3rd NSP Report - September, October, November 2010

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Resources for health campaign

Fund the fund

During this period TAC continued to lobby for expanded resources to health. Expanded funding for health is necessary to save the millions of lives of people not yet accessing treatment. During November 2010 UNAIDS released its Report of the Global Epidemic on AIDS, from the report it was clear that the gap between those who need treatment and those who are able to access it remains far too wide. More money is needed to expand treatment programmes for the millions of people still unable to access it. An estimated 33 million people live with HIV worldwide, of these, about 15 million are in need of antiretroviral treatment and only 5.2 million are receiving treatment.

In September, TAC received a grant from the Foundation Open Society Institute that allowed us to accelerate and scale up our resources for health campaign prior to the Global Fund replenishment conference held in October 2010. TAC organised activities during the week prior to the conference that coincided with global activities carried out by partner organisations.

TAC developed briefs explaining the need for full replenishment of the global fund and sent letters to governments calling on them to commit to their fair share. TAC and partner organisations carried out pickets across the globe demanding government uphold their commitments to universal access for HIV treatment, prevention and care.

TAC?s actions targeted the German embassy in Cape Town and the Italian embassy in Johannesburg; both were coordinated with actions by activists in the donor countries.

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During the picket at the German embassy, the Consul General told TAC that Germany remains committed to the fight against HIV and TB, but refused to sign TAC?s memorandum. At the replenishment conference, Germany committed $822.4 billion over three years ? 87% of its fair share. However Germany is currently withholding money citing fears of corruption.

Italy was targeted because the country has failed to make payments to the Global Fund on pledges from the previous round, owing the Global Fund US$30 million. During the picket, the Italian Ambassador refused to come out but sent the first secretary, Mr Dario Armini, outside to address TAC. Mr Armini informed TAC that Italy would make payments on its Global Fund pledges by December 2010 and that Italy would make a pledge to the Global Fund. To date Italy has not made these payments, nor did they make a pledge for the Global Fund?s upcoming round. TAC will continue to pressure the Italian government.

During the replenishment conference governments and donors failed to meet the Global Fund?s lowest scenario of US$13 billion, raising only US$11.7 billion. TAC and partner organisations will therefore continue to mobilise for resources for health.

TAC General Secretary calls on Germany to commit its fair share.

Italian first secretary accepts TAC's memorandum.

Financial Transaction Tax

As part of our resources for health campaign, TAC released a brief calling for the implementation of a financial transaction tax on currency exchanges to raise money for health. TAC sent briefings to the Deputy President Kgalema Motlanthe and Health Minister Aaron Motsoaledi asking them to pledge South Africa?s support to the financial transaction tax. Health Minister Aaron Motsoaledi pledged South Africa?s support for the financial transaction tax and eventually authored an Editorial in support of the Tax.

Monitoring budgets and expenditure

CEGAA/TAC

From September to November, TAC continued to capacitate itself to monitor government?s budgets and expenditure and rollout community level surveys. The surveys aimed to assess community satisfaction with health service delivery as well as challenges. The surveys were designed by CEGAA (Centre for Economic Governance and AIDS in Africa) to provide baseline data that would inform the ongoing budget monitoring project.

The TAC/CEGAA project and the preliminary results of the surveys were presented to communities, stakeholders and government during public hearings. TAC uMgungundlovu held public hearings during October 2010. TAC Lusikisiki held public hearings during December 2010. CEGAA and TAC are currently finalising the results of the surveys. Preliminary reports from uMgungundlovu highlight challenges faced in the district. These challenges are discussed below.

Integrated Support Team Reports

Through the Budget and Expenditure Monitoring Forum, TAC and partners held workshops on the Integrated Support Team Reports on 12 November 2010. The Reports, commissioned by Barbara Hogan during her time as minister of health were released in June 2010 following pressure from the Budget and Expenditure Monitoring Forum. The reports describe the crisis situation in the Department of Health.

The forum received report backs from Gauteng and Eastern Cape that indicated that little progress has been made since the IST reports were commissioned. The report backs revealed that the Auditor General found that the Gauteng department of health was unable to account for an alarming R19 million in the 2009/10 financial year. The Eastern Cape Department of Health has accrued R1.6 billion in debt from its last financial year and consequently does not have funds to pay its creditors. However the forum also learned that the Eastern Cape Department of Health, unlike the Gauteng Department of Health, is taking steps to address these problems in disciplining or dismissing corrupt officials.

The forum called on national government to take an active role in assisting provinces in addressing these problems and will continue to lobby for the implementation of recommendations from the IST reports.

State of healthcare in districts

Derby clinic in Gert Sibande.

Implementation of new guidelines ? challenges and successes

Between September and November, TAC policy communications and research staff reported on the challenges and successes of implementing the new guidelines and health service delivery in their districts. The information below is a compilation of their reports.

The biggest improvement of this quarter was that there were far fewer stock-outs of antiretrovirals identified than over the previous year. For the first time no stock-outs of tenofovir ? a first line antiretroviral - were reported, allowing districts to ensure that new patients are now receiving this drug. TAC Gert Sibande noted that they have seen an improvement in supply of medicines and ARVs following their intervention with the district department of health last quarter, however they cautioned that facilities not monitored by TAC continue to face challenges.

TAC districts reported that pregnant women and TB patients are getting treatment at CD4 counts of 350 and other patients are receiving treatment at 200. However TAC Gert Sibande carried out a survey revealing that patients that are neither pregnant nor have TB are on average only receiving treatment at a CD4 count of 120.

More districts are also now providing stable patients with 2 to 3 months of ARVs at a time. This helps to ease the load on healthcare workers and reduces the number of visits to facilities. TAC Mopani, Khayelitsha and Gert Sibande reported that stable patients are given more than one month of medication at a time. In Lusikisiki?s facilities patients are not offered three months of medication, but can receive it on request. Facilities in uMgungundlovu do not yet provide three months of ARVs to stable patients.

TAC Khayelitsha noted that they have had success with ARV clubs for stable patients. In these clubs, patients will bring their clinic cards to adherence/support groups and one person will then collect their medication. This strategy is now also being adopted by other facilities.

More facilities have also now implemented task-shifting. All of the districts in which TAC operates, apart from uMgungundlovu have reported some level of task-shifting since April with nurses initiating treatment and community health workers starting to provide finger prick HIV tests. However TAC Mopani noted some challenges. In some cases nurses have not received adequate training and have prescribed patients the wrong combinations of ARVs. In such cases we are alerting both patients and healthcare workers.

Despite the positive impact of expanded task-shifting, all districts continue to face shortages of healthcare workers. Districts also report that irregular hours and closure on weekends prevents many patients from receiving the care they need and often results in long queues and overcrowding in facilities.

As identified in past NSP reports, delays in receiving lab results continue to impact the delivery of quality care across South Africa. TAC Mopani reported that delays in receiving PCR results for infants delayed the initiation of treatment

for HIV positive infants. TAC Mopani, Lusikisiki and uMgungundlovu again reported delays in receiving pap smear results, with results taking up to six months or not coming back at all. Patients in uMgungundlovu also reported frustrations with delays in receiving results for CD4 counts, viral loads and TB tests.

The provision of isoniazid preventative therapy (IPT) is also irregular across districts. Facilities in uMgungundlovu, Lusikisiki and Khayelitsha are providing IPT to HIV positive patients that are TB smear negative. Ekurhuleni is only providing IPT to children living with people that have TB. Gert Sibande has IPT at facilities but healthcare workers are not prescribing it, citing fears of wrongly prescribing to patients that are incorrectly diagnosed as smear negative.

Voluntary medical male circumcision (which reduces the risk of contracting HIV for a heterosexual man) was rolled out in April in KwaZulu-Natal. TAC has campaigned against the use of the unsafe Tara KLamp device in KwaZulu-Natal?s medical circumcision drive (see Tara KLamp link). Facilities in Gert Sibande, Lusikisiki and Ekurhuleni are now also rolling out VMMC ? these areas are not using the Tara KLamp. TAC is mobilising men to come forward and get circumcised and, in Gert Sibande, TAC has developed referral forms for men interested in VMMC. Gert Sibande has reported challenges in scaling up VMMC due to the shortage of healthcare workers. Facilities providing VMMC are also far apart making it difficult for men to access these services.

Poor access to facilities is an ongoing challenge in Lusikisiki. There is also no available transport to reach facilities when needed. Community healthcare workers including adherence counsellors have reported that they may be unable to reach patients that are lost to follow up due to lack of transport.

Districts reported that the department of health is scaling up access to ARVs by accrediting more facilities. TAC Mopani has noted that the district is facing challenges in this process. Many facilities do not have the space to cater to daily patients. The lack of space has also created a situation where some patients? HIV status is unintentionally disclosed to all patients in the facility. TAC uMgungundlovu also reported insufficient space and overcrowding.

In Gert Sibande, the accreditation process has been alarmingly slow. Only three of the ten clinics identified for accreditation are now able to start new patients on ARVs. When TAC Gert Sibande questioned the lack of progress, they were told the delays are due to health facilities switching from municipal to provincial management.

Special Report from Gert Sibande

By Simonia Mashangoane

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TAC members discuss challenges in Gert Sibande.

Poor access to services, shortages of medicines, shortages of human resources and poor management has led to poor quality of care in Gert Sibande.

There are too few health care workers in rural Gert Sibande. Specialists are particularly rare, and the majority work only part-time in the public sector. As a result, when patients are referred to Gert Sibande hospitals, they are often referred onward to other hospitals in different districts or in Gauteng province. This means that money must be spent on transport between facilities, and patients in need of emergency treatment often do not receive the rapid care that they need.

Many of these human resource problems are the result of poor management and a lack of funding. Gert Sibande relies heavily on external funding from NGOs for essential positions relating to HIV care. The clinic at Bethal has 15 staff members, but only five of these are employed by the Department of Health. Of the five, one is a cleaner, one is a data capturer, and just three are health professionals hired to care for over 4,000 patients. The other staff members are employees of the non-profit organisation Right to Care. TAC provides a treatment literacy trainer.

Last year the only doctor at Amsterdam Clinic in Gert Sibande was retrenched because the NGO that paid him ran out of funds. The clinic nurses had not yet been trained to initiate patients onto ARVs and the facility could no longer offer this service. TAC intervened by arranging a meeting with the head of the Mpumalanga department of health, DR JJ Mahlangu. We obtained a promise to reinstate the doctor on the department of health payroll.

Similar funding problems impact the employment of community health workers in Gert Sibande. Often they are simply not paid. In some areas, home-based caregivers are paid just once a year. Here too, NGOs step in to pay monthly salaries.

Drug shortages are also a constant problem in the area. In 2010 Health-e reported shortfalls lasting several months at a time in over 80 different types of medication. Hospitals and clinics borrowed medicines and supplies from each other. During the third quarter of 2010 ARVs were so scarce that TAC demanded an urgent meeting with the provincial MEC for Health. Following this meeting the ARV stock-out was resolved in facilities that TAC actively monitors. In other areas, shortages of essential medicines and ARVs continue.

The Mpumalanga Integrated Support Team (IST) report, released in 2010, indicated that stock-outs are widespread in the province. The report found that this was due to poor supply-chain management, and also to poor financial management, which resulted in government being unable to pay suppliers on time.

Poor management and a lack of accountability amongst those in leadership are the major reasons why our health system struggles to cope.

TAC continued to support the targets of the National Strategic Plan (2007-2011) and the implementation of the updated guidelines for HIV/TB prevention and care through our programmes.

Interventions at a district level

TAC members distribute condoms in Lusikisiki.

TAC?s prevention and treatment literacy programme provides ongoing HIV and TB education through face-to-face dialogues in public health facilities. Depending on the agreement with the facility, TAC?s prevention and treatment literacy practitioners provide a range of services on top of health education. TAC prevention and treatment literacy practitioners reported on carrying out adherence counselling, VCT counselling, defaulter tracking, pill counting, triage as well as facilitating support groups and ART clubs.

TAC is able to reach community members outside of public health facilities through the community health and advocacy programme. During this period the community health advocacy programme carried out door to door campaigns, educating community members about HIV and TB, HIV testing, cervical cancer, voluntary medical male circumcision, stigma and gender based violence.

TAC extends its reach through its branch structures. TAC branch members provide similar services to prevention and

treatment literacy practitioners. They also carry out community level campaigns and picket during rape or other gender based violence-related trials involving community members. All TAC branch members are unpaid volunteers working to make an impact in their own communities. TAC provides ongoing treatment literacy and leadership training to branches.

TAC Community Health Advocates and branches continued to distribute material and condoms to communities during this period.

TAC districts reported that stock-outs and shortages of female condoms have prevented them from reaching their targeted figures for female condom distribution. South Africa continually faces shortages of female condoms, yet the interruption of governments tender for female condoms, due to complaints that it is biased in favour of a single manufacturer have exacerbated the problem.

At a district level, TAC further works to support the NSP through participating in Local and District AIDS Councils. On 29 November TAC celebrated the launch of the Gert Sibande District AIDS Council. Prior to this, TAC Gert Sibande requested a meeting with the mayor to discuss the non-existent and/or dysfunctional AIDS councils in the area, focussing on the Gert Sibande District AIDS Council. The mayor agreed to have weekly meetings with TAC and other stakeholders in order to relaunch the Gert Sibande District AIDS Councils. A TAC Gert Sibande representative has been appointed Deputy Chair on the Council.

Issues spotlighted

Tara KLamp

From September to November, TAC continued its campaign against the use of the Tara KLamp to perform circumcisions in KwaZulu-Natal. The Tara KLamp is a plastic device that is clamped onto the penis for 7 to 10 days until the foreskin necrotises and falls off along with the clamp. A clinical trial on the device showed it to be unsafe for use on adolescents and adults.

TAC initially greeted with enthusiasm the announcement by KwaZulu-Natal, backed by King Goodwill Zwelithini, that the province would roll out medical circumcision. However this enthusiasm was clouded when it emerged that the province would use the Tara KLamp in public health facilities.

TAC brought the safety issues to the attention of government and the public. However the KwaZulu-Natal government refused to discontinue to use the clamp informing TAC that ?What we have explained to the Minister and now indirectly to you is that we are committed to massive Medical Male Circumcision in KZN as directed by His Majesty our King. We will do it medically as the Majesty instructed us. The king has instructed us that no one should die as a result of our MMC intervention but he did not instruct us that no one should have pain.?

TAC has heard accounts of injury by men who have undergone circumcision using the Tara KLamp. To pressure government to discontinue the use of the Tara KLamp, TAC published a four-part series of articles titled ?Money for Mutilation?. In this article we raised concerns regarding the safety of the device, the tender process through which it was procured, the unethical marketing of the device and the lack of responsible leadership by government and the World Health Organisation in relation to the device.

The Mail and Guardian newspaper also ran articles during this period questioning the tender for the device and exposing the murky past of the device?s distributor Yusuf Ibrahim. The Mail and Guardian quotes sources alleging that Yusuf was involved in Mandrax smuggling and is a fugitive from his native country, Zambia.

Following these articles KwaZulu-Natal Premier Zweli Mkhize agreed to meet with TAC. We met with him along with men who had sustained injury from the clamp. At the meeting Mkhize informed TAC that the province would continue to use the clamp - thus necessitating ongoing pressure from TAC and civil society calling for the devices removal.

The Tara KLamp is clamped onto the penis for 7 to 10 days until the foreskin necrotises and falls off with the clamp.

Infant feeding

Under South Africa?s revised prevention-of-mother-to-child transmission guidelines (April 2010), HIV positive mothers are advised to exclusively formula feed or exclusively breastfeed with infant nevirapine (NVP) or maternal HAART.

In 2010, following the release of the South African guidelines, the WHO also revised their infant feeding guidelines. The revised guidelines recommend that national health authorities decide whether to counsel mothers to exclusively breastfeed or exclusively formula feed taking into account the local context and availability of services.

The WHO guidelines state that in light of new evidence that ARVs prevent HIV transmission and the benefits of breast milk, national authorities are justified in recommending exclusive breastfeeding as a single option.

South Africa has now begun to move away from providing formula milk to mothers with HIV, promoting the use of maternal HAART or infant nevirapine (NVP) instead. However research carried out by TAC revealed that there is little consistency across districts in how mothers are counselled or what services they are provided.

The availability of formula milk differs between provinces. KwaZulu-Natal has now stopped providing formula milk to HIV-positive women. In Gauteng some facilities still offer formula milk but there are constant shortages and most facilities are now promoting exclusive breastfeeding with infant NVP. Lusikisiki also experienced shortages of formula milk during October and November. Khayelitsha and Gert Sibande facilities are providing formula milk as well as infant NVP and counselling mothers on both options. The challenge with ongoing and unpredictable stock-outs is that they can force mothers to mix feed their infants which increased the likelihood of transmitting HIV.

South Africa?s infant feeding recommendations must balance the risk of acquiring HIV against the risk of mortality caused by other diseases commonly associated with formula feed. Studies have shown that the risk of HIV transmission from exclusive breastfeeding is significantly reduced by ARV prophylaxis to below 2%. While formula feeding removes any risk of HIV transmission, it is associated with increased mortality as germs in the water, bottle or cup can cause illnesses such as diarrhoea. Breast milk also has nutritional advantages over formula milk, providing proteins, vitamins, fats and carbohydrates that the infant needs and contains antibodies that protect the infant from infection.

The challenge with removing the option of formula milk is that it may not be a feasible strategy for many mothers in South Africa. A large portion of mothers in South Africa will return to work within 6 months of delivery, which can prevent them from exclusively breastfeeding.

TAC will continue to educate women about transmission during infant feeding, their options and advocate against stock-outs. During this period TAC published and distributed Pregnancy In Our Lives, a prevention-of-mother-to- child

transmission curriculum for mothers, community healthcare workers and healthcare workers.

Gender based violence

Young TAC members say no to Gender Based Violence.

Our communities face unacceptably high rates of gender based violence (GBV). In response to this TAC assists gender based violence survivors to access health and justice services, calls for justice through picketing during trials and educates and mobilises communities against GBV.

During this period TAC uMgungundlovu mobilised around the case of a 15 year old girl allegedly raped by her stepfather. TAC Gert Sibande mobilised around the case of a 7 year boy allegedly raped by a neighbour. TAC Lusikisiki supported a 5 year old girl, raped by her uncle, to access post-exposure prophylaxis and lay a charge with the police. TAC Mopani demanded justice during the trials of two men that allegedly raped their teenage daughters. TAC Ekurhuleni demonstrated during the trials of a suspected rapist and murderer of a 9 year old girl from their community. And, TAC Khayelitsha continued to mobilise for justice for Zoliswa Nkonyana. Zoliswa a member of TAC and the Triangle Project was murdered by a gang of men in 2006 because she was openly lesbian.

Frustration around delays and failures in the justice system for victims of GBV pushed TAC Khayelitsha and partners to picket at court houses and police stations. TAC Khayelitsha, the Social Justice Coalition and other organisations based in Khayelitsha marched to the Provincial Legislature on 23 September. At the launch of the 16 Days of Activism on 25 November TAC again held demonstrations around the country demanding government address the failings of the justice system.

On 29 October TAC Ekurhuleni marched against ongoing persecution of homosexual individuals in their community. They handed over a memorandum at a local police station demanding action against escalating attacks.

TAC also carried out door-to-door and other community campaigns, calling for an end to GBV and informing community members of their rights. In uMgungundlovu, TAC held a community campaign, informing communities of signs that a child has been abused and how to respond if a child tells an adult that (s)he has been raped.
