Briefing for Meeting with Department of Health

22 October 2009

There are many challenges to the optimal implementation of the HAART and PMTCT programmes, too many to cover productively in this meeting. Therefore we are confining the discussion to certain budget-related issues. That is after all the primary purpose of the Budget and Expenditure Monitoring Forum (BEMF).

We do not have much accurate data on the HAART and PMTCT rollouts, a consequence of there being no proper monitoring and evaluation system in place. One central problem with the Department of Health's provincial HAART enrolment data is that it counts many patients who started HAART but are no longer on the programme. The most accurate HAART data was recently published in the SAMJ but it is only up until mid-2008. The monitoring of the PMTCT programme is even more problematic. Nevertheless we have accumulated sufficient information to identify serious problems. These are exemplified by the Free State. More than half of Free State patients on the programme die before they have start treatment. This is because the median waiting period to initiate HAART is four months. The problem is not confined to the Free State: a study in several Durban facilities found a median waiting period of three months. We have also seen the Free State Integrated Services Team (IST) report. It paints a bleak picture of incapacity, particularly with regard to financial management.

The two main reasons for this in our view are a shortage of human resources and insufficient ARV stocks. To what extent the former affects the latter is unclear. The HR shortage is compounded by vacant positions being unfilled. These appear to us to be primarily budget and expenditure problems. There is either insufficient money to fill posts and purchase ARVs or health department managers do not have the capacity to spend their budgets appropriately or both. We speculate that the nurses' OSD has resulted in a massive shortfall in the health budget and consequently managers are spending goods and services budgets to cover salaries. However there is a lack of adequate information on the OSD as well as how the conditional grants for AIDS are spent. Consequently it is difficult to move beyond speculation.

We have analysed the ARV tender in detail and its relation to the conditional AIDS grants. The ARV tender for June 2008 to May 2010 is well-planned. We have calculated that if its predicted volumes are purchased it can just about meet the NSP treatment targets as specified in the NSP costing annexure (ie it caters for about 800,000 people on treatment by mid-2010). It also provides for improved drug regimens, such as tenofovir and paediatric abacavir, even though these are not yet part of the official DOH published guidelines. This is commendable.

As the table at the end of this document shows, purchasing the predicted tender volumes would cost R4.3b over its two year period, or about 2.1b a year on average. The conditional AIDS grants over this period are R4b and R4.6b in 2008/9 and 2009/10 respectively. While a substantial portion of the conditional AIDS grants goes towards non-ARV costs such as part of the salaries of health workers working on the HAART and PMTCT programmes, condoms, formula milk etc, the bulk of it should be to purchase ARVs. As can be seen from these figures, there should be more than enough money to procure the predicted volumes on the tender.

Yet we have received information that the predicted tender volumes are not being met and that the provincial procurement processes are erratic resulting in regular shortfalls, if not outright stock-outs.

We understand that the Minister of Health had proposed a Vote for Health Campaign towards World Aids Day 2009, with the purpose of scaling up testing, and that this has been endorsed by all SANAC leaders. However, if the current programme challenges for those who are currently accessing care are not dealt with, this campaign's results will be very limited.

Therefore we need the following commitments from the Department of Health:

- **Most critically: A public statement that no government officials will interrupt, delay or halt the initiation of HAART or PMTCT. Furthermore, this statement must reiterate that the memo circulated by David Kolombo in February 2009 is government policy.**
- The amount of ARVs purchased against the tender volume must be made publicly available immediately and updated regularly thereafter.
- The IST reports must be made publicly available so that civil society can assist government with its capacity problems.
- The provincial HIV conditional grant expenditure must be made publicly available and broken down by certain categories, including the amount spent on ARVs, formula milk, condoms and salaries.
- Contract an appropriate institution to develop and implement an effective monitoring and evaluation system for the HAART and PMTCT programmes.

Table 1: Provincial conditional AIDS grants in millions of rands according to last year's MTEF

Province	2008/9	2009/10
Eastern Cape	441	480
Free State	207	275
Gauteng	803	933
Kwazulu-Natal	1,338	1,463
Limpopo	244	301
Mpumalanga	228	272
Northern Cape	352	375
North West	135	145
Western Cape	276	310
Total	4,023	4,554

Table 2: Summary of public sector ARV tender, June 2008 May 2010

Item	Dose	Company	Volume	Total Cost
ABC	240ml	GSK	1,747,000	234,849,210
ABC	300mgx60	GSK	43,000	13,765,590
DDI	25mgx60	Sonke	37,000	2,003,550
DDI	50mgx60	Sonke	26,000	1,464,580
DDI	100mgx60	Sonke	683,000	46,327,890
EFV	200mgx90	MSD	1,104,000	328,130,880
EFV	600mgx30	Adcock	7,000,000	756,210,000
EFV	600mgx30	Aspen	3,000,000	347,880,000
3TC	240ml	Aspen	3,138,000	67,184,580
3TC	150mgx60	Aspen	9,735,200	290,887,776
3TC	150mgx60	Sonke	2,433,800	72,794,958
PEP Starter	3TCx6,AZTx18	GSK	15,000	855,000
3TC/AZT	150mg+300mgx 60	Aspen	20,000	1,835,800
3TC	300mgx30	Cipla	1,601,000	68,042,500
Lop/Rit	5x60ml bottle	Abbott	1,066,000	340,128,620
Lop/Rit	133.3mg&33.3 mgx2x90	Abbott	256,000	81,681,920
Lop/Rit	200mg&50mgx 120 HS	Abbott	617,000	196,823,000
NVP	20ml	Cipla	10,000	128,000
NVP	240ml	Aspen	45,000	1,633,500
NVP	200mgx60	Aspen	8,801,000	282,600,110
Ritonavir	90ml	Abbott	50,000	3,186,500
Ritonavir	100mgx84	Abbott	200,000	14,888,000
D4T	15mgx60	Aspen	489,000	8,288,550
D4T	20mgx60	Aspen	770,000	13,051,500
D4T	30mgx60	Aspen	8,728,000	147,939,600
D4T	30mgx60	Sonke	2,182,000	38,512,300
TDF	300mgx30	Aspen	3,687,000	588,039,630
AZT	20ml	Aspen	731,000	9,393,350
AZT	200ml	Aspen	200,000	4,530,000
AZT	100mgx100	Aspen	70,000	4,957,400
AZT	300mgx60	Aspen	4,000,000	284,360,000
Total				**4,252,374,294**