut of R400 million. We find it hard to believe that there is not money for health services when we look at senior administrator salaries and management suites, or we look at the budget of R3 billion that has been found to upgrade stadia in the Province, or the billions spent on buying the recently delivered corvettes. If we have money for these expenses, how can we not have money for our most valuable resource, our people. How can we not have the money to preserve the most sacred of rights, the right to life.

You are our government, our representatives, the custodians of our resources, the guardians of the poor, the frail, the aged and the sick, of those who cannot fend for themselves. You have an responsibility and duty to fulfil.

Don't be fooled by the numbers. I will give you one simple equation: health cuts equal death and suffering for our people.

Find the money, reverse the cuts, stop the closures! We believe it can be done.

[END OF SUBMISSION TO PARLIAMENT]

- Health Finance
- HIV/AIDS National Strategic Plan

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