

BUDGET AND EXPENDITURE MONITORING FORUM

Fax: +27 (0)11 339 4311 Email: bemforum@gmail.com Mail: PO Box 32361 Braamfontein 2017

Founding members: ALP, CAPRISA, DENOSA, ECHO, Equal Education, Free State AIDS Coalition, HST, NEHAWU, PSAM, Southern African HIV Clinicians Society, TAC

10 September 2009

Dr Aaron Motsoaledi
Minister of Health
Private Bag X399
Pretoria 0001

Per Fax: 012 325 5526 and 021 465 1575

Dear Minister Motsoaledi

CONCERN ABOUT AIDS PROGRAMMES

We write as a forum of organisations concerned about the provision of health care in the country and particularly the provision of health care services to HIV-positive people. The founding members of the forum are the AIDS Law Project (ALP), Centre for the AIDS Programme of Research in South Africa (CAPRISA), Democratic Nursing Organisation of South Africa (DENOSA), Enhancing Children's HIV Outcomes (ECHO), Equal Education, Free State AIDS Coalition, Health Systems Trust (HST), National Education Health and Allied Workers Union (NEHAWU), Public Service Accountability Monitor (PSAM), Southern African HIV Clinicians Society and the Treatment Action Campaign (TAC).

This letter raises problems with current budget, expenditure and management practices on health care delivery with a focus on the highly active antiretroviral treatment (HAART) and prevention of mother-to-child transmission (PMTCT) programmes. It requests steps be taken to remedy them.¹

At the outset we wish to emphasise that we appreciate fully that these problems are not of your making and that you have demonstrated commitment to addressing them. We wish to work with you to achieve this.

Concerns related to the provincial health budgets

In the last financial year, several budget-related decisions were taken which we believe led to violations of the Constitution, the National Health Act (NHA), the Public Finance Management Act (PFMA) and the Promotion of Administrative Justice Act (PAJA). One of these was the moratorium on the initiation of new patients onto HAART in the Free State that began in November 2008 and continued through March 2009. The Southern African HIV Clinicians' Society estimated that at least 30 lives a day were lost as a result of the moratorium alone, not taking into account cutbacks to other services as well.

At the Free State Health Summit that was held from 16-17 July 2009, representatives of the Free State Department of Health announced that, due to financial constraints, it is expected that a new moratorium on initiating patients onto HAART would be implemented in September 2009, unless additional funds were made available from National Treasury. This is distressing.² We have received several reports, which reveal that the health system is under considerable strain as a result of a lack of sufficient financial resources and administrative competency. These reports include:

- There are widespread instances of medical goods stock-outs, including antiretrovirals (ARVs), TB medications, cotrimoxazole, vaccinations and shortages of infant formula at both clinic and hospital levels.
- The service at some Free State PMTCT facilities is inconsistent, with cases of HIV-positive

1 Even though the TB epidemic is closely linked to the AIDS one, we have deliberately left out our very serious concerns about TB. We will address these with you at another stage.

2 Pleasingly, in a meeting on 8 September between the MEC for Health and members of the Free State AIDS Coalition, the MEC gave assurance that there would be no moratorium.

mothers and their babies not receiving ARV prophylaxis.

- Waiting lists for initiating new patients onto HAART have grown with some patients having to wait for many months to be initiated, regardless of their CD4 counts and the urgency of their situation.
- The public sector tender volumes are not being filled. We have received reports that some provinces are handling procurement poorly and ordering erratically.

Some members of our forum, who work in the health system, have seen the consequences of this directly. For example, in one incident a patient died in the car of one of our members after being repeatedly turned away from the public health sector.

We also note that, while we understand that the flawed implementation of the occupation specific dispensation (OSD) for nurses has significantly contributed to over-expenditure of provincial health department budgets, these over-expenditures should not be allowed to impact programmes funded primarily through conditional grant allocations, such as HIV treatment and prevention programmes.

Concerns about failing to fill the volumes provided for in the public sector ARV tender

The latest reliable estimate of the number of people on ARV treatment in the public health system is about 450,000 as of July 2008. About 770,000 people eligible for treatment, according to current guidelines, were untreated at that time.³ The HIV & AIDS and STIs Strategic Plan, 2007 – 2011 (NSP) anticipates a need of approximately 700,000 people to be on treatment in the public sector by the end of the current financial year. Our calculations of the quantities of medicines to be purchased in the current public sector ARV tender allows for a nearly sufficient amount of drugs to cover this need. It also provides for much needed improvements to ARV treatment regimens, specifically the addition of tenofovir and abacavir.

However, we have learned that the quantities of drugs provided for in the tender are not being purchased, particularly (but not exclusively) in relation to these new drugs. This can only mean that far fewer people are accessing treatment than are provided for in the tender and the funds made available through the Comprehensive HIV and AIDS Grant (HIV Conditional Grant). Furthermore the treatment guidelines have not been published since 2004 so many health workers are reluctant to prescribe tenofovir and abacavir even though they are provided for in draft guidelines.

Concerns about integrity of essential health systems data

The monitoring and evaluation of the HAART and PMTCT programmes is inadequate. Not even the number of patients participating in these programmes is known with any confidence, let alone more sophisticated data, such as median CD4 counts, viral loads, regimens used etc.⁴

We have also learned that the data on the public health system's personnel system is unreliable and out of date. Even though there were plans to correct it in 2000, this has never been done. This in part contributed to the OSD problem.

3 Adam MA and Johnson L. 2009. Estimation of adult antiretroviral treatment coverage in South Africa. *SAMJ*. September 2009, Vol. 99, No. 9. Note that the latest estimate of 743,000 on treatment by the Department of Health includes data from some provinces that report cumulative number of people on treatment and is for this and other reasons unreliable.

4 See for example, Mate et al. *Challenges for Routine Health System Data Management in a Large Public Programme to Prevent Mother-to-Child HIV Transmission in South Africa*. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=19434234>. This study examined 316 health facilities in Kwazulu-Natal. The abstract states, "Data elements were reported only 50.3% of the time and were 'accurate' (i.e. within 10% of reconstructed values) 12.8% of the time. The data element 'Antenatal Clients Tested for HIV' was the most accurate data element ... 19.8% of the time, while 'HIV PCR testing of baby born to HIV positive mother' was the least accurate with only 5.3% of clinics meeting the definition of accuracy."

Conclusion

It is apparent that there are a number of concerns in relation to budgeting and expenditure for health. We recommend that the following steps be taken:

1. Make public all the reports drafted by the Integrated Support Team (IST) earlier this year. We believe that these reports contain information that is crucial for members of the public to know, particularly as the 2010/11 budgeting process has started.
2. The National Department of Health must ensure that no further moratoriums take place in any of the provinces. Provinces at risk of resource constraints should be identified and supported.
3. Monitoring and evaluation of the provincial HAART and PMTCT programmes must be prioritised. While it is clear the entire public health system is under strain, these programmes, when properly implemented, will ease the burden on public hospitals and clinics.
4. The volumes provided for in the ARV tender must be filled so that the NSP target for this financial year can be met. We also urge you to consider mechanisms to be built into the ARV tender to take advantage of new technological developments.⁵

The member organisations of our forum are willing to work with and assist you in fulfilling the above requests.

Sincerely

Vuyiseka Dubula
General Secretary
Treatment Action Campaign

Mark Heywood
Executive Director
AIDS Law Project

Francois Venter
President
Southern African HIV Clinician's Society

Kabelo Makhetha
Free State HIV/AIDS Coalition

Jeanette R Hunter
CEO
Health Systems Trust

Colm Allan
Director
Public Service Accountability Monitor

Sheila Barsel
Health Researcher
NEHAWU

⁵ For example, a generic company (Matrix Laboratories) has developed two complete ARV regimens that only have to be taken as one pill once a day. These products are approved by the US FDA for use in PEPFAR programmes. The company, according to the Clinton Foundation AIDS Initiative, will sell one of them at \$17.50 per patient per month and the other at \$19.92 (about R140). These are competitive with the current 1st-line. They are both better regimens, more convenient for patients and it is easier to manage stocks of combination pills. These drugs are not registered in South Africa, there are unresolved patent issues and they are not provided for in the public sector ARV tender, but none of these should be insurmountable problems. Other generic companies would likely produce similar regimens if the Department of Health showed interest in purchasing these on the ARV tender.