ANTIRETROVIRAL TREATMENT

MORATORIUM IN THE FREE STATE:

NOVEMBER 2008 – FEBRUARY 2009

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A report regarding the ongoing financial and health crisis in the Free State[1]

Between November 2008 and February 2009 a moratorium was imposed to stop initiating ARV treatment for new patients. There is evidence to suggest that the moratorium was unlawful. In addition it has had dire consequences for people's health and public health in general. For the first two months of the moratorium there was almost no public information explaining the cause of the moratorium, how long it was to last and on how health services were to be managed during this period.

However, in January and February, primarily as a result of pressure from civil society, the Free State and national departments of health began to provide information about the moratorium and committed to addressing it. According to latest communication with the national Department of Health the moratorium will be lifted by 13 February 2009.

BACKGROUND

As a result of an apparent over-expenditure of the provincial health budget, health services in general have been scaled back in the Free State. In particular, the Free State health department took a decision on 3 November 2008 to stop initiating new patients on antiretroviral (ARV) treatment.[2] There is no evidence of any consultation with those who were to be affected by the decision, or of an assessment of what cuts to non-essential expenditure could have been made in order to preserve access to life-saving health care services.

Soon after this decision was taken, the AIDS Law Project (ALP), the Treatment Action Campaign (TAC) and Southern African HIV Clinicians Society (SAHCS) began to receive complaints from concerned health care workers in the Free State. These reports were alarming, resulting in the ALP and TAC undertaking to establish the facts of what was taking place in the Free State. This entailed: (a) writing to the relevant state departments (including the national and provincial treasuries and the national and provincial departments of health) in an attempt to obtain clarity;[3] and (b) visits to various public health facilities in the Free State in order to hear directly from patients, officials and health care workers.[4]

The ALP also received claims that there is a broader budgeting crisis in health. These claims estimate that there has been a total overspend of approximately R10 billion in the financial year 2008/09. It seems that this was caused mainly by over-expenditure in respect of the Occupation

[1] This report was compiled by Adila Hassim, Mark Heywood, Brian Honermann, S'khumbuzo Maphumulo, Agnieszka Wlodarski and Jonathan Berger. The authors would like to express their gratitude to those patients and health care workers in the Free State whose testimonies and interviews – on file with the AIDS Law Project – form the basis of this report. In particular, the authors would like to thank Trudie Harrison, co-ordinator of the Mosamaria AIDS Ministry in Mangaung.

[2] Email from Dr M Tshabalala (Manager, Comprehensive HIV and AIDS Management, Free State) to public sector doctors.

[3] The ALP is still awaiting a response from the Director-General (DG) of Health to a set of questions sent to him in his capacity as the accounting officer. A similar response from the DG of the National Treasury is also outstanding.

[4] The site visits and interviews took place between 2 and 5 February 2009.

Specific Dispensation (OSD) for nurses. It appears that some – if not most – of the provinces mismanaged the implementation of the OSD, resulting in many nurses receiving the OSD even though they did not qualify for it. Inadequate human resource budgets meant that funds had to be found somewhere, resulting in budget cuts for all programmes in the Free State. We have yet to establish how the HIV/AIDS conditional grant could be affected as this is a ring-fenced allocation. We believe that the Ministers of Health an Treasury have an obligation to make public the facts of these issues – not least because they have a direct bearing on people's rights of access to health care services.

IMPLICATIONS OF THE MORATORIUM ON HEALTH

We believe that implementing the moratorium was ill-advised from a public health and human rights perspective. Up until the moratorium was announced, the Free State had – on average – been initiating approximately 1,500 new patients onto ARV treatment each month.[5] This means that during the moratorium an additional 5 000 patients would have been added to already long waiting lists. Analysis provided by the SAHCS estimates that the demand for ARV treatment in the Free State translates into the need to initiate about 2,600 new patients every month.[6]

There are multiple and interlinked implications of the moratorium. The Treatment, Care and Support Technical Task Team (TCS TTT) of SANAC outlined these in a communiqué to the council's Programme Implementation Committee (PIC):[7]

> **No new patients initiated onto ARVs:** As the current South African ARV treatment guidelines only warrant a person starting on treatment in the very late stage of HIV disease (i.e. WHO Stage 4 or with a CD4 count of less than 200), and given the already large unmet need with people on waiting lists, there will undoubtedly be an upsurge of mortality in the areas affected by drug shortages. Additionally there will be more cases of opportunistic infections and hospitalizations as a result of delayed treatment, with their own cost implications and strain on an already overburdened healthcare system.
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> **Patients already on treatment** may face the possibility of having to stop ARV therapy. This is worryingly possible not only in the Free State but also in other provinces where there have been reports of single drug shortages (such as d4T in Mpumalanga). The unavailability of a single drug ordinarily means the discontinuation of ARV treatment, as continued use of the other drugs in the cocktail would encourage the rapid and inevitable development of drug resistance. Interruption of therapy for an individual on ARVs potentially has serious negative consequences, namely the development of drug resistance, the difficulties in adhering to treatment once the drugs become available, and the inevitable deterioration in immunological status (i.e. plummeting CD4 count with attendant complications and development of AIDS depending on the length of interruption and the patient's prior state of health).
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> **Prevention of mother-to-child transmission of HIV (PMTCT):** The non-availability of ARVs threatens the impact and sustainability of the PMTCT programme. In particular, the NSP target of reducing MTCT to 5% will not be attained. Instead, the country is likely to take a huge step backward in moving back up to vertical transmission rates of as high as 25-30%, at a time when the National Department of Health (NDoH) – under the leadership of Health Minister Barbara Hogan – is spearheading a campaign to accelerate PMTCT.

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[5] See NDoH, *National Strategic Plan for HIV and AIDS/ National Comprehensive HIV and AIDS Plan Statistics*, October 2008.
[6] Email from Dr Francois Venter, 12 December 2008.
[7] Communiqué dated 3 February 2009, presented to the PIC meeting of 5 February 2009.

Post-exposure Prophylaxis (PEP) for survivors of sexual assault as well as occupational injuries and exposures: Where facilities completely run out of the necessary ARVs for this vital service, individuals are at risk of seroconverting (i.e. contracting HIV) as a result of their possible exposure to the virus. In addition to preventing avoidable new HIV infections, this may open the state up to damages claims and thus place further pressure on an already strained public health budget.

TB programme: There is unquestionably a link between the rising incidence of TB and the HIV epidemic. Fewer patients with advanced HIV disease commencing ARV treatment will place more people at risk of contracting TB, adding to the pool of TB infected cases, some of which will develop MDR.

Further, the moratorium increases the backlog of patients that are in need of treatment, making it harder to reach all these patients timeously if and when the drugs are made available. The public health sector will require increased capacity in order to catch up. In addition, the moratorium weakens HIV prevention efforts by undermining health seeking-behaviour. Having to wait in queues only to be turned away time and again will deter patients from seeking treatment, further undermining their confidence in the public health system.

As recommended in the TCS TTT communiqué, there needs to be proper communication regarding the crisis, an early warning system developed to ensure sustainable drug supply, and a triage system in place in the event that drug shortages cannot be averted so that those in desperate need are able to access treatment.

These measures were not taken in the Free State. The immediately felt result is pain and loss of life for many individuals in need of ARV treatment, not to mention the indignity of being sent from pillar to post as a direct consequence of poor planning and communication. This report records some of the consequences of the moratorium. The identities of some of the health care workers and patients that were interviewed are kept confidential for their protection.

FINDINGS

The ALP's investigation in the Free State uncovered ten different areas of concern. Our findings are summarised in respect of each area, with each summary being followed by the factual basis upon which the concerns are based. The areas of concern are:

- Ill health and death of patients needing ARV treatment;
- Drug shortages for patients already on ARV treatment;
- No access to CD4 count tests or results;
- Concerns about the accuracy of waiting lists;
- Drug shortages limiting children's access to ARV treatment;
- Donor-funded public-private partnerships operating at capacity;
- Undermining prevention programmes and efforts in the province;
- Lack of counselling and support for patients refused treatment;
- Scaling down of the entire health system; and
- Environment of fear amongst medical practitioners.

1. Ill health and death of patients needing ARV treatment

The moratorium has exacerbated the health problems in the Free State and caused the death of patients. Recent studies conducted in Cape Town have shown that the delay of even two to three

weeks in initiating patients with low CD4 cell counts onto treatment significantly increases the morbidity and mortality of patients.[8] Health care workers have testified that the effect of the moratorium results in the decline of the health of all their patients and the death of some. In addition, there is seemingly no system in place to triage those patients who are in urgent need of treatment, prioritizing their needs over those whose health will not suffer significantly as a result of a short delay in accessing ARV treatment.

I have been visiting doctors more regularly due to my deteriorating health. I am always coughing, feel very tired and suffer from regular diarrhoea. I have no appetite and have lost a lot of weight in the recent past. One of the doctors I visited told me that my condition is becoming worse and that I should be initiated on ARV treatment immediately. ... I am also concerned that I might die if I do not get treatment urgently.

Testimony of Nontsokolo Julia Tantiso, 5 February 2009

Patient "A" recently had surgery to have his appendix removed and is still in recovery. His CD4 count was 42 when it was last tested, but he has not yet been initiated on treatment.

Interview with Patient "A" at Bongani Hospital, 3 February 2009

Patient "B" was recently admitted to Bongani Hospital with both meningitis and tuberculosis. His CD4 count when last taken on 9 January 2009 was 8. He has not been initiated on ARV treatment due to the moratorium.

Interview with Patient "B" at Bongani Hospital, 3 February 2009

Patient "C" had a CD4 count of 165 when his blood was tested on 5 January 2009 at Bothaville Clinic. He was subsequently referred to Virginia Hospital for treatment. Virginia Hospital then referred him to Wesselsbron Hospital, which in turn referred him to Bongani Hospital for treatment. He has still not been initiated on ARV treatment due to the moratorium.

Interview with Patient "C" at Bongani Hospital, 2 February 2009

I have nothing to offer HIV positive patients. I am aware of at least two patients who urgently require ARVs but cannot access them as a result of the moratorium.

Interview with Dr Petro Basson, 2 February 2009

The Mangaung University Community Partnership Programme (MUCPP) ARV clinic has a list of over 100 HIV positive patients who have been turned away from the hospital since the moratorium came into effect. At least three patients have died as a result of being turned away.

[8] A Boulle, P Bock, M Osler, K Cohen, L Channing, K Hilderbrand, V Zweigenthal, N Slingers, K Cloete, F Abdullah, *Antiretroviral therapy and early mortality in South Africa,* Bulletin of the World Health Organisation, September 2008.

Interview with Dr "Z", 2 February 2009

The nurses at the clinics are frustrated – [they] have just been trained to prescribe ARVs and now they cannot do so. Furthermore, they have to face the patients and their families who are getting sicker and even dying.

E-mail from Free State health care worker to SAHCS, 20 January 2009

It is heartbreaking to have to turn people back, some of whom have gone through drug readiness training [and are e]xpecting to get well.

E-mail from Free State health care worker to SAHCS, 13 December 2008

2. Drug shortages for patients already on ARV treatment

One of the reasons advanced for the moratorium is to ensure continuity of care for those already on ARV treatment. However, it seems that the supply of drugs for existing patients is still inadequate. Some of them are being left with an inadequate supply of medication, which, in some cases, has resulted in patients sharing drugs.

Patients have reported that there have been no drugs available to them in Brandfort or Bloemfontein since October 2008.

E-mail from Free State health care worker to SAHCS, 20 January 2009

It now also seems that the medicine for those already on ARVs [is] running out. The ARV pharmacies are constantly borrowing drugs from each other – to the extent that I don't think they know who owes who what any more. At present, the pharmacy at National Hospital only has 3TC stock for two days – and the depo[t] tells us they have not got much either.

The poor patients are also sent from clinic to clinic in search of medicine – making control of drugs almost impossible. Some patients were given private prescriptions for certain ARVs – who knows how many are taking mono or dual therapy because they cannot afford all 3 drugs.

E-mail from Free State health care worker to SAHCS, 20 January 2009

Patient "D" has been on treatment since sometime in 2007. Until recently, she had never had a problem collecting medications. In December 2008 when she attended the clinic she was only given some of her medications as the others were apparently unavailable. On 4 February 2009, "D" attended the clinic for her monthly visit and was told by the sister that they did not have any ARVs for her and that she should return on 9 February 2009 to attempt to collect them.

Interview with patient "D"'s husband, 5 February 2009

Some of the HIV positive patients on treatment are being forced to interrupt their treatment as a result of drug shortages. This may lead to resistance amongst these patients.

Interview with Dr Petro Basson, 2 February 2009

Doctors in Mangaung have to borrow supplies from other facilities to avoid any interruptions of treatment. ARV bottles have to be shared by multiple patients and there is no guarantee of supply.

Interview with Dr "Z", 2 February 2009, and Dr "Y", 2 February 2009

Kaletra for adults is not available which is a problem for patients on Kaletra because we have to disrupt the treatment. This week I also noticed that there is a shortage of AZT. It's currently not available in the hospital [and] the 2 clinics that are being used as assessment sites have a limited supply.

E-mail from Free State doctor to SAHCS, 4 December 2009

3. No access to CD count tests or results

There is some confusion on the current practice regarding the availability of CD4 count tests. In some circumstances, it seems, patients are being turned away when they request or are referred to have their CD4 count tested. In others, while blood has been drawn for a CD4 count, the results of the test are either "lost" or "unavailable" for weeks at a time. In the meantime, patients who should be informed of their general state of health are continually asked to return week after week. Some patients are unable to afford the transport expenses or are becoming discouraged as their faith in the public health system wanes.

[I]n November 2008, I tested for HIV at Freedom Square Clinic and was diagnosed as HIV positive. They also drew blood for a CD4 count and told [me] to come back after a week for the results. When I went back after a week, they said that the results were not available. They told me to come back the following week. When I returned they were still not available.

I felt that it was a waste of time and money to keep returning to the clinic to be told yet again that the results were not available. As a result, I do not know what my CD4 count is at the moment. ...

I do not know of any person who has been able to get a CD4 count test result in the public sector since October 2008.

Testimony of AM, 5 February 2009

In April 2008, I went to Thusong Clinic for a CD4 blood count. When the results came back, I was informed that my CD4 count was 265 at the time.

Thusong Clinic referred me to . . . MUCPP . . . in order to commence ARV treatment. My MUCPP appointment was scheduled for October 2008. ... When I arrived at MUCPP in October 2008, I was told to go back to Thusong Clinic as I did not qualify for ARVs because my CD4 count was above 200. When I returned to Thusong Clinic, the nursing staff told me that they could not assist me any further. They did not draw blood for another CD4 count, even though 6 months had elapsed since my last CD4 counts was done. ...

About three weeks ago, I developed a rash on my body and was generally not feeling well. I was also losing a lot of weight. I decided to go to Thusong Clinic again for medical assistance. Blood was drawn from me by the nursing staff. I was told that the blood was going to be analysed at the laboratory for a CD4 count and that I had to return for the results a week later.

When I recently went back for the results on Monday 26 January 2009, I was told that my blood test results had been lost. On 29 January 2009, I went back to the clinic for blood to be drawn again and was told to return after two weeks.

Testimony of MI, 5 February 2009

I have been advised that as part of the moratorium, public sector facilities have stopped conducting CD4 tests. I understand that CD4 tests will only be resumed if and when the moratorium is lifted in the next financial year. In addition, some of our clients who have managed to have blood taken for CD4 tests at public sector facilities have yet to receive their results.

Interview with Trudie Harrison, co-ordinator, Mosamaria AIDS Ministry, 2 February 2009

4. Accuracy of waiting lists

The NDoH has confirmed that there are approximately 15,000 people currently waiting to be initiated onto ARV treatment in the Free State.[9] As noted earlier, the waiting lists in the Free State have historically been long. However, it is not clear what criteria are being used to place people onto the waiting lists, and subsequently whether these waiting lists give an accurate reflection of the unmet need in the province.

As discussed above, the moratorium has also resulted in no knowledge of patients' CD4 counts, either because patients are being refused access to CD4 count testing or because the results are being withheld or lost. If the waiting list is only for those who are eligible to initiate ARV treatment in accordance with the National ART Guideline (generally, a CD4 count below 200), the fact that Free State public health facilities have stopped performing routine CD4 count tests for patients who test HIV positive calls into question the accuracy of the waiting lists.

Likewise, as is discussed below, ARV treatment sites have instructed testing centres that they are no longer to refer patients for initiation of ARV treatment. As a result, those patients who are not being referred but may in fact require access to ARV treatment are not even being placed on any

[9] Communication by the DG, SANAC PIC teleconference (9 February 2009)

waiting list. They will only be able to be put on a waiting list if and when the moratorium is lifted.

> *It is difficult to know how many patients are awaiting treatment [because] the clinics [are] not booking any new cases apart from the patients [in line with the moratorium] who are being given priority to start treatment.*
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> **E-mail from Free State doctor to SAHCS, 4 December 2009**
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> *It was stated that there are no new referrals from clinics to Bongani Hospital's ARV clinic as the testing sites have apparently been ordered to stop referring patients on.*
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> **Interview with Free State health care worker, 2 February 2009**
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> *Shortly [after I became aware of the ARV moratorium] … Mosamaria was instructed by the public clinics not to refer any more of our clients who tested positive to the public sector ARV treatment programme run at these clinics. We are only permitted to make referrals for the treatment of opportunistic infections (such as tuberculosis) and sexually transmitted infections (STIs).*
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> **Interview with Trudie Harrison, 2 February 2009**

5. Drug shortages limiting children's access to ARV treatment

While the moratorium that was issued on 3 November 2008 states that "no new clients should be started on ARVs except for pregnant women in the PMTCT program, that includes their babies",[10] it seems that – as with adults – the Free State is limiting access to ARV treatment for children. In one case of which we are aware, a child has been denied access to treatment on the basis of the moratorium. Even in cases where children are prescribed ARV treatment, pharmacies are often out of stock of paediatric formulations. Additionally, the lack of access to ARV treatment for parents endangers children. This is because young children's continued good health is often dependant on them having healthy parents.

While the terms of the moratorium state that pregnant mothers may have access to ARVs through the PMTCT programme, it is unclear whether this includes access to ARV treatment itself (as the most effective form of PMTCT). Under both the old and new PMTCT protocols, pregnant women in need of ARV treatment – at CD4 counts of 200 and 250 under the old and new protocols respectively – are supposed to be initiated on ARV treatment. It is unclear whether such women are in fact accessing such treatment, or whether access to PMTCT is limited to single-dose nevirapine or "dual therapy" protocols.[11]

> *I am afraid that if my condition continues to deteriorate, I will not be able to work in order to support my child and meet my other financial commitments. I am also*

[10] Email from Dr M Tshabalala, 3 November 2008.

[11] Even if such women are indeed accessing ARV treatment, this only assists mothers whose HIV positive status was established during their pregnancies.

concerned that I might die if I do not get treatment urgently. If I die, my child will not have a proper support structure.

Testimony of Nontsokolo Julia Tantiso, 5 February 2009

In Pelonomi and National Hospitals, 3TC was not available resulting in child patients having to share doses. In December, there was no access to Kaletra for a two week period for children and again, at the time of the interview, Kaletra was again out of stock.

While treatment for children is still prescribed, when the children attempt to fill the prescriptions at the pharmacy they are turned away due to the shortage.

Interview with Paediatrician "X" in the Free State, 4 February 2009

At least one HIV positive child was told that there were no ARVs for him at MUCPP in Mangaung.

Interview with Doctor Petro Basson, 2 February 2009

6. Donor-funded public-private partnerships operating at capacity

As a result of the moratorium, patients who would ordinarily have been initiated onto ARV treatment in the public sector have been referred to various donor-funded public-private partnerships such as Prime Cure's PEPFAR-funded programme and the Tsepang Trust. These programmes, however, are constrained by limited resources and capacity. In fact, they are already operating at capacity. As a result, patients referred to these programmes are now being turned away without being initiated onto ARV treatment.

We do have 2 private ART Sites here in Bloemfontein run by Prime Cure, which is part of the Netcare Hospital Group, and is funded to supply free ARVs by PEPFAR. They cannot keep up with the huge number of people seeking ARVs who have CD4 counts way below 200. Last week when I was at one site with a child needing ARVs, the people who were sitting waiting were so emaciated and sick and weak, it was heartbreaking to see.

Email from Trudie Harrison, 15 December 2008

The ARV clinics are overcrowded. Donor-funded private organisations such as Prime Cure are now also turning away patients who require ARVs as they do not have sufficient funds. Patients are therefore turned away regularly.

Interview with Dr Petro Basson, 2 February 2009

The Prime Cure ARV clinics cumulatively have a 1 500 patient capacity. Each clinic has a specific number and group they cater. Prime Cure is run by Netcare and it runs its ARV programme in collaboration with the DoH. The programme is currently

financed to run for 18 months, after which the patients are to be referred back to the public health care system to access their ARVs.

All the clinics, with the exception of the youth clinic, are running at maximum capacity and cannot accept any more new patients.

Interview with "E", a registered nurse at Prime Cure, 5 February 2009

One of the doctors I visited told me that my condition is becoming worse and that I should be initiated on ARV treatment immediately.

I was then referred to another doctor who suggested that I should contact an organisation called Tsepang Trust in Johannesburg and request that I be admitted onto their ARV programme. This was surprising as I expected to be treated in the public sector at one of my local clinics or hospitals.

When I contacted Tsepang Trust, I was informed that they are not able to take any new clients who require ARV treatment. I have now learnt that public sector clinics and hospitals in the Free State have stopped initiating people on ARV treatment.

Testimony of Nontsokolo Julia Tantiso, 5 February 2009

7. Undermining prevention programmes and efforts in the province

The moratorium on initiating new patients onto ARV treatment has an impact on other health services, not the least of which is the HIV prevention programme. Convincing people to test for HIV has been a difficult battle with which the country still struggles. When ARV treatment is not available, it reduces the incentives that patients have to volunteer for an HIV test and undermines confidence in the public health system generally. The longer the moratorium continues, the more public confidence in the health system will be reduced, and the harder it will be to regain the trust of patients who have not yet tested for HIV.

For as long as the moratorium continues, it will become increasingly difficult to convince people to test for HIV. Ultimately, this will undermine HIV prevention efforts in the Free State, leading to a greater need for ARV treatment in the future.

Email from Trudie Harrison, 15 December 2008

There is much publicity encouraging people to test and now there is no capacity to provide treatment.

Interview with "E", a registered nurse at Prime Cure, 5 February 2009

8. Lack of counselling and support for patients refused treatment

When a patient is referred for ARV treatment in the public sector, the process of treatment readiness

involves several weeks of counselling and support for patients' mental and emotional health. Currently, however, people referred to ARV clinics – who would have just learned their HIV status and would ordinarily benefit from counselling – are being turned away without receiving any such support. This results in patients not only having to cope with being diagnosed HIV positive in the absence of knowledge of their actual health status (with no access to CD4 count tests), but also dealing with a public health sector that is unable to provide the treatment that they may very well need.

> *In some places, if someone who has tested HIV [positive] is referred to a clinic, they are told that there is nothing that they can do for them and they are sent away – not even given any counselling or psychosocial support.*
>
> **Email from Trudie Harrison, 19 January 2009**

9. Scaling down of the entire health system

In the rush to curtail expenses after the Free State health department realised its budgeting failures, the moratorium it issued scaled back more than just the ARV treatment programme. It rather scaled back "almost all [health care] services … because of budgetary constraints".[12] Unfortunately, this cutting of services seems to have been done with little regard to whether a particular service is essential or lifesaving.

The result raises two concerns. First, bed cuts have been put into effect on top of the cut back in ARV treatment services. This is self-defeating as the scale back in the provision of ARV treatment and other essential services will actually increase the need for hospitalisation due to the increased vulnerability of people with HIV/AIDS to opportunistic infections and slower recovery times for patients who don't have access to treatment.

Second, patients are being told that they must pay either pay for their own medication or go without, even in the context of tuberculosis (TB) where the inability of patients to adhere to treatment has resulted in the development of multi-drug resistant and extensively drug-resistant TB.

> Beds in Universitas Hospital have been substantially cut, resulting in the hospital taking on fewer referral patients, particularly for elective surgery. There are now waiting lists to be admitted to the hospital.
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> **Interview with Dr van Zyl, 4 February 2009**
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> At Bongani Hospital and in Bloemfontein, almost 50% of the beds have been cut since November 2008. Patients are unable to be admitted as a result. The hospital is currently operating at 50% capacity and the outpatient unit has been closed.
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> **Interview with medical practitioner "W", 3 February 2009**

[12] Letter from MEC for Health, Free State to TAC, 26 January 2009.

The lack of ARVs is a big problem as, when they are not available, other opportunistic infections will set in. The shortage of ARVs has become a source of many other health related problems and diseases.

Interview with Dr Petro Basson, 2 February 2009

The cut backs are also affecting elective surgery whereby anaesthetists and surgeons are not working at maximum capacity. At the moment, there are no drugs available for bone marrow transplants.

Interview with Dr "V", 2 February 2009

All services offered in state clinics and hospitals have been affected. Many of them have collapsed. To save money, patients' TB treatments were stopped despite the negative impact this decision will have on the overall TB programme.

Interview with Dr "Z", 2 February 2009

When I went back to National Hospital I was told to buy my own medicines. I could not afford the approximately R350.00 that was needed for that medication. As I have already indicated, I earn as little as R1000.00 per month. The earnings depend on my state of health and whether I can report for work. …

On the 4th of February 2009, I went back to my private doctor, Dr Mokeki and tried to purchase ARVs with a once off donation of R300.00. Dr Mokeki was reluctant to initiate treatment for me because he was concerned about how I would be able to afford treatment in [the] future. He then referred me back to Chris de Wet Clinic so that I could access free ARVs. When I went to the clinic they drew blood for a CD4 count and told me to return on 12 February 2009.

Testimony of Nontsokolo Julia Tantiso, 5 February 2009

10.Environment of fear amongst medical practitioners

Few public sector doctors working in the provinces from which we have received complaints are willing to go on the record. Most are fearful of retributive action being taken against them, as happened to public servants such as Drs Pfaff and Blaylock (2008 at Manguzi Hospital, KwaZulu-Natal), Dr Costa Gazi (1999 at Cecilia Makiwane Hospital, East London) and Drs Naude and von Moellendorff (2001 at Rob Ferreira Hospital, Nelspruit, Mpumalanga). We believe that many more complaints and much better information would be available if health care workers were actively encouraged to speak out about their concerns in the public health facilities in which they work.

CONCLUSION

The decision to cut essential health services in the Free State is morally indefensible. For the patients who face such indignity the Constitution holds little comfort. In order to ensure that this calamity does not recur, there are a number of measures that ought to be taken under the direction of the Ministers of Health and Finance.

First, there needs to be an independent investigation into the causes of the financial crisis. This should take place so that the state is accountable to society as constitutionally required. It is also necessary so that we may learn from past errors in order to avoid repeating them. The accounting officers at the national and provincial levels of the department of health, as well as the provincial and national treasuries, have statutory responsibilities to prevent such a crisis from occurring. For this reason, we still request answers to our letters to the relevant officials, so that the facts may be clearly established.

Second, it is imperative that there is transparency when crises such as this occur. Without transparency, it is difficult to work in partnership. We need to remind ourselves of the injunction of the Constitutional Court in the *TAC* case:[13]

> The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its three spheres and the panoply of resources and skills of civil society are marshalled, inspired and led. This can be achieved only if there is proper communication, especially by government.

Third, the fear of victimisation by health care workers for speaking out about the failures of the public health system is unacceptable. This is a hangover from the past leadership of the health department. In order to signal a break with this intolerant past, the Minister of Health should publicly call on health care workers to report problems and challenges, and to assure health care workers that they will not be victimised for so doing. In order to repair the parts of the health system that are failing we need to know where it is failing and work together to fix it.

Fourth, those aspects of the National Health Act, 61 of 2003 that deal with inspection of health establishments and standards compliance should be urgently brought into effect. Section 77 requires that each province should establish and inspectorate for health establishments. In addition section 78 requires the Director General to establish an Office of Standards Compliance 'which much include a person who acts as ombudsperson in respect of complaints in terms of this Act'. There are number of critical functions that are assigned to this office. Both of these sections remain unproclaimed.

Finally, we welcome the announcement that the Minister of Health made at the National Assembly on 9 February 2009 of an investigation into cost-drivers in the health system. However, we believe that this should not detract from the need to establish precisely the cost of meeting the country's health needs, including the growing need for access to ARV treatment. Linked to this are broader concerns regarding the implementation of budgets in a manner that is in accordance with the Public Finance Management Act, 1 of 1999.

[ENDS]

[13] 2002 (5) SA 721 at paragraph 123