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REPORT OF THE JOINT HEALTH AND TREASURY TASK TEAM CHARGED WITH EXAMINING OPTIONS TO SUPPLEMENT COMPREHENSIVE HIV/AIDS CARE IN THE PUBLIC HEALTH SECTOR

Attached to this letter are overheads that the Treatment Action Campaign (TAC) has obtained of a presentation made to the Health MinMec on 9th May 2003 by Dr Ayanda Ntsaluba, the Director-General of the Health Department.

The overheads summarise key findings in the report of the above task team. They make it clear that a government-appointed expert committee believes that an antiretroviral programme, *supplementing other interventions*, will defer potentially hundreds of thousands of deaths over the next ten years. The benefits of this will be not only the lives saved, but the orphans prevented and a potentially massive reduction in the misery that AIDS is causing in our communities. The report also demonstrates that the programme is affordable and that it is indeed cheaper to add antiretroviral treatment to care programmes than to manage opportunistic infections alone (the “no antiretroviral treatment” option).

Our decision to provide you with this information is not an easy one. Since we suspended our civil disobedience campaign on 25 April 2003, we have tried to demonstrate to government our desire to work hand-in-hand to prevent and treat HIV infections. This remains the utmost desire of every TAC member and of its leadership. But this report, we believe, demonstrates that there are now no more justifications for delaying treatment. Of course, more and more investigations could be conducted, and we understand that we still have a fair bit to learn about implementation, but delays in starting this programme will cause preventable deaths, orphans and suffering. Therefore, withholding this report from other key players in our country is not an option for us. We urge government to publish the report without any further delay.

In the two months since this report has been completed, thousands of people have become ill and many died prematurely. Since 1 March 2003, more than 25 TAC members and leaders have died of AIDS-related illnesses. Dr. Ntsaluba’s presentation to the MinMec did not include the report’s calculation that many “deaths could be deferred until after 2010”. On the conservative assumption that ARV therapy leads to 4-5 additional years of “relatively illness-free life” (on page 42):

- At 20% people receiving ARV therapy, 293 000 deaths would be deferred.
- At 50% people receiving ARV therapy, 733 000 deaths would be deferred.
- At 100% people receiving ARV therapy, 1,7 million deaths would be deferred.

We ask you to study these overheads and to join with us now in calling for an urgent

meeting with all relevant players in government to demand the implementation of this programme. The report demonstrates the government's constitutional and legal duties; we urge you to remember that these include the rights to life, dignity and equality. In doing so, we would also like you to pledge your total commitment as a trade union, church, business or other leader to working with government and making these programmes work to save lives.

Joint Health & Treasury Technical Team

Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector

Presentation to MINMEC, 9th May 2003

(Fonts enlarged from report obtained by TAC
for ease of reading.)

Assessment of Current Treatment Package

- Significant funding increases devoted to strengthening treatment package since 2002
- Standard Treatment Guidelines for:
 - Treatment of Opportunistic Infections
 - DOTS treatment for Tuberculosis
 - Prophylaxis for common Opportunistic Infections
 - Palliative and Terminal Care
 - Community & Home Based Care
 - Step Down Care
- Quality of care still needs improvement, especially through training
- Work in progress on nutrition interventions and guidelines
- Only major treatment option currently excluded from package is antiretroviral therapy

WHO Consensus Guidelines on ART

- Team convened a clinical expert panel to convert WHO guidelines on ARV therapy in resource constrained settings for use in South Africa
- Aim was to develop a simple, robust and affordable model of care suitable for use in public facilities by non-specialist medical officers and nurses
- Recommended a simple, two-regimen model of care, with simple clinical eligibility criteria

Clinical Eligibility Criteria

- Adults:
 - WHO Stage 4 AIDS-defining illness and/or Symptomatic with CD4 <200, TB not present
- Children:
 - WHO Paediatric Stage 3 AIDS-defining illness and/or Symptomatic with CD4 <15% or 20% (by age)
- AND patient has completed three weekly compliance and preparation visits prior to commencement of treatment
- In general, moribund patients should not be treated with ART (“ART is never an emergency treatment”)

Recommended Regimens

- Regimen 1
 - D4T, 3TC, Efavirenz (Nevirapine for pregnant women)
 - Monitoring: CD4 & Viral Load (6 monthly)
- Regimen 2
 - AZT, DDI, Lopinavir & Ritonavir
 - Monitoring: CD4 (6 monthly), FBC
 - Patients who develop TB while on Regimen 2 would have Saquinavir substituted for Lopinavir
- No third-line or “Salvage” regimens in public sector

Drug Costs per Patient per Year (Adult):

| | Current SA Prices | Best World Prices |
|----------------|-------------------|-------------------|
| Regimen 1- EFV | 9,554 | 5,461 |
| Regimen 1- NVP | 8,619 | 2,093 |
| Regimen 2 | 16,739 | 9,115 |

Total Costs (Drugs, Laboratory Monitoring & Service Delivery):

| | Current SA Prices | Best World Prices |
|--------------------|-------------------|-------------------|
| Regimen 1 – Year 1 | 12,232 | 8,139 |
| Reg. 1 – Year 2+ | 11,705 | 7,611 |
| Regimen 1 – NVP | 10,630 | 4,104 |
| Regimen 2 | 18,177 | 10,554 |

Treatment Coverage Scenarios

- “No ARV”
 - Provide the full current package (OI treatment, prophylaxis, and palliative care) to all people with AIDS, plus a nutrition intervention for 50% of PWAs
- “20% ARV”
 - As “No ARV” *plus* phase up to provide ARV treatment for 20% of all new AIDS cases by 2008
- “50% ARV”
 - As “No ARV” *plus* phase up to provide ARV treatment for 50% of all new AIDS cases by 2008
- “100% ARV”
 - As “No ARV” *plus* phase up to provide ARV treatment for 100% of all new AIDS cases by 2008

Total Numbers on Treatment by 2008

- “No ARV”: None
- “20% ARV”: 200,000
- “50% ARV”: 600,000
- “100% ARV”: 1,200,000

Note:

- All scenarios phase up from zero patients on ARV in public sector at present
- The “100%” scenario is an “upper limit” illustration of the maximum risk, and is quite unlikely to be reached in reality due to limited uptake by patients themselves

Total Treatment Costs by Scenario

Billions of Rands per Year

| Scenario | 2003 | 2005 | 2008 | 2010 |
|----------|-----------|-----------|-------------|-------------|
| No ARV | 5.4 | 6.3 | 6.7 | 6.7 |
| 20% ARV | 5.5 | 6.6 | 7.8 – 8.1 | 8.2 – 9.0 |
| 50% ARV | 5.5 | 7.0 | 9.6 – 10.5 | 10.8 – 12.9 |
| 100% ARV | 5.6 – 5.7 | 7.9 – 8.3 | 13.4 – 15.7 | 16.9 – 21.4 |

Current Earmarked Funding for HIV/AIDS

Billions of Rands per Year

| | 2003/04 | 2004/05 | 2005/06 |
|-----------------------------|---------|---------|---------|
| Estimated Baseline Spending | 4.2 | 4.2 | 4.2 |
| Equitable Share Increment | 1.1 | 2.0 | 2.5 |
| Conditional Grant | 0.3 | 0.5 | 0.5 |
| National Dept. of Health | 0.3 | 0.3 | 0.3 |
| Total Estimated HIV/AIDS | 5.9 | 7.0 | 7.5 |

n.b. Above estimates include ±R500 million for prevention expenditure, which is not included in preceding estimates of treatment costs

Benefits of ARV Treatment

- Significant reductions in AIDS mortality
- Significant extension in years of healthy life
- Significantly reduce / defer numbers of children becoming orphans
- But no compelling evidence that ARVs would reduce numbers of new infections

Constitutional & Legal Analysis

- Must ensure programme meets the needs of people in “desperate need” (the very sick and the very poor)
- Provision for the rural poor must not be delayed until after urban or affluent populations served
- The State must have a clear, transparent and reasonable plan, which has the flexibility to address changing circumstances
- Phased implementation over time is acceptable
- Must work towards realisation of a programme to which everyone in need will ultimately have access
- Rationing on the basis of patient characteristics is probably discriminatory

Implementation Requirements – Non-ARV Option

- Improve quality of care and training of service providers
- Establish Regional Training Centres
- Improve availability and affordability of essential drugs
- Develop nutritional support guidelines and delivery systems for People with AIDS
- (n.b. all the above also apply to ARV options)

Implementation Concept – ARV Programme

- Phased implementation of ART at public hospitals over a three year period
- ART introduced at selected hospitals in three “waves” during this three year period
- Strong national direction, coordination and support for provincial-level implementation
- ART provided in all appropriate public hospitals and CHCs by end of three year phasing period

Implementation Requirements – ARV Options

- Implementation of an ARV programme will fail without adequate planning and coordination
- Key tasks include:
 - Establish strong national and provincial programme implementation structures
 - Strengthen registration and pharmacovigilance functions of MCC
 - Fast-track price negotiation, voluntary and compulsory licensing processes
 - Support continued VCT expansion
 - Collaborations with NHLS
 - Selection of sites for first, second and third wave implementation
 - Rapid and intensive training of selected health professionals who will deliver the intervention

Implementation Support Costs

- Implementation support costs (national and provincial) over 3 years:

Millions of Rands

| | 2003/04 | 2004/05 | 2005/06 |
|---------------|---------|---------|---------|
| 50% Scenario | 48.5 | 77.4 | 86.1 |
| 100% Scenario | 52.5 | 89.1 | 70.3 |

Communications Strategy

- Intensive and active communication will be required at multiple levels from the moment any decision to introduce ARV treatment was taken
- Reinforce key messages:
 - Everyone should know their HIV status
 - Early diagnosis allows early provision of OI prophylaxis
 - Not everyone who is HIV positive needs ARVs
 - Adherence to ART is critical to avoid treatment failure
 - People receiving ARVs have a responsibility to change their behaviour to protect others from infection
 - Disclosing HIV status allows relatives, friends, or community members to offer support and assistance

Omitted Slides

From government study 

Deaths Deferred

Deaths deferred until after 2010 on assumption that ARV therapy leads to 4-5 additional years of “relatively illness-free life”:

- At 20%, 293 000 deaths would be deferred
- At 50%, 733 000 deaths would be deferred
- At 100%, 1,7 million deaths would be deferred.

From government study



Orphans

Without ART, projected 1,8 million orphans between 2003 and 2010. Benefits of ARV therapy in terms of orphans:

- 20% would reduce the number of orphans by 140 000 children
- 50% would reduce the number of orphans by 350 000 children
- 100% would reduce the number of orphans by 860 000 children

From government study

