Why TAC is protesting

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A health system in crisis and without leadership: A TAC briefing sheet

23 August 2006

On 19 November 2003 the Department of Health published the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (Operational Plan) that included the rollout of treatment. This was the culmination of a long and difficult TAC campaign. Antiretrovirals are now available at clinics in every district and the mother-to-child transmission prevention programme has been rolled out to over 1,600 of the approximately 4,000 health facilities. Government estimates that there are over 160,000 people on treatment. So why is TAC dissatisfied? There are numerous reasons.

The central problem is poor political leadership. The Minister of Health, appointed and supported by President Mbeki, promotes pseudo-science and has failed in every critical aspect of her job. The consequences of this have been a poorly implemented care and treatment programme, poorly implemented mother-to-child transmission prevention programme, a failed prevention programme, an escalating human resources crisis in the health system, obstructionism in the Durban Westville court matter and the pervasiveness of charlatans offering unproven remedies for HIV/AIDS.

Poorly implemented treatment and mother-to-child transmission prevention programme

The Actuarial Society of South Africa (ASSA) estimates that about half-a-million people have AIDS but are not on antiretroviral treatment. The Operational Plan set several targets for the number of people on treatment in the public sector. Everyone of these has been missed - by far. The target for the year ending March 2006 was over 381,000. Even by government's own estimate, we have only reached 40% of the target.

Furthermore, the programme has no properly implemented nationally co-ordinated monitoring and evaluation mechanism in place. So we can have no confidence in government statistics of the number of people on treatment. This is not just scepticism for the sake of it. The pharmaceutical company that sells most of the drugs to the public sector through the state tender has released its sales figures. The amount of antiretrovirals it has sold to government appears to be far lower than possible if 160,000 people are on treatment.

Many health workers are working extremely hard to make the treatment rollout work. Their efforts should be commended. They justifiably complain that people are getting tested too late. From studies of antiretroviral pilot sites and laboratory data, it appears that most patients get tested when their CD4 counts are below 100 and they are desperately ill. It requires substantial health worker time and resources to save patients in this situation. If people with HIV got tested much earlier they could be treated earlier with far fewer complications. This would result in better patient outcomes and a lighter burden on the health system. But there is no systematic effort by the Minister of Health, the President or any Cabinet minister to encourage people to get tested for HIV and to get treated.

The Minister of Health frequently exaggerates the toxicity of antiretrovirals. This is ironic considering the failure of the Medicines Control Council (MCC) to register new and better antiretrovirals, such as tenofovir. The current first line regimen includes a drug called stavudine (aka d4T). While the benefits of this drug outweigh its risks, it is associated

with more common and serious side-effects than most other antiretrovirals. It commonly causes peripheral neuropathy, which albeit not fatal can be debilitating. More seriously it causes lactic acidosis in a small number of patients, particularly overweight women. This condition has a high fatality rate. Tenofovir has a much better side-effect profile and should replace stavudine in the first-line regimen, at least for some patients. Yet, despite it being available in the United States and Europe for years, it is available in South Africa only under special authorisation from the MCC on a patient-name basis. This is a further example of the growing incompetence of a regulatory institution that is supposed to be independent but is actually underfunded and beholden to the Minister of the Health.

The mother-to-child transmission prevention programme by now should have rolled out to every maternity clinic in the country. It is far from attaining this goal. But again, because there is no proper monitoring and evaluation, it is difficult to estimate how many pregnant women actually access the programme. Critically, all provinces outside of the Western Cape continue to use the sub-optimal single-dose nevirapine regimen which reduces transmission by 30 to 50% (to about 8-12% of children born to HIV-positive women). With South Africa's resources we should have moved to a much more effective regimen that reduces transmission to at most 5%. With truly committed leadership, we could even eliminate the paediatric epidemic.

No prevention plan

By the best estimates there are well over 1,000 HIV infections a day. Our HIV infection and incidence rates remain among the highest in the world. HIV prevention efforts in South Africa have been sparse. The Minister of Health talks a lot about prevention being the cornerstone of government's policy, but our prevention efforts have failed. The prevention plan expired in 2005 and there is no new plan. The Khomanani contract has not been renewed and there is hardly any public information campaigning on prevention. No effort has been made by government to bring down the price of the female condom. Most schools remain without proper life-skills education programmes and condoms. Accessing post-exposure prophylaxis is still extremely difficult for most women who have been raped. So clearly the Minister of Health is not serious about prevention.

A human resources crisis without a proper plan to end it

The annually published South African Health Review by Health Systems Trust shows the extent of the human resources shortage in our health system. Nurse and doctor patient ratios in the public sector are extremely high and appear to be getting worse. Precise statistical estimates of the human resources crisis have to be treated with caution because the personnel database system has technical problems. Furthermore, a Human Sciences Research Council (HSRC) survey of four provinces published in 2002 found a nearly 16% HIV infection rate among nurses. The same survey found that morale was low among health workers and that this was due in part to the effects of the HIV epidemic with the consequent effects of increased numbers of patients and increased mortality among them.

The Department of Health has recently published the Framework for a Human Resources Plan. However, the plan is very weak and contains hardly any concrete targets or suggestions; it is mostly empty rhetoric, not a plan. The Operational Plan committed to placing an additional 22,000 health workers in the public health system by 2008, but because there are such poor monitoring systems, there is no way to know if progress is being made to meeting this goal.

South Africa spends more on health care than the average of middle-income countries. But there are great disparities. The private sector, which according to the household survey published last year by the HSRC manages about 20% of patients versus over 70% by the public health system. Yet the private health system consumes more than 50% of health spending. This glaring inequality is at the root of the human resources crisis.

Take Khayelitsha as an example. Khayelitsha probably has better public health care than most of South Africa's townships and rural areas. Yet patients have to queue for several hours to get served. The township has only three health facilities (a fourth is being built) serving over 500,000 people. It really needs ten but there are insufficient nurses and doctors to staff the current clinics, let alone ten.

Catalysts for TAC's decision to return to mass protest

The above problems have been ongoing. But there are two further problems which have compelled TAC to return to mass action: (1) the Westville prison case and (2) the continued support of AIDS denialism by the Minister of Health.

Westville Prison case

Westville Correctional Centre is situated in Durban, KwaZulu-Natal, one of the regions worst affected by the HIV/AIDS epidemic in the world. Many prisoners held at Westville have HIV or AIDS, and many are dying. Fifteen prisoners and TAC represented by the AIDS Law Project took government including the Department of Health and Department of Correctional Services (DCS) to court. On 26 June 2006, Judge Pillay of the Durban High Court ordered government to

?remove the restrictions that prevent... the applicants and all other similarly situated prisoners at Westville Correctional Centre, who meet the criteria as set out in the National Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, from accessing Anti-Retroviral Treatment at an accredited public health facility.... and that [government] is ordered with immediate effect to provide anti-retroviral treatment to the applicants and all other prisoners at Westville.. at an accredited public health facility."

The state appealed this judgment first on the grounds that the judge must recuse himself because his daughter was an attorney that helped to serve papers, and then on the grounds that they are doing enough for inmates with HIV. The Judge granted them leave to appeal but ordered that they must immediately begin the treatment for those prisoners that need it, and that government must produce a plan for the court about how they will do this. The deadline for this order was 14 August. Government refused to produce a plan and they have disobeyed a direct order from the court. Instead they again appealed. This shows a disregard for the rule of law in our country as well as a disregard for the rights to life, dignity and health.

Since the judgment, one of the applicants of the case known as ?MM? has died. He should have been put on treatment last year when his CD4 count was 86. Instead he was only put on treatment in July, three weeks before his death - far, far too late. More than 110 other prisoners died of AIDS in 2005. Prisoners are dying in their cells, and in the prison hospital ward. Many have untreated opportunistic diseases such as TB and thrush. Some of them cannot walk, wash or eat food by themselves because they are so sick.

Since October 2005, the AIDS Law Project and TAC have assisted inmates to access HIV/AIDS treatment. DCS has refused TAC access to prisoners to conduct HIV/AIDS education, treatment literacy and treatment preparedness workshops. It has also refused TAC's offer of help to get antiretroviral treatment to inmates. On 22 August, a few TAC members went to the prison with health care workers to give assistance to prisoners. They were threatened with guns and dogs by the warders and turned away.

State supported AIDS denialism and the abundance of charlatans

Underlying all the above problems is continued support of pseudo-scientific theories by the Minister of Health and the President. This was epitomised at the recent International AIDS Conference in Toronto by the South African exhibition which featured lemon, garlic and African potatoes. The Minister of Health, as she did at the previous International AIDS Conference in Bangkok, made her presence felt by making several pseudo-scientific comments.

The Minister of Health has created a false dichotomy between treatment and nutrition. No-one of repute denies the importance of nutrition, both for people with and without HIV. But nutrition is not an alternative to medicines; for people with HIV, both are needed. Nor can nutrition be simplified to a few products, such as the vegetables promoted by the Minister. For most people in South African faced with food insecurity, the key challenge is not whether to eat

chicken or beef, lemons or beetroot. The key challenge is for poor people to have enough money to buy sufficient healthy food to eat. The Minister has grossly misrepresented the challenge of nutrition. Furthermore, an analysis by the Joint Civil Society Monitoring Forum of nutritional interventions in the public health system found these woefully inadequate. The Minister's rhetoric bares no resemblance to the reality.

The problem of politically supported AIDS denialism cannot be underestimated. It is what lies behind the failures to address the problems of the treatment rollout, implement effective HIV prevention measures and promote early testing. It is also the reason why a plethora of charlatans, including Matthias Rath (high dosage multivitamins), Zeblon Gwala (Ubhejane), Tine van der Maas (garlic concoction), Steven Leivers (Secomet) and many others, sell their unproven products with impunity in South Africa as alternatives to antiretrovirals. The Department of Health has explicitly supported Gwala's Ubhejane and it has been caught red-handed on several occasions colluding with Matthias Rath. These charlatans break the law and endanger lives. It is unacceptable that the Minister of Health has created an environment in which they can thrive.

It is on the basis of continued failed leadership that TAC has returned to mass action and made the following five demands:

1. Convene a national meeting and plan for the HIV/AIDS crisis now.
2. End deaths in prisons - provide nutrition, treatment and prevention.

3. Dismiss Health Minister Manto Tshabalala-Msimang.

4. Respect the rule of law and the Constitution.

5. Health for all - End health Apartheid, Build a People's Health Service.

The cost of denial

The cost of denial can be measured in human lives. We close this briefing with a graph taken directly from Statistics South Africa. It shows the changing age pattern of mortality in South Africa since 1997. Since 2000, more adults have been dying in their 20s, 30s and 40s than at older ages, a perverse occurrence in a modern society. And the situation is getting worse year by year. Behind the deaths depicted in this graph are lost mothers, fathers, brothers, sisters, children and friends. It is the President and Minister of Health who hold primary responsibility for this situation.

Graph taken from Statistics South Africa Changing age-pattern of death in South Africa 1997-2004 (not all 2004 death certificates have yet been processed) P0309.3, May 2006 update

Further reading

- TAC. 2006. Westville Prison. Everyone has the right to life and dignity.
- TAC. 2006. What do South Africa's AIDS statistics mean? A TAC briefing paper.
- Department of Health. 2003. Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.

- HSRC. 2002. The Impact of HIV/AIDS on the Health Sector.
- HSRC. 2005. South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005.
- Actuarial Society of South Africa. 2005. ASSA2003 Summary Statistics.

- AIDS Denialism
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