Brochure A3 folded down to A5. (Like the Talk about ARVs brochure)
Front cover.

meet the NSP targets for HIV/TB

treatment prevention

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Why we need more resources for health

TAC
TREATMENT ACTION CAMPAIGN

Join our march on

19 July, 4pm from Kaizergracht to the Convention Centre

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Why we need more resources for health

5 million people live with HIV in South Africa. About 500,000 people are infected each year, 60,000 of whom are infants.[1]

Life-expectancy has dropped to about 50 years. Because of the HIV epidemic, Tuberculosis (TB) has become the biggest cause of recorded deaths and TB deaths have tripled over the last decade. The HIV epidemic is large and relatively new. Consequently it is the biggest challenge to our health system. Effectively responding to the HIV epidemic will improve health delivery for other infectious diseases as well as cancer, heart disease and diabetes. Improving HIV programmes will benefit people without HIV too.

The HIV/AIDS National Strategic Plan (NSP) set targets to treat 80% of people who need ART by 2011, to give 95% of women access to prevention-of-mother-to-child transmission (PMTCT) services by 2011, and reduce new HIV infections by 50% by 2011. It is essential that we achieve these targets to reverse the decline in life-expectancy caused by AIDS and to alleviate its heavy burden of opportunistic infections on our health system.

The Constitution says everyone has the right to access health care services, including reproductive health care. It also says the state must take measures, within its available resources, to achieve the progressive realisation of this right. Furthermore, the ANC has promised to prioritise health-care and education.

We are marching to highlight the challenges of meeting the NSP targets and improving the HAART and PMTCT programmes, challenges that can only be overcome by increasing and better using resources for health. We are ready to work with the national and provincial health departments as well as other relevant government institutions to meet these challenges.

1. ASSA2003. See http://www.tac.org.za/community/files/SummaryStatsASSA2003.xls

meet the NSP targets for HIV/TB
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Our goal: Achieving the NSP treatment and prevention targets

Next page:
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meet the NSP targets for HIV/TB

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Our goal: Achieving the NSP treatment and prevention targets

How this goal can be met:

1. Scaling up treatment

We must ensure that the ART rollout is sufficiently funded and properly managed to meet the NSP targets.

As of mid-2008, about 600,000 patients had access to life-saving antiretroviral therapy (ART). This is a considerable achievement. South Africa has the biggest public sector ART programme in the world. But this is less than half the number of people who meet the Department of Health's criteria for initiating treatment.[2]

There are many challenges to the ART roll-out. In late 2008, the Free State instituted a moratorium on providing ART to new patients. The moratorium has since ended, but about 30 additional people died a day while it was in place.[3] Reports that TAC receives from the Free State indicate that even now, the effects of the moratorium continue to be felt. Across the country there are long waiting lists for ART. Drug shortages regularly occur. Research from the Free State shows that the vast majority of people who die on the ART programme do so while waiting for their treatment to commence. An important study conducted in the Free State showed that 87% of people who died while enrolled in the public ART programme in the province were not accessing ART.[4] Furthermore, the Department of Health is currently R1 billion short of the amount needed to meet the NSP's targeted number of people on ART for 2009.

2. PMTCT

The monitoring and evaluation of the PMTCT programme must be improved.

The implementation of the PMTCT programme beyond pilot sites began in 2002. Evidence from some sites, including Khayelitsha, shows that it is has prevented many paediatric infections and therefore saved many lives.[5] Many women have initiated treatment because of the PMTCT programme.

However, the monitoring and evaluation of the programme need to be improved. The data that is available shows that uptake is often low and that there is great variability in the quality of the programme across the country. The PMTCT programme is an opportunity to get more women onto treatment and thereby make progress to achieve the NSP treatment target. However, low uptake of the programme means this opportunity is often lost. In addition to this, TAC's district offices frequently encounter inconsistent supplies of formula milk to women who choose this method of feeding.

To meet the NSP's prevention target, the PMTCT programme needs to be implemented very well. We can only adequately identify areas for improvement if the monitoring and evaluation of the programme is improved and regular accurate progress reports on PMTCT are produced.

3. Other improvements to the HIV and TB programmes

There are many ways to improve the HAART, PMTCT and TB programmes. We can take advantage of new scientific developments to improve the health of people with HIV and make the NSP more effective. These interventions require resources, but they also offset costs to the state by reducing opportunistic infections, reducing new infections and improving the health of people. Here are three important examples (there are many more):

A. Early Treatment for HIV-positive infants

The CHER study was conducted in South Africa. It is one of the most important studies on HIV in recent years and demonstrates the excellent quality of our country's HIV scientists.

The study showed that by treating infants with HIV aged under one year as soon as they are diagnosed, we can reduce their mortality from 26% to 4%, a four-fold, or 75%, improvement.[6] The WHO and US guidelines recommend early infant treatment on the basis of this study. This intervention will save many lives and help us get nearer the NSP treatment target. It is already being implemented in some facilities, but many doctors and nurses are reluctant to implement its recommendations without the protocol being updated.

One reason why early infant treatment has not yet been implemented across the country is that new Department of Health ART treatment guidelines have not been published since 2004.[7] As a result, new, life-saving scientific developments such as this one are seldom implemented in the HAART and PMTCT programmes. Patients therefore miss out on their potential benefits.

B. Changing the ART initiation criteria

Several studies have shown that mortality in people with HIV can be reduced if they initiate ART when their CD4 count drops to 350/mm^3 instead of 200.[8] Currently, because of long waiting lists and patients presenting late for treatment at healthcare facilities, most patients initiate ART with a CD4 count in the region of 100.[9] So this intervention on its own will only benefit patients who find out their status early. But coupled with public information campaigns that advertise the benefits of getting tested and which include treatment for HIV-positive people when appropriate, many more patients can benefit if this change to the ART initiation criteria is made.

While it is true that this will increase the cost of the HAART rollout, it will also reduce opportunistic infections and new HIV infections. This is because people on ART are less infectious and people who know their status are less likely to have unsafe sex, especially if they receive good quality counselling through voluntary counselling and testing programmes (VCT).[10]

C. Integrating the treatment of HIV and TB

A study conducted by a South African research institute has found that mortality in TB patients who are HIV-positive can be greatly reduced by starting ART with TB treatment.[11] The TB and ART treatment guidelines should be changed to reflect this finding.

It is much easier to implement this intervention in facilities that treat TB and HIV together. This means that patients do not have to travel to two facilities and consult with two sets of health workers to be adequately treated. It is therefore a priority to encourage health departments to integrate the management of TB and HIV.

A further advantage of integrating the management of TB and HIV in clinics is that many patients diagnosed with TB are also HIV-positive but do not know their status. If HIV treatment is offered at TB facilities, this will encourage health workers to offer VCT and patients to test.

4. Task-shifting

We are more likely to meet the NSP targets if healthcare is decentralised. This means making ART more available at primary care level facilities and expanding the roles of health workers. The models used in Khayelitsha and Lusikisiki have demonstrated that this can work.

This is a significant challenge but one that government can meet partly through task-shifting in clinics, but taskshifiting is not currently policy in South Africa. The Department of Health should formalise the role and employment of community health workers to engage them in task-shifting, and make the necessary policy changes to empower nurses to initiate, treat and manage ART.

This will expand the role of nurses and community health workers in assisting to meet the NSP targets, especially in rural areas where shortages of heath workers are most acute. The recent doctors' strike has drawn attention to the human resources crisis and the difficult working conditions in the public health sector. Task-shifting will allow creative ways and optimal use of the existing limited professional human resources, including those offered by community health workers.

This will improve access and adherence to treatment, and is also likely to have cost-saving effects.[12]

5. Financing and managing the health system and the NSP

Meeting the NSP treatment and prevention targets is a difficult challenge. The health system is underfunded and existing funds are being spent sub-optimally. The provincial health budgets are not needs-based. Identifying the exact nature of the budget and expenditure problems is a challenge in itself. TAC understands that resolving these problems is difficult. To assist the Department of Health to address these challenges, over the next few months we will work with partner organisations to improve our own understanding of health budgets.

In this regard, an integrated support team made up of finance and health systems specialists led by Deloitte and Touche has produced 10 reports; one on each provincial health department and one on the national department. These reports can help us understand and rectify the financing and managerial challenges in the public health system. They need to be made public.

TAC and our partners also support the concept of National Health Insurance (NHI). The details of NHI need to be discussed and negotiated. All of us (in civil society and in government) need to improve our understanding of the various ways of implementing NHI. NHI, properly implemented, will help relieve the resource problems facing the health system. But NHI can only be properly implemented if we address the most serious problems of the public health system, including managerial capacity.

We are in a recession and there are many capacity problems in the public health system. TAC understands this and sympathises with the difficult choices the state has to make. But the health of people in South Africa is a priority according to the Constitution as well as the ruling party which has received a clear mandate to improve health and education. The state, the private sector and civil society have to work together to ensure the resource challenges for health are overcome and that we achieve the NSP targets.

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2 Presentation by Leigh Johnson, SA AIDS Conference. See: http://www.i-base.info/htb/v10/htb10-5-6/4th.html

3 30 people died a day during the moratorium according to the Southern African HIV Clinicians Society.

4 Fairall L. R. et al. 'Effectiveness of antiretroviral treatment in a South African program: a cohort study', Arch Intern Med. January 2008 14; 168 (1): 86 – 93.

5 See presentation by Virginia Azevedo at http://www.tac.org.za/community/files/KhayelitshaCapeTownCityCouncil-July2007.pdf

6 Violari, A. et al. Early antiretroviral therapy and mortality among HIV-infected infants. N Engl J Med. 2008 November 20. 359, 2233-44. http://www.ncbi.nlm.nih.gov/pubmed/19020325

7 A few protocol changes have been introduced via memorandums. E.g. AZT has been introduced to the PMTCT programme.

8 See URL: http://www.i-base.info/htb/v10/htb10-3-4/when.html.

9 Ford, N. et al. 'Rationing Antiretroviral Therapy in Africa – Treating Too Few, Too Late', N Engl J Med. 30 April 2009. 360,1808-1810.

10 We acknowledge that this improvement to the HAART programme has implications for the 1st-line treatment regimen because initiation of HAART with nevirapine is contra-indicated in women with CD4 counts > 250. But this is not an insurmountable obstacle.

11 Abdool Karim, S. et al. Initiating ART during TB Treatment Significantly Increases Survival: Results of a Randomized Controlled Clinical Trial in TB/HIV-co-infected Patients in South Africa. 2009 February. http://www.retroconference.org/2009/Abstracts/34255.htm

12 Lehmann U. et al. 'Task shifting: the answer to the human resources crisis in Africa?', Human Resources for Health, June 2009, 7:49.

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Join our march on

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