'OUR PEOPLE ARE SUFFERING, WE NEED TREATMENT' (Health care worker in the Eastern Cape)

TREATMENT ACTION CAMPAIGN (TAC) & AIDS LAW PROJECT (ALP)

UPDATED FIRST REPORT ON THE IMPLEMENTATION OF THE OPERATIONAL PLAN FOR COMPREHENSIVE HIV/AIDS CARE, MANAGEMENT AND TREATMENT FOR SOUTH AFRICA (OPERATIONAL PLAN)

JULY 2004

A preliminary report monitoring the implementation of the Operational Plan that was researched and produced by the ALP/TAC was presented to the People's Health Summit (PHS) held on 2-4 July 2004. Additional information was received after the summit from TAC branches, health care workers and some provincial governments. This information has been very useful because it has helped us to unpack many of the problems identified in the first report. Also, because of the media attention given to the first report, many provinces have realised the value of sharing information publicly. Due to the pressure emanating from the release of the first report, some provinces have since publicly released patient numbers. Where applicable, this information has been incorporated into the updated version of the report, which of course by its very nature has its own limitations. The purpose of this report is not to attack the commitment of health care workers who are trying to make the ARV programme a success; instead the report is a necessary tool to monitor the efficacy of the programme, to share information and to make government accountable to the people who will most benefit from the Operational Plan. Of course, the process of information gathering is on going. It is important to note that the report covers the first seven months since the Operational Plan was announced and approved in November 2003. It focuses primarily on the numbers of people who have begun to receive ARV treatment that we are aware of, as this is a critical gauge of whether systems are in place and whether lives are being saved. It also reports on the degree to which information about the Plan and its implementation is being made available to the public. Future reports will add more qualitative information, such as the age and gender ratio in access to treatment, an important measure of whether people in South Africa are receiving equal access to treatment and not suffering prejudice. Other aspects of the Operational Plan, such as the provision of nutritional support, will also be evaluated later. Of course, where government refuses to share information, it makes the compilation of such a report extremely difficult. The purpose of this report is not to mislead the public. Instead we are concerned with sharing information, where possible.

If you or your organisation would like to add to or correct information in this report please contact:

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A. EXECUTIVE SUMMARY

This report shows that substantial effort is being directed at implementing the Operational plan at district and provincial level. However, this effort is not being matched with the degree of prioritisation and political commitment to this service that is necessary at a national level. This is making it more difficult for provinces to overcome many of the difficulties that they encounter in speedily implementing the Operational Plan.

Communication about and popularisation of the plan is also extremely weak in most provinces. The national department of health (NDoH) continues to violate the right to access health care services by operating secretly, and refusing to make important information about timelines and targets available to the public (revised Annexure A in particular). While lists of some accredited sites are made available to internet users and the media, the list and contact details of actual sites that are providing treatment are not being made available to ordinary people who have some access to radio, television and/or newspapers. Provinces such as Gauteng, KZN, FS and the WC are examples of how public media should be used, but the same level of information dissemination is also needed in other provinces. Adverts about antiretroviral (ARV) treatment have also disappeared from television – and there are rumours that this was on the order of the Minister.

Further, despite the importance of civil society support for the rollout, SANAC, the government's highest consultative body, has still not had an extensive discussion on the Operational Plan. Early drafts of the Operational Plan proposed the creation of a national Programme Implementation Unit (PIU). This idea was removed because of fears that it would contribute to a vertical programme. However it is obvious now that ongoing and systematic engagement and support from the NDoH is important.

While several provinces and thousands of HCWs must be supported because of their bold and tireless commitment to making treatment a reality, other provinces have been very slow in starting and/or expanding treatment at accredited sites. The failure to provide national leadership is widening the gap between resourced and under-resourced provinces – in particular assistance and instruction is needed in provinces such as the Eastern Cape and Limpopo. It is also important that the NDoH inform its provincial counter-parts that they are under a constitutional duty to inform the public about this programme. One particular concern is that although hospitals and clinics are coming under pressure to start to provide a treatment service, they are not getting the additional capital or human resources that the plan promises. This is a critical management question – the Operational Plan is meant to better the health service,

rather than further overload it. There is no justification at all for the failure to meet simple needs for more storage space, patient folders etc – as is reported from Umtata General Hospital.

Equally important is that the NDoH has to devise an emergency training and human resource plan. Waiting lists at Johannesburg's hospitals already run into 2005 – many patients will die waiting for an appointment. An appeal for support for the Plan nationally and internationally would surely lead to many health workers coming forward to offer services.[1] The private sector too has a significant role to play in making sure the ARV rollout works in the public sector, by working to ensure greater and equitable access, assisting with providing specialist services, assisting with training and creating public/private partnerships. It may even be necessary for private ARV practitioners to initially assist public facilities (local clinics and HIV units) with clinical monitoring on a volunteer part time basis.

Finally, there are clear problems with drug supplies. Accredited sites that have capacity are holding back because they cannot guarantee drugs to patients. This too is a management and monitoring issue.

The updated report estimates reflect that not more than 10 000 people (the figure is closer to 6000)[2] are receiving ARV treatment in SA at public health facilities. Of these, many are funded by donor agencies. At this rate, the Plan will fall far short of the target announced by President Mbeki of 53 000 people on treatment by March 31, 2005 – a target that is already more than 100 000 people less than that proposed in the Plan.

So, despite the best efforts of health care workers, political prevarication and weak management continue to deny many people access to health services that would save their lives. Despite the attack by the Minister regarding TACs ability to report objectively about the rollout, and despite some provinces accusing TAC of misleading the public, we are satisfied that the updated report confirms that not even 10 000 patients are receiving ARV treatment in public facilities across South Africa.

Below is a table that summarises the comparison between national targets as they appear in the Operational Plan and estimates of patients on ARV treatment as at 20 July 2004.

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[1] Of course this is dependant on the NDOH and the Department of foreign affairs entering into some agreement to fast track the registration of non SA citizens (work permits). Note that subsequent to the release of the first report at the PHS, Gauteng has committed to assist very sick patients who have been placed on the waiting list with speedier appointments.

[2] At the International AIDS Conference in Thailand the Minister was reported as saying that 6000 people are receiving ARV medicines through the public sector treatment programme.

B. COMPARISON OF NATIONAL TARGETS V ACTUAL NUMBER OF PATIENTS RECEIVING ARV MEDICINES[3]

Table 1

Province	Operational Plan March 2004 target[4] (Revised for 2005)	Numbers on treatment (Adults and children)
Gauteng	10 000	2300 (Adults 1924) (Children 416)
North West	1 808	130 (Adults 130) (Children -)
Northern Cape	790	51 (capacity July-September 600) (Adults 51) (Children -) Possibly < 100
Eastern Cape	2750	298 (Adults 287) [227 MSF, 60 Province] (Children 11) [11 MSF]
Western Cape	2728	May 2004 3059 (Adults 2256) [537 Province 1719 Donor] (Children 803) [304 Province 499 Donor] (Inc.MSF, ARK, Tshepeng Trust, donor funded) 20 July 2004 3750 patients
KZN	24 902	120 Possibly max. 250
Limpopo	6965	Do not know Does not appear to have started dispensing ARVs
Mpumalanga	1934	51 Possibly <100
Free State	2127	Not > 50 (capacity next 2 months 90) [*SACBC 100 patients at 3 sites per year- pending]
TOTAL	**54 004 (53 000)**	**<10 000 (close to 6000)**

[3] This figure does not include total number of patients enrolled in treatment programmes; it merely indicates the total number of patients receiving ARV treatment already that we have knowledge of.
[4] **See Table 16.9 at page 248 of the Operational Plan '**Expected total number of cases on ARV treatment by Province'. The figures are slightly higher than Table 16.8 at page 248 which estimates new cases starting ARVs per year as **2003/04 53,000; 2004/05 138,315; 2005/06 215,689; 2006/07 299,516 and 2007/08 411,889.**

C. BACKGROUND TO THE OPERATIONAL PLAN - PATIENT/SITE NUMBERS

On 19 November 2003 Cabinet publicly announced its approval of the Operational Plan. The Minister accepted full responsibility for its development. The critical features of the Operational Plan include the recognition that ARV medicines play a critical role in the treatment of people with HIV. Second, it provides for ARV medicines to be made available at public health facilities for the treatment of poor people with HIV/AIDS who cannot afford ARV medicines that are readily available in the private health sector. Third, it provides for the urgent implementation of the Operational Plan.

Table 16.7 at p 247 of the Operational Plan reflected a rollout of treatment which would see total numbers of patients enrolled rise from 265 000 in 2003/2004 to 3 169 368 in 2007/2008. It contemplated that the number of patients on ARVs would rise from 53 000 in 2003/2004 to 1 001 534 in 2007/2008. However, at the end of March 2004 and to date, substantially less than 53 000 people are on ARV treatment in the public health sector in South Africa. It is estimated that the total numbers of patients who are receiving ARV medicines do not total more than 10 000. In the President's State of the Nation address to Parliament on 21 May 2004, he indicated that Government now hopes to reach the target of 53 000 people by March 2005, that is, a one year delay in reaching initial patient targets.

Also, in publishing its decision to adopt the Operational Plan on 19 November 2003, Cabinet committed Government to establishing *'at least one service point in every health district … by the end of the first year of implementation and within a period of five years to provide [access to ARV treatment for] all South Africans'*. On 10 February 2004, the Minister of Health in her response on the debate on the State of Nation Address committed to *'achieving the target of a service point in all 53 district and metropolitan councils within one year'*.

The Minister has indicated that fifty-two (52) health *facilities* are accredited to provide ARV treatment.[5] We will continue to monitor whether these facilities have commenced ARV treatment programmes. According to the Operational Plan, once a site (which may include several facilities) is accredited, it meets the requirements to commence ARV treatment. At first, the accreditation process provided that unless sites could meet all the accreditation criteria it would not be able to provide treatment. This was subsequently changed to permit sites that satisfy minimum standards to commence

[5] M Tshabalala Msimang 'Government responds to TAC report on Aids plan' in Mail and Guardian, 9 July 2004.

ARV treatment. In March 2004, Dr Nono Simelela indicated at a SANAC meeting that the minimum entailed the availability of VCT, trained doctors and nurses; access to laboratory testing and facilities for drug storage. In other words, if sites can satisfy the minimum criteria they will be permitted to commence ARV programmes. Despite this, we are aware of two instances where even though sites were accredited, they were prevented from commencing treatment. In particular, in KZN, the 12 additional accredited sites commenced treatment several weeks after they were accredited (these additional sites signalled that KZN wanted to commence treatment at more than 1 site per district). The reasons for the delay still remain unclear. The same trend appeared in the NC. Fortunately, in both KZN and the NC, treatment has now commenced at the additional accredited sites. In some provinces, paediatric treatment has not yet commenced. This is partly because drug supplies arrived only recently and because some sites are waiting for 'approval'.

D. ACCESSING AND SHARING INFORMATION

In the first few months of monitoring the implementation of the rollout we have attempted to confirm and verify information about site details, commencement dates, patient numbers and budgetary allocations for ARV treatment and medicines. However, not all provinces have been willing to publicly share information about their programmes. Their lack of openness has made the task of monitoring and reporting on the ARV rollout unnecessarily difficult.

In early 2004 TAC and the ALP begun corresponding with all the provincial health departments as well as the national department of health (NDoH). This process is on going. Our efforts to assist government have been formally welcomed by the provincial governments of Gauteng[6], Mpumalanga[7], the Northern Cape[8] and informally welcomed by the provincial governments of the Western Cape and KZN. Some provinces such as Free State, Gauteng, Northern Cape, Western Cape and North West[9] have publicly released information about their ARV programmes. Their approach to making information available must be applauded and encouraged. Some provinces released patient numbers in response to the first report that was presented at the PHS. The latter was important because it succeeded in soliciting several responses from provinces that previously refused to share information.

[6] Gauteng 5 March 2004.
[7] Mpumalanga 13 May 2004
[8] Northern Cape May 2004
[9] In particular, see the press statement issued in response to the report by the province of the North West dated 12 July 2004.

However, provinces such as the Eastern Cape and Limpopo have to date not released substantial information about their ARV programmes. Despite repeated requests at the PHS to the MEC for Health in the Eastern Cape, to reply to three requests for information submitted during April – June 2004, the MEC has to date not responded. Also, Limpopo has to date not replied to any of our requests for information despite stating in our report that we do not have any information about the status of the ARV programme in Limpopo.

Information sharing is important because the people who are to benefit the most from the implementation of the Operational Plan are poor people who need treatment in the public sector. They must have accurate and reliable information at their disposal so that they can make important decisions about accessing treatment. It is therefore worrying that several months after the Operational Plan was publicly released, information relating to time-lines and targets which are contained in what is referred to as Annexure A (or since revised) have not been made public. After several months of informal and formal attempts to obtain the information using the provision of the *Promotion of Access to Information Act,* 2000, on Friday 18 June 2004 TAC filed legal papers in the Pretoria High Court against the Minister to compel her to make the information available. The Minister has filed a notice of intention to oppose the application. The case is pending.

E. DRUG PROCUREMENT

The formal tender process commenced in February 2004, several months after Cabinet instructed the NDoH to develop a treatment plan and is unlikely to be completed before the end of August 2004. Fortunately,, even though the Minister initially signalled a rigid adherence to the formal tender process[10], a decision was taken on 23 March 2004 by MinMEC to make use of interim procurement mechanisms to enable provinces to obtain ARV medicines through a national price quotation system. This was occasioned by the threat of legal action by the TAC against the Minister on the issue of interim procurement.[11] At present, it appears that provinces that have commenced providing

[10] See the Minster's response to Sindiswa Moyo in the Sunday Times, 20 February 2004.
[11] On 22 March 2004 we sent an advanced copy of our legal papers in the interim procurement case per courier to the Minister. We notified the Minister that unless the flexibilities in our law were used to permit interim procurement we would file the papers in a court of law by 25 March 2004. On 23 March 2004 (the following day) MinMEC approved the interim procurement mechanism.

ARV treatment are obtaining supplies of ARV medicines by using the interim mechanism approved by MinMEC.[12]

F. SUMMARY OF KEY ISSUES AFFECTING THE SPEEDY IMPLEMENTATION OF THE OPERATIONAL PLAN[13]

1) DRUG SUPPLY, PROCUREMENT AND LICENSES

The slow MCC registration process and the lack of signed voluntary licences in respect of some of the ARVs that appear on the tender list are delaying access to affordable and sustainable medicines. For example, efavirenz (600mg) was only registered in May 2004 by the MCC. On 29 June 2004 the MCC sent us a letter indicating that it will be holding an extraordinary meeting on 2 July 2004 where paediatric formulations will be considered. Also, that the meeting will "deal with the registration of most of the ARVs in the pipeline based on the Ministerial Directive of subjecting them to expedited review". The meeting proceeded on 2 July 2004. However, from the information available on the MCC website (14 July 2004) it appears that of the outstanding ARV medicines that were awaiting registration, only Aspen AZT (300mg) was registered on 2 July 2004.

Pursuant to the Competition Commission case spearheaded by TAC in 2002, and the settlement agreements entered into as a result on 10 December 2003, Aspen Pharmacare has secured and signed extended licence agreements with GSK and BI. Thembalami signed licence agreements with GSK on 9 June 2004 and with BI on 30 April 2004. GSK has yet to issue two additional licences and BI has to issue one additional licence. CIPLA Medpro, whose medicines are registered with the MCC, have not as yet secured licence agreements with GSK and BI. Also, while Aspen have secured and signed two licence agreements, some of Aspen's ARV products have not as yet been issued with the requisite regulatory approval by the MCC, save for AZT 300mg. On the other hand, Thembalami's (Rambaxy) ARVs products are already registered with the MCC.

2) INTERIM PROCUREMENT

[12] Even though Limpopo has received its supplies of medicines and everything is in place to commence treatment, it has not commenced treatment.

[13] Information in this summary is taken from national and provincial press statements, Parliamentary briefings, Provincial reports, site visits, correspondence with health departments and official documents.

In early 2004 the NDoH indicated that the procurement of ARV medicines through the normal tender process would be only completed at the end of June or during July 2004 and that contracts were only likely to be awarded at the end of July 2004. This failed to take into account that our regulatory framework provides for quick procurement by any practical means whenever "it is impractical to invite competitive bids", for instance "in urgent or emergency cases or in case of a sole supplier".

Towards the end of 2003, the NDoH established a drug procurement team (DPT), headed by Dr Humphrey Zokufa. The names of the team members have to date not been publicly released. The DPT met for the first time in early February 2004.

On 13 February 2004, some two and a half months after the Operational Plan was accepted, the formal tender process began with the publication of the notice in the *Tender Bulletin* calling for the 'Expressions of Interest' to supply ARV medicines. Interested parties were given two weeks to respond. A week later, on 22 February 2004 the Minister responded to an open letter written by Sindiswa Moyo to the President that appeared in the Sunday Times two weeks earlier.[14] The Minister did not mention that alternative procurement options existed nor did she mention a letter that her department sent to suppliers on 4 February 2004 asking for interim quotes and supplies.[15]

On 5 March 2004, a further advertisement dealing with the Request for Proposals (RFP) was placed in various national newspapers. Interested parties were given 28 days to respond, that is, by 2 April 2004. At about this time the TAC met with senior representatives of the ANC and at their request provided them with a memorandum on the procurement regulatory framework, which explained in detail, the steps government could take immediately to purchase an interim supply of ARVs. On 12 March 2000, TAC met with the acting Director-General (DG) and other senior members of the department to discuss the provision of ARV medicines at sites that were by then ready to provide treatment. [16]

On 9 March 2004, an information session for firms and consortia interested in supplying the advertised ARV medicines was held where they were provided with the necessary

[14]The Minister advised Sindiswa to be 'patient'. She said that the formal tender process had to be used otherwise the department could face legal action.
[15]The Minister has never publicly raised this letter. In doing so she created the impression that the formal tender process was the only means of procuring ARV medicines.
[16]A copy of the legal memorandum given to the ANC was given to the department. At that stage, TAC had hoped that the outcome of the meeting would "make it possible to avert any legal action". Nevertheless, the Minister continued to resist making use of these interim measures.

tender documents, due to have been submitted by 2 April 2004. On 2 April 2004 eligible suppliers were to have been short-listed.

On 23 March 2004 the Minister stated that MinMEC resolved to continue with the tender process, and in the mean time to implement a quotation system as in interim arrangement. MinMEC acknowledged that flexibility in procurement methods was acceptable. TAC welcomed the decision taken at MinMEC and advised the Minister on 25 March 2004 that we would closely monitor the interim mechanism.[17] On 11 May 2004 we received a response wherein the Minister advised of the dosages and medicines that were to be procured to meet interim needs. According to the Minister quotations were received in 5 April and 7 April 2004. Quotations were accepted on 8 April 2004 and suppliers and provinces were accordingly informed on the same date. Provincial patient targets were to have been submitted by 5 April 2004. We do not know if all the Provinces complied with this deadline.

On 28 May 2004 TAC wrote to the acting DG of Health communicated our concerns about the inadequate list of dosages, ARV medicines and paediatric formulations that would be procured to meet interim needs. We also requested information about quantities ordered and delivery dates. To date, there has been no response save from the MCC.

In respect of the Formal Tender Process, the Minister first said that 10 companies were short-listed[18] and more recently indicated that 8 companies have been short-listed. According to the Minister the tender awards will only be made at the end of August 2004, whereas it was initially estimated that it would be awarded at the end of July

The Minister also asked that TAC 'desist from embarking on unnecessary and pointless litigation'. TAC accepted the bona fides of the Minister and agreed not to proceed with legal action. On the same day, TAC requested additional information from the Minister on the interim measure approved by MinMEC. On 30 April 2004 TAC wrote to the Minister again (after her re-appointment) asking for an urgent response to the concerns we raised in the letter of 25 March 2004.

[18] During a Parliamentary Media Briefing in May 2004 the Minister stated that '[b]ecause the tender process for ARVs is quite complex and lengthy, interim arrangements were made for Provinces to purchase initial supplies of the drugs. The interim measures have not been entirely problem free. The range of generic drugs currently available is limited and this means prices have been relatively high. And long lead times between order and delivery have imposed constraints. The paediatric drugs are in particularly short supply and Provinces are experiencing problems accessing them. The tender process for long term supply of ARVs is well underway. The next step will be for the 10 short-listed companies to make presentations. Companies will be selected from this group to make a final bid for the contracts. Clearly several suppliers will be awarded contracts - because of the range of drugs involved in the treatment and because of the need to ensure large, uninterrupted supplies. It is expected that the number of generic suppliers will increase in the near future, as the fast track registration process of the Medicines Control Council will be is concluded later this week and as more manufacturers secure voluntary licences'.

2004. Once they are, it could take up two 6 -8 weeks before Provinces will receive supplies through this process. [19]

On 8 June 2004, the Chairperson of the Parliamentary Portfolio Committee on Health recommended that the Pharmaceutical Cluster in the NDoH appear before and address the Committee on steps taken to procure ARV medicines and to address perceptions held by some Provinces about shortages of ARV medicines.[20] This briefing is yet to take place.

3) BUDGET

According to information from IDASA's budget analysis unit, National Treasury has specifically allocated R1.439 billion in the national budget for HIV/AIDS programmes and services for the financial year 2004/5. Depending on how provinces make use of the HIV/AIDS financing made available to them via the equitable share, total funds targeted for HIV/AIDS in 2004/5 will likely comprise between R1.439 billion and R3.339 billion. The amount designated for HIV/AIDS in this year's budget is nearly 7 times what was set aside to fight HIV/AIDS in the 2000/1 national budget three years ago. However, funds earmarked for HIV/AIDS in the national budget still constitute less than 1% of the total consolidated budget, and health expenditure remains a steady 11% of consolidated national and provincial spending. A total of R373 million is designated for ARV treatment programmes in the national budget for 2004/5, the first year of the rollout. Of the total new conditional grant funds for ARV treatment, KZN receives the largest slice (22%), followed by Gauteng (16%) and Eastern Cape (14%). KZN, Gauteng and Mpumalanga's shares of the total ARV CG funds are disproportionate to their heavy HIV/AIDS burden. The critical issue is the ability and commitment of national and provincial health departments to speedily get ARV treatment programmes up and running. Some provinces may struggle to spend the additional ARV funds—especially Eastern Cape and Mpumalanga. For those provinces with weaker financial and project management skills, absorption capacity could very well be the primary obstacle to rollout. It is important to note that a new clause inserted in the 2004 Division of Revenue Bill will allow unspent HIV/AIDS health conditional grant funds to be reallocated to better-performing provinces. For additional information about budgetary

[19] Provinces will order directly from suppliers and receive direct deliveries [within the quantity (units) determined by the NDoH].

[20] On 21 June 2004 GSK wrote to the ALP stating that it "is able to supply the quantities (as estimated by the Department of Health) of 3TC syrup and tablets to the public sector within the agreed upon lead times. GSK is in contact with the department of Health regarding updates on supply and the Department of Health is comfortable with the approach. GSK has no stock shortages of 3TC in the private sector".

allocations see the section on 'Provincial Assessments' and contact the AIDS Budget Unit, Budget Information Service (BIS) at IDASA on (021) 467 5600.

4) LABORATORY SERVICES AND MONITORING

Of the 200 NHLS labs (excludes KZN which are yet to be incorporated into the NHLS) 21 NHLS labs are performing CD4 tests and 7 NHLS labs are performing viral load tests. The NHLS fee is R60 for a CD4 count and R300 for a viral load (R360) – all provinces pay the standard preferred provider fee of R360.00 for both tests. In April 2004, the NHLS conducted about 11 000 CD4 tests, which were mainly requested by Gauteng because it commenced its ARV treatment programme on 1 April 2004. To simply quote the number of tests conducted by the NHLS is therefore misleading because it may contain substantial provincial bias.

G. PROVINCIAL SUMMARY AND ASSESSMENT

In June 2004 we wrote to every province asking them to provide us with *inter alia* site details and patient numbers in order to have accurate data. To date, only the FS has responded to our request.[21] The following information is therefore drawn from informal communications and our own limited attempts to obtain information from provincial ARV task team members, HCWs at accredited sites and TAC branches.

1. Northern Cape

Table 2

Northern Cape site and patient number information*

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
Kimberley	1 May 2004	51 adults	Frances Baard (8 sites)	Yes
Springbok	June 2004	?	Namaqua (13 sites)	Yes
Gordonia	June 2004	?	Siyanda (12 sites)	Yes
De Aar CHC	June 2004	?	Karoo (11 sites)	Yes
Kuruman	?August 2004	?	Kgalagadi (6 sites)	Not yet
		End June 51		

*R14 million for ARVs through NCG, (estimated need is R32 million

*Capacity 600 for period July-Sept. 2004

SUMMARY

On 1 May 2004 treatment commenced at the Kimberley Hospital Complex (with several feeder clinics).[22] As at 27 June 2004 approximately 51 adults were on ARV treatment. The Northern Cape has envisaged 5 treatment sites, one in each district. Each treatment site will be supported by a number of assessment sites. 4 additional sites - Springok, Gordonia, De Aar CHC, Kuruman (with feeder clinics) have been identified to provide treatment. Gordonia, De Aar and Springbok are accredited and recently received the go ahead to begin enrolling patients. A 4-6 week assessment cycle is being used and patients who are eligible will start receiving ARV treatment at these 3 additional sites in a few weeks. The fourth site, Kuruman, is expected to commence

[21] EC, Mpumalanga and Gauteng acknowledged our requests and undertook to revert to us. The WC and Gauteng provided us with data on patient number. Mpumalanga asked for a time extension, which we agreed to, but have failed to revert since then. The WC, Gauteng and FS have provided us with copies/summaries of their respective provincial treatment plans.

[22] Correspondence dated 4 May 2004 from NC.

treatment by end August 2004. The small numbers of patients in the NC are also worrying because reports by community organisations indicate a substantial need.[23]

The NC has indicated that it has insufficient funds in its provincial budget for the procurement of ARV medicines. This may hamper patient numbers in the 2004/5 financial year.[24] However, the NC expects that they will have a 6-month supply of medicines for at least 600 patients for the period July-September 2004. These patient targets will be re-evaluated at the end of the 3-month period. [25]

The NC has readily communicated details of their programme and has indicated a willingness to engage in a constructive relationship with civil society.[26]

The disadvantage that poorer / smaller provinces such as the NC is facing is that the richer/bigger provinces advertised for key HR posts much earlier and were able to attract the very small pool of specialist ARV practitioners. This means that poorer/smaller provinces will have the double burden of having to recruit and train– delaying achieving optimal patient targets.

The development of a national equitable HR and training programme is therefore essential -one in which all provinces are able to benefit from the small pool of available specialist ARV practitioners.

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[23] They cite the travelling distance to the Kimberley complex as a barrier coupled with the reluctance of patients to seek the assistance of health care workers at the Kimberley complex who they perceive as unhelpful.

[24] The NC has been allocated R14 million for ARVs through the NCG. The NC also indicated on 4 May 2004 that the Provincial Training Plan will build capacity in the following target groups: Doctors, Nurses, Pharmacists, Laboratory Technicians, Nutrionists, Social Workers, Lay Counsellors, Caregivers and Community Structures. As at 4 May 2004, 150 HCWs completed a course on managing ART and a further 300, a course on managing Opportunistic Infections. An aggressive recruitment strategy resulted in the first infectious diseases specialist being appointed due to have started on 1 July 2004.

[25] In correspondence dated 4 May 2004 the NC indicated that 'a national shortage of some of the treatment regimen's' may affect its 'ability to proceed with some aspects of the implementation'.

[26] On 27 May 2004 we requested confirmation and additional information about site information, patient numbers and budget allocations. We have not received a formal response but the office of the Head of Health has undertaken to follow up on our request. On 18 June 2004 we requested a copy of the Provincial Treatment Plan for the NC. We do not anticipate that the NC will refuse to make the Plan available.

2. North West

Table 3

North West site and patient number information

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
Klerksdorp Hospital plus Tshepong Clinic	1 May 2004	63 adults	Southern	Yes
Mafikeng plus Bophelong Clinic	1 June 2004	22 (24) adults	Central	Yes
Rustenberg	1 June 2004	45 adults	Bojanala	Yes
		12 July 130		

SUMMARY

On 1 May 2004 North West commenced treatment at its first site, Klerksdorp Hospital (with Tshepong Clinic). [27] As at 12 July 2004 approximately 63 patients were on ARV treatment at Klerksdorp.[28] Klerksdorp estimates that it will scale up to provide treatment to about 40 new patients per month. According to a press statement issued by the NW provincial government on 12 July 2004, in response to the first report presented at the PHS, 130 patients are receiving treatment at its three service points: 22 (24) in Mafikeng Provincial Hospital, 63 in Klerksdorp/Tshepong Complex and 45 in Rustenburg Provincial Hospital. [29] Mafikeng and Rustenberg were accredited by 8 April 2004 but only commenced providing treatment on 1 June 2004. The reason for the delay is unclear.

Adults are the main recipients of ARV treatment. The lack of paediatric formulations has been cited as the reason why children are not receiving treatment as yet. The NW has not responded to requests by TAC and the ALP about information on sites, patient numbers and budgetary allocations (7 April 2004 and 28 May 2004).

On 18 June 2004 we requested a copy of the Provincial Treatment Plan. To date we have had no response.[30] The pace of the rollout in the NW is slow but the commitment

[27] According to the NW health department.
[28] This is in line with our estimates in the first report of 30 patients on treatment with capacity for another 20.
[29] MEDIA RELEASE: MORE PEOPLE COMING FOR ANTIRETROVIRAL TREATMENT IN NORTH WEST, 12 July 2004. Issued by the North West Provincial government. The press release is a direct response to the first report tabled at the PHS.
[30] On 16 March 2004 a press release from the office of the MEC indicated that on 18 March 2004 the NW treatment plan would be publicly unveiled. Inexplicably, the public unveiling and announcement was cancelled. But on 8 April 2004 the NW issued a media statement indicating accredited sites (Klerksdorp, Mafikeng, Rustenberg) and stated that all 3 sites would begin enrolling patients by conducting medical assessments, conducting lab testing, providing nutritional assistance and providing treatment literacy.

showed by HCWs in the province to scale up must be welcomed and supported. A lot is being done at a district level and we must support these efforts.

The main obstacle faced is the lack of doctors that are willing to work in rural areas despite the recently introduced scarce skills allowance. Often even though posts are advertised they are not filled. The continued training of HCWs has also been identified as a factor that has delayed the scaling up of treatment. In such a sparsely populated province, transport services to treatment sites have also been a problem. There have been no TAC site visits to Mafikeng and Rustenberg as yet. The TAC site visit to Klerksdorp was conducted on 17 May 2004.

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3. Western Cape

Table 4

Western Cape site and patient number information*

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SITE	DATE	ADULT	CHILDREN	ACCREDITED
1.G F Jooste	1 Dec. 2003	140 (Tshepeng Trust)	O	Yes
2.Red Cross		20	209 (PPP)	Yes
3.Groote Schuur		151	212 (PPP)	Yes
4.Tygerberg		235	197 (PPP)	Yes
5.Victoria		42	25	Yes
6.Masiphumelele		21	0	Yes
7.Guguletu CHC		255 (MSF)	2	Yes
8.Site B Khayelitsha		384 (MSF)	30	Yes
9.Michael Mapongwana		307 (MSF)	20	Yes
10.Nolungile		294 (MSF)	52	Yes
11.Hout Bay		67	0	Yes
12.Langa		114	9	Yes,
13.Paarl				Yes
14.Eben Donges		30	9	Yes
15.Mitchells Plain CHC	1 March 2004	66	0	Yes
16 Hottentots Holland	1 March 2004	15	0	Yes
17.George		67	18	Yes
18. Westfleur	TBA			
16.Beaufort West	TBA			
		End May 3059 20 July 3750		

SUMMARY

As at the end of May 2004 3 059 patients (2256 adults and 803 children)[31] were on ARV treatment at 17 treatment sites.[32] The majority of patients on ARV treatment in the public sector are in the WC because ARV treatment commenced prior to the adoption of the Operational Plan. It has also benefited from substantial donor. Two additional sites have also been identified to start treatment shortly.

[31] Province is funding 537 adults and 304 children. Donors are funding 1719 adults and 499 children.
[32] 20 July 2004 the figure is 3750

On 9 June 2004 at a Parliamentary briefing on the WC health budget the Head of health indicated that they aim to get 6000 patients on ARV treatment by the end of 2004. The WC aims to expand its treatment programme to approximately 45 sites by the end of 2005.

The WC has invited civil society to work together in mobilising communities and to assist with treatment literacy and training of health care workers and counsellors.[33] It is the only province to have regular public briefings on the rollout in the province.[34]

On 2 June 2004 the WC undertook to revert to our request about site, patient and budget information that we submitted on 27 May 2004. We expect that they will do shortly. To date they have readily shared information. Between February and April 2004 TAC sites visits were conducted at: Mitchell's Plain; GF Jooste; Langa; Eben Donges; Groote Schuur; Hout Bay; Red Cross and Tygerberg.

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[33] In respect of the Khayelitsha programme MSF has reported that links with family and assistants are central to ensuring adherence to treatment regimens…community mobilisation is necessary (MSF et al 2003).
[34] The first briefing was held on 6 February 2004 and TAC recorded the undertakings made at the briefing on 27 February 2004. The next briefing is scheduled for 11 August 2004.

4. Gauteng

Table 5

Gauteng site and patient number information*

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
1.JHB Gen	1 April 2004	941 (Adults 838) (Children 103)	JHB	Yes
2.Chris Hani Bara -Harriet Shezi clinic	1 April 2004	785 (Adults 682) (Children 103)	JHB	Yes
3.Coronation	1 April 2004	62 children (or 75)	JHB	Yes
4.Helen Joseph	1 April 2004	212 adults (or 264)	JHB	Yes
5. Kalafong	1 April 2004	291 (192 adults) (99 children)	Tshwane	Yes
6. Natalspruit	?	?	Ekurhuleni	Yes
7. George Mukhari	1 July 2004?	?		Yes
8. Pta Academic	1 July 2004?	?	Tshwana/Metsweding	Yes
9. Leratong	1 July 2004?	?	West Rand	Yes
10. Far East Rand	1 July 2004?	?		Yes
11. Kopanong	1 July 2004?	?	Sedibeng	Yes
12. Tembisa	?	?	Ekurhuleni	Yes
		28 June 2340		

- 45 million for ARV roll out through NCG
- 28 June Total assessed 7693

SUMMARY

On 1 April 2004 Johannesburg Hospital, Chris Hani Baragwanath, Helen Joseph, Coronation and Kalafong commenced ARV treatment.[35] As at 28 June 2004 indicates 2 340 patients were receiving treatment at these 5 sites. Of these, 1924 are adults and 416 are children.

[35] According to the Gauteng health department and the office of the Premier. TAC site visits were conducted at Helen Joseph on 13 February 2004; and office visits on 24 and 26 March 2004 to Daveyton Clinic and Chris Hani.

Several other sites will start during the second, third and fourth quarters of the 2004/5 financial year; and it is estimated that fifteen (15) hospitals and eight (8) community healthcare centres will provide treatment to about 10 000 patients by the end of the 2004 financial year (March 2005).[36] Seven (7) additional sites commenced treatment in the last week of July 2004. We do not have information about patient numbers enrolled at these sites as yet. [37]

In Gauteng waiting lists are already running into 2005 at some sites. However, pursuant to the release of our first report, Dr Rispel has indicated that her department will speedily assist patients with treatment if they are too sick to wait for an appointment.

Gauteng has already procured ARV medicines while waiting for the conclusion of the national tender process. [38] We have also learnt that Gauteng has already placed orders for Efavirenz 600mg.

Gauteng has invited civil society to work together to strengthen the fight against HIV/AIDS.[39] On 4 June 2004 Gauteng acknowledged our request for information about site names, patient numbers and budget allocations. We expect (Dr LC Rispel) to revert to us shortly. To date Gauteng has readily shared information.

Gauteng's ability to rapidly scale up is being hampered by the slow pace of HR appointments and lengthy waiting lists. Complaints have been received about the bureaucracy involved in making appointments. For example, at Coronation, clerks were only interviewed in late June 2004.

An emergency HR appointment plan is required in provinces such as Gauteng. Urgent meetings with provincial government and hospital/site management are therefore warranted to ensure that doctors, nurses and administrative staff are speedily appointed.

HCWs in Gauteng are also concerned about the lack of national follow up regarding implementation at individual sites.

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[36] According to the estimates in the Gauteng Treatment Plan it has a population of about 9 million people (20% of the national population) and is the second most densely populated province in the country. The mining sector and the public sector are the main employees in the province.

[37] Dr L Rispel. Head of Department. Radio debate with Tim Modise and Mark Heywood on 702, Cape Talk, 7July 2004. Transcript available from ALP.

[38] The Premier confirmed this on 7 June 2004.

[39] On 1 March 2004 TAC met with the Gauteng inter-sectoral AIDS unit. Also, the Tshwane district has requested civil society to work together in mobilising communities and to assist with treatment literacy and training of health care workers and counsellors.

5. Free State

Table 6

Free State site and patient number information

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
Bongani Regional (Phomolong, Matjhabeng, Welkom)	3 May 2004	552 enrolled CD4 below 200 = 213 capacity for 50 at 14 June 328 for VCT at 2 July.	Welkom	Yes
Motheo Site: National Hospital (Batho, MUCPP, Heidedal)	28 June 2004	225 for VCT at 2 July	Bloemfontein	Yes
Thabo Mofutsanyana (Manopo Hosp)	2 August 2004			?
Xhariep	October 2004			?
Northern Free State	October 2004			?
		14 June 50 Capacity 90 in ff. 3 months		

SUMMARY

Patients were enrolled at the first ARV site on 3 May 2004 at Bongani Hospital (with three referring clinics - Matjhabeng, Welkom, Henneman).[40] The second site (Motheo) commenced its programme on 28 June 2004. The number of eligible patients are unknown but as at 2 July 2004 225 patients sought VCT. 3 additional ARV sites (with 3 referring clinics each) will start treatment later in the year. The number of patients that visited the Bongani site at the end of June 2004 amounted to 552 (213 are eligible for treatment – CD4 below 200). About 50 patients were due to have received ARV medicines in the week commencing 14 June 2004. Since then 328 patients have been for VCT but the number of eligible patients is unknown at this stage. [41]

[40] Correspondence dated 4 June 2004.
[41] On 4 June 2004 the FS was the first to respond to our request to provinces submitted on 27 May 2004 for information about site, patient and budget information. The FS has also been the first province to respond to our request for copies of the provincial treatment plan submitted on 18 June 2004.

Note that the SACBC intends to assist the province by funding treatment at 3 sites[42], where they aim to treat 100 patients per site per year (300 per annum). The FS's health portal contains full details about its ARV treatment programme. http://healthweb.ofs.gov.za/othersites.html

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[42]Bethulie, Botshabelo, Fisckburg

6. Limpopo

Table 7

Limpopo site and patient number information

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
Mapulaneng	?	?	Bohlabela	Yes
Mokopane	?	?	Waterberg	Yes
Tshilidzini	?	?	Vhembe	Yes
Siloam	?	?	Vhembe	Yes
St Rita	?	?	Sekhukhune	Yes
Mankweng	?	?	Capricorn	Yes
Pietersberg	?	?	Capricorn	?
Letaba	?	?	Mopani	Yes
Roman Catholic Church	1 February 2004	?		Yes, private donation?
		Unsure of patient numbers on ARVs		

SUMMARY

We do not have any information about Limpopo's treatment programme. According to a presentation made to a national meeting held on 4 March 2004 and according to a Parliamentary briefing on 8 June 2004 it **appears** that Limpopo has 8 accredited sites -Letaba, Mapulaneng, Mokopane, Tshilidzini, Siloam, St Rita, Mankweng, Pietersberg. [43]

Limpopo failed to respond to our first request for information sent on 7 April 2004. In respect of our second request submitted on 27 May 2004 about site, patient and budget information, on 9 June 2004 Limpopo responded as follows: *You are humbly advised to refer to the widely published national "Comprehensive Plan for Management, Care and Treatment of HIV/AIDS". All the issues raised are addressed therein. Our Province is equally and well addressed as part of the national plan.* [44]

At a Parliamentary briefing on 8 June 2004, the Head of Health in Limpopo said that treatment would commence in the 'near future' because it had only 'recently been supplied with ARV stock' (where supplies are limited to 3 months). We have

[43] The 8 sites are the same as those listed by the Minister in her statement dated 31 March 2004.
[44] The Operational Plan provides the conceptual framework for the implementation of the Plan, but Provincial data about site details, commencement dates, patient numbers and ARV budgetary allocations are not in the Operational Plan

recently learnt that Limpopo has substantial supplies of ARV medicines – but they are not being dispensed.

On 18 June 2004 we were given a copy of the Limpopo 'Business Plan for the comprehensive HIV & AIDS Care, management and Treatment (Roll out Plan)' by an anonymous source.[45] The Plan provides for 5330 patients to be put on treatment in the 'first year'.

3 districts in Limpopo have however requested civil society to work together in mobilising communities and to assist with treatment literacy and training of health care workers and counsellors.

The lack of co-operation and transparency therefore appears to be concentrated within the provincial department and not at a district level. For example, in February 2004 TAC site visits were conducted at Mankweng; Tshilidizini and Siloam. But despite repeated requests to the MEC for health for a meeting– this meeting has not taken place. In June 2004 the MEC for Health was due to meet the TAC Limpopo office, but then he inexplicably cancelled the meeting at the eleventh hour. [46]

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[45]The projections contained in the Plan are as follows: total patients to be assessed in first 6 months amount to 5450 and total patients to be put on treatment in the same period amount to 2140. The Plan provides for 5330 patients to be put on treatment in the first year. It is unclear when the 'first year' runs from. The Plan also indicates March 2004 as the launch of the 8 sites (which has now been delayed). It appears that about R 7 million has been set aside for procurement, management and distribution of drugs.

[46]Surprisingly, on 29 June 2004 we learnt however that Limpopo placed orders for Efavirenz 600mg.

7. Mpumalanga

Table 8

Mpumalanga site and patient number information

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
Rob F	?	?		?
Shongwe	1 June 2004	50-55 adults (16 on ARVs)	Ehlanzeni	Yes
Themba	?	Capacity for 64	Ehlanzeni	Yes
Philadelphia	?	?	Nkangala	Yes
Witbank	1 June 2004	20 adults enrolled	Nkangala	Yes
Bethal	?	?	Gert Sibande	Yes
Evander	?	?	Gert Sibande	Yes
		Less than 50		

SUMMARY

Six (6) sites are accredited: Shongwe, Themba, Philadelphia, Witbank, Bethal and Evander. Witbank and Shongwe started providing treatment on 1 June 2004.[47] Shongwe has about 50 patients enrolled with approximately 16 receiving ARVs (adults). Witbank has about 20 enrolled adult patients. We are unable to confirm start dates and/or patient numbers in respect of the other accredited sites. We have heard however that they will only commence treatment in August 2004. Themba has capacity for 64 (10 assessments per week).[48]

It appears that less than 50 patients are on treatment in public hospitals in Mpumalanga. Even though paediatric supplies were received in the last week of June 2004 and were due to have been delivered to sites by Friday 2 July 2004 children are not as yet receiving treatment. [49]

Mpumalanga has a high turnover of doctors (community service). A HR strategy to retain doctors and nurses in the public sector in Mpumalanga is therefore vital.

[47] It appears that treatment was delayed at the accredited sites until 1 June 2004 because the Province could not get supplies of ARV medicines.
[48] During March 2004 TAC site visits were conducted at Shongwe and Rob Ferreira
[49] Note that Ndlovu medical centre in Mpumalanga, a private initiative and donor funded programme, is treating 220 (adults and children) and plans are afoot to expand over time.

Vigorous VCT campaigning is also required in the province. This is because patients who are seeking VCT at present are already very sick.
Mpumalanga acknowledged our request submitted on 27 May 2004 for site, patient and budget information and undertook to respond to us [50] They subsequently requested an extra week and we expected a response by 5 July 2004, but this was not forthcoming.

In any event, Mpumalanga has requested civil society to work together in mobilising communities and to assist with treatment literacy and the training of health care workers and counsellors.[51].

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[50] See correspondence dated 3 June 2004
[51] In response to correspondence sent by TAC on 7 April 2004, on 13 May 2004, the office of the MEC indicated that the MEC would consider our request for information. The MEC 'congratulated' TAC for the 'good work it is doing for the people of South Africa'.

8. KZN

Table 9

KZN site and patient number information

SITE	DATE	PATIENT NO (end May)	DISTRICT	ACCREDITED
1. King Edward VIII	1 April 2004	5 adults	Ethekweni	Yes
2. Gandhi	1 April 2004	10 adults	Ethwekni	Yes
3. Addington	1 April 2004	15 adults	Ethwekni	Yes
4. Church of Scotland	1 April 2004	25 adults (?100 through donor money)	Umzinyathi	Unsure?
5. Ngwelezane	1 April 2004	16 adults	Uthungulu	Yes
6. Stanger	1 April 2004	25 adults	Ilembe	Yes
7. Benedictine	1 April 2004	23 adults	Zululand	Yes
8. Kokstad (EG Usher)	1 April 2004	10 adults	Sisonke	Yes
9. R K Khan	27 June 2004		Ethekweni	Yes
10. Murchison	27 June 2004		Ugu	Yes
11. Edendale	27 June 2004		Umgungundlovu	Yes
12. Mseleni	27 June 2004		Umkhanyakude	Yes
13. Ladysmith	27 June 2004		Uthukela	Yes
14. Madadeni	27 June 2004		Amajuba	Yes
15. Prince Mshiyeni	27 June 2004		Etheweni	Yes
16. Port Shepstone	27 June 2004		Ugu	Yes
17. Greys	27 June 2004		Umgungundlovu	Yes
18. Newcastle	27 June 2004		Amajuba	Yes
19. Lower Umfolozi	27 June 2004		Uthungulu	Yes
20. Dundee	27 June 2004		Umzinyathi	Yes
21. St Marys (Marianhill)		Unsure of numbers		Donor funded
22. McCord		Unsure of numbers		Donor funded
		End June 120 Possibly max. 250		

SUMMARY

8 sites started providing treatment in KZN during March – April 2004. They are: King Edward VII, Gandhi, Addington, Church of Scotland, Ngwelezane , Stanger, Benedictine, R K Khan and Kokstad Usher Memorial. [52] At the end of June 2004, 120 adults were receiving ARV treatment at the 8 accredited sites. It appears that 100 patients are receiving treatment through a donor-funded project at Church of Scotland.[53]

It appears that 12 additional accredited sites were given the provincial 'go ahead' to start providing treatment on Monday 27 June 2004. These 12 sites were accredited a while ago and the reason for the delay appears to be the Ministers refusal to permit treatment to commence at these sites. We do not have information about patient enrolment numbers at these 12 sites.

4 other sites have also been identified and hope to commence treatment after they are accredited. This will bring the total number of ARV sites to 24.

Paediatric drug supplies were received in the second week of June 2004. This has resulted in lengthy waiting lists at sites. At King Edward about 200 children are on the waiting list already. However, we have learnt that even though paediatric regimens are now available, children have not as yet been placed on treatment at King Edward. The reasons for this are unclear. [54] KZN is also facing HR related problems, with posts not being speedily filled. The M & E process in KZN also seems to be lagging.[55] This will affect the provinces ability to reach optimal patient targets.

KZN has requested civil society to work together in mobilising communities and to assist with treatment literacy and training of health care workers and counsellors. But, KZN has not responded to our request for information relating to patient targets, site details and budgetary allocations nor have they provided us with a copy of their Provincial Treatment Plan. ⇓

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[52] 32 centres are accredited to provide treatment (training completed, drugs available, lab facilities available) and each centre now has to commence / expand accordingly.

[53] TAC sites visits were conducted at Stanger; Ngwelezane and Empangeni.

Dr Chris Jack (ARV co-ordinator) is due to have a public briefing on the KZN rollout on 21 July 2004.

[55] It appears that KZN has decided to only monitor viral load test results. It is important to note that labs in KZN are not part of the NHLS as yet, and thus the NHLS reporting envisaged by the national M & E process will probably not include KZN lab results

9. Eastern Cape

Table 10

Eastern Cape site and patient number information

SITE	DATE	PATIENT NO	DISTRICT	ACCREDITED
Lusikisiki	2003	238 (227 adults) (11 children)	O Tambo	-
Nelson Mandela Metropole Uitenhage PE	June 2004	20 adults		 Yes Yes
East London	June 2004	10 adults		Yes
Queenstown	July 2004	1 adult		Yes
Umtata	June 2004	8 adults (plus 11 prescriptions Capacity for 100		Yes
St Lucy	July 2004	5 adults		Yes
Grahamstown	1 May 2004	< 20 adults		Yes
Rietvlei	?	Capacity for120 adults		Awaiting
Sterkspruit	?	-		Awaiting
		End June 298		

Budget unknown, site contact list available from ALP

SUMMARY

In 2003 Lusikisiki (13 service points) started providing ARV treatment through MSF (donor funded). As at the end of May 2004, 227 adults and 11 children were on treatment at the MSF site.

Uitenhage and PE started providing treatment mid June 2004 using government funds. 20 adults appear to be on treatment.

The following sites started treatment recently:

East London – with less than 10 adult patients on treatment;

Queenstown – one (1) adult patient on ARV treatment.

Umtata has eight (8) patients on ARVs, whilst another 11 have prescriptions but have not yet commenced treatment. It appears that Umtata has the capacity to treat more than 100 patients. However, delays in treatment at Umtata are illustrative of many other sites in the EC and in the rest of the country. It also explains the small patient numbers. [56]

[56] Umtata was initially identified as a site, and was visited in November 2003 by the NDoH accreditation team. By February 2004 Umtata was excluded from pharmaceutical training. Training was only provided on 28 June 2004. This is because the NMHC was the preferred site. Subsequently

At St Lucy's 5 adults were on treatment as at 5 July 2004.
Grahamstown commenced treatment on 1 May 2004. Less than 20 adult patients are on treatment. Rietvlei Hospital has the capacity to treat 120 adult patients in its first year but it appears not to have commenced with its programme.

The EC has invited civil society to assist with training of HCWs. However, better salaries for nurses and doctors and an aggressive HR strategy to recruit and retain HCWs is vital. The capacity to train HCWs is seriously lacking in the province. As with other provinces, the filling of critical posts is necessary.

The EC has not responded to two requests for information and data on sites, patient numbers and budget allocations. [57]On 18 June 2004 we also requested a copy of the Provincial Treatment Plan to which we have had no response. [58]

The EC is one of the poorest provinces in SA. It is therefore worrying that additional resources are not being provided to the EC to expand its treatment programme. [59]

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Despite Umtata's proactive efforts to identify its needs on several occasions since November 2003, it has not received any substantial assistance save one lockable cupboard mid June 2004. For example, even though 6 posts for community pharmacists were advertised for NMHC none were advertised for Umtata. Interestingly, correspondence in the possession of TAC suggests that Umtata is the stronger site when compared to St Lucy's and Rietvlei.

[57] 7 April 2004 and 18 June 2004.

[58] At a Parliamentary briefing on 8 June 2004, it was recorded that while the EC HIV/AIDS Business Plan has been submitted to the NDoH, addendums to the Plan were still outstanding.

[59] Statistics (2001) indicate that EC is home to about 15% of the country's population and is the third most densely populated with majority (60%) living in rural areas.

Appendix A

Provincial ARV contact persons

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