

NSP REVIEW

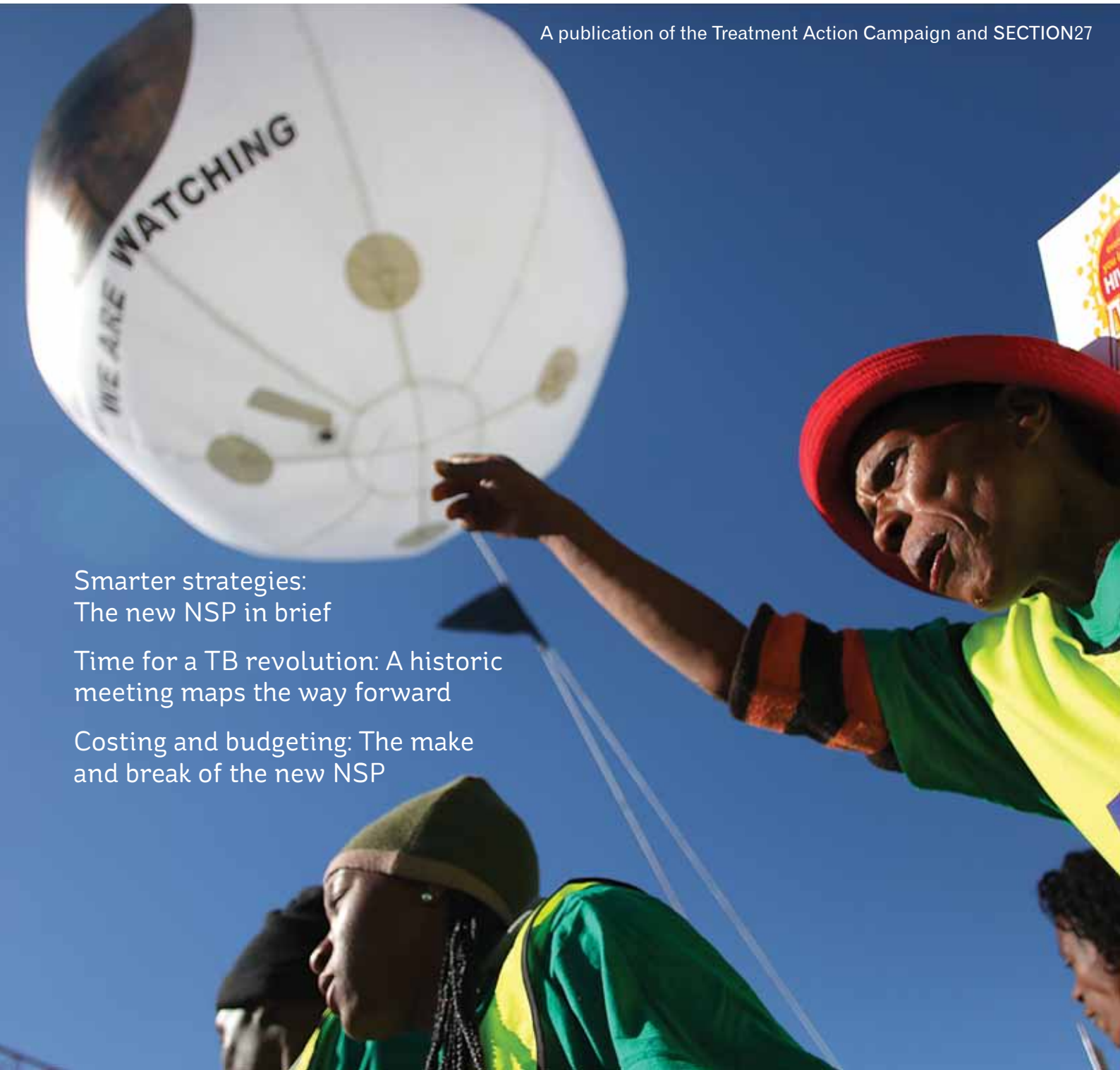
Engaging with South Africa's National Strategic Plan for HIV, STIs and TB | Edition 1 December 2011 – March 2012

A publication of the Treatment Action Campaign and SECTION27

Smarter strategies:
The new NSP in brief

Time for a TB revolution: A historic
meeting maps the way forward

Costing and budgeting: The make
and break of the new NSP



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The Treatment Action Campaign (TAC) advocates for increased access to treatment, care and support services for people living with HIV and campaigns to reduce new HIV infections. Learn more about TAC's work at www.tac.org.za.



SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights, particularly the right to health. Learn more about SECTION27's work at www.section27.org.za.



"This is the first issue of NSP Review. In this, and in future issues, we aim to provide quality analysis and monitoring of the implementation of the new NSP. It is our hope that this publication will increase awareness of, and critical engagement with the NSP. We will try to keep it relevant with evidence from new research and feedback from the various district offices of the Treatment Action Campaign **as well as organisations with which we work closely**. Our vision is a vibrant, evidence-based publication that will help all stake holders drive a more successful response to HIV, STIs and TB. We encourage you to get in touch with us should you want to contribute to future editions of NSP Review. You can e-mail the editor at nsp@tac.org.za."

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EDITORIAL

On 1 December, World AIDS Day 2011, TAC and SECTION27 joined the rest of South Africa and the world in welcoming the launch of a new five-year National Strategic Plan on HIV, STIs and TB (2012–2016). The plan's target is that by 2016 80% of people are on ARV treatment, that deaths from TB have been halved, and that new HIV infections are cut by 50%. This plan is unique, because millions of people's lives depend on its successful implementation. Already there are over a million people on treatment. By the time the plan is complete that number must be three million.

We therefore congratulate the Minister of Health and the South African National AIDS Council (SANAC) on ensuring that the NSP has been completed on time and making a political commitment to its implementation.

The NSP 2012–2016 succeeds the 2007–2011 plan. It is the beginning of a new era in the response to HIV, TB and the social drivers of these epidemics. Since the last five-year plan, we have seen a revolution in the response to AIDS. South Africa started the last plan with Manto Tshabalala-Msimang as the Minister of Health and Thabo Mbeki as President. Although the plan was adopted by the government, it was resisted by the Minister. Some of the key interventions it proposed, such as a programme to provide voluntary medical male circumcision (VMMC) on a large scale, were delayed; for several years the roll-out of ARVs was kept as slow as possible. Preventable infections and deaths continued.

Five years later all that has changed. We have almost all the tools and policies to fight HIV and TB. What we need now is accountability for implementation.

We have mass programmes on HIV Counselling and Testing (HCT), VMMC, prevention of mother-to-child transmission (PMTCT) and access to HIV and TB drugs. What we need now is to be sure of the quality and sustainability of these interventions.

The NSP 2012–2016 has been developed through an unprecedented degree of collaboration between civil society and the Department of Health, under the auspices of SANAC. It is a bold plan. South Africa is showing leadership at a time when many other parts of the world are retreating from their commitments on HIV. In parts of Africa large numbers of people are dying again and they are losing hope.

But, despite this, TAC and SECTION27 are aware of the challenges that lie ahead. Some of these are summarised below:



- The NSP must be properly budgeted for! Although the plan makes a commitment to being fully costed and budgeted for, we will remain vigilant to see that this actually happens. By the 2013/14 financial year we expect to see clear budgets for the implementation of the NSP in the national budget, provincial budgets and the budgets of government departments.
- Operational plans must be agreed at provincial and local level by April 2012! The NSP is a national guideline. But its first test will be in its implementation by provinces and municipalities. Provincial and local operational plans must reveal real programmes at community level around HIV prevention in places like schools, workplaces, taverns and churches. There must be measurable programmes for voluntary HIV testing in schools and amongst people with higher risk of HIV. We must see plans to stop violence against women. We must see clinics with systems for infection control.
- Human rights need to be protected and not just talked about! The NSP makes some bold commitments that will need leadership from the government, including the long-delayed issue of the decriminalisation of sex work (promised in the last NSP).
- SANAC must be made a statutory body that is efficient, transparent and effective! In the last five years SANAC has played a growing leadership role and has improved its visibility. But it has also wasted money and become an institution where some of its members lack accountability and scrutiny. This must change. More than many other institutions, SANAC is entrusted with people's health and lives. It cannot become another feeding trough.
- TAC and SECTION27 will continue to assist the government at every level. We will help to build effective local and district AIDS councils and communities where people know about their rights. But we will also remain independent, monitoring to make sure that the plan is felt in villages and factories, not just in conference rooms and hotels.

Mark Heywood

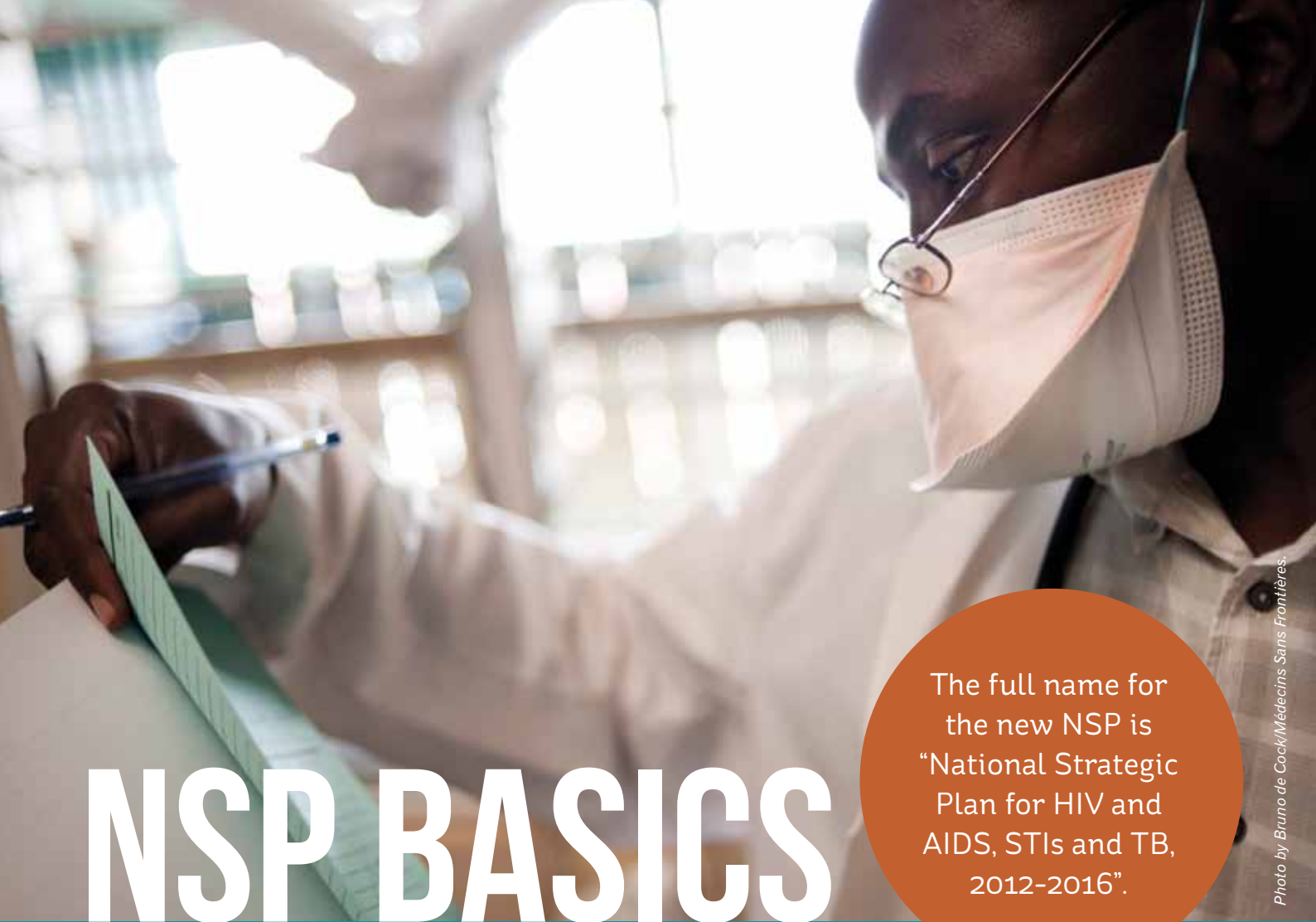


Photo by Bruno de Cock/Médecins Sans Frontières.

NSP BASICS

The full name for the new NSP is “National Strategic Plan for HIV and AIDS, STIs and TB, 2012–2016”.

VISION OF THE NEW NSP

The vision of the new NSP sets ambitious, long-term targets which can direct South Africa’s AIDS response beyond the five-year coverage of the 2012–2016 NSP.

While the new NSP might only cover five years, the underlying vision looks far further into the future. As a 20-year goal, the new NSP prioritises three objectives, known as the ‘three zeros’, suggested in the UNAIDS ‘Getting to Zero’ strategy.

The ‘three zeros’ are:

1. Zero new HIV, STI and TB infections;
2. Zero deaths associated with HIV and TB; and
3. Zero discrimination.

Reaching these goals will take many years of commitment and hard work. We can use the new NSP to guide, coordinate and strengthen our efforts.



NSP FIVE-YEAR GOALS

The new NSP's five-year goals set shorter-term targets that can help us achieve the vision of the 'three zeros' in the long-run.

While the 'three zeros' is an ambitious long-term vision, most of the new NSP is concerned with short-term goals that we can try to achieve in the next five years. The broad five-year goals inform more specific and immediate objectives, like the number of condoms we should aim to distribute per year.

The new NSP identifies the following five-year targets:

1. **Reduce new HIV infections by at least 50% using combination prevention approaches.** Combination prevention approaches use a number of different prevention interventions simultaneously to help curb new infections. These interventions include, amongst others, medical male circumcision, early treatment initiation and condom roll-out.
2. **Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% of those alive and on treatment five years after initiation.** This target demands that we not only get more people who need ARVs onto treatment, but also that we retain people in care. This requires interventions like improved adherence support, early detection of opportunistic infections, and maintaining an uninterrupted supply of antiretrovirals.
3. **Reduce the number of new TB infections as well as deaths from TB by 50%.** This will require efficient diagnostics, improved infection control and better treatment.
4. **Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP.** This target demands a legal system that protects the right to health, life and dignity.
5. **Reduce self-reported stigma related to HIV and TB by at least 50%.** Stigma and discrimination threaten basic human rights and continue to impact people's ability to access essential services. Anti-stigma interventions will need to engage health care workers, communities, families, workplaces and institutions, and will require a re-assessment of social norms and public discourse.

We helped
write the NSP

From March to May 2011 TAC brought together the people living with HIV (PLHIV) sector to hold public consultations in seven provinces, as well as a national consultation. A number of the recommendations stemming from these meetings were included in the final NSP. After the release of the first draft in August, TAC made three further submissions.

STRATEGIC OBJECTIVES OF THE NEW NSP

The strategic objectives of the new NSP focus our efforts by highlighting key priority areas that will help maximise our impact. These strategic objectives inform the long-term vision of the NSP as well as the five-year goals and more specific targets.

The four strategic objectives identified for the new NSP are:

1. Focus on Social and Structural Approaches to HIV and TB Prevention, Care and Impact;
2. Prevention of HIV and TB infections;
3. Sustain Health and Wellness; and
4. Protection of Human Rights and Promotion of Access to Justice.

The new NSP gives substance to these strategic objectives by identifying a number of specific goals under each. For example, the objective to 'Protect human rights and promote access to justice' is substantiated by highlighting specific laws that need to be re-examined to ensure that the human rights of people living with or affected by HIV and TB are not compromised.

On the next page, some of the targets of the new NSP are explored in more detail, with specific reference to the strategic objectives they embody.

NSP HIGHLIGHTS

The new NSP contains a vast number of broad and specific targets. It would be impossible to discuss all of them here. Instead, we have selected for discussion some of the most interesting targets set by the new NSP. These targets are grouped

and contextualised within the wider strategic objectives of the new NSP in order to demonstrate how specific targets are informed by the broad objectives and vision of the NSP.

Each strategic objective set by the NSP has a number of sub-objectives which provide more detail on how we can focus attention on the identified areas of concern. In future issues we will examine many of these targets and strategies more closely.

STRATEGIC OBJECTIVE 1:

Focus on Social and Structural Approaches to HIV and TB Prevention, Care and Impact

This objective emphasises the social, economic, political, cultural and environmental factors that lead to increased vulnerability to HIV, STIs and TB. These factors include unemployment, insufficient social services, income inequality, poor infrastructure, inefficient legal services and questions of gender justice. The strategic objective to focus on structural and social approaches to HIV and TB has eight sub-objectives.

Amongst others, Sub-Objective 1 states: “The poor living conditions in informal settlements provide fertile ground for HIV, STI and TB transmission, as well as the spread of many other communicable diseases, especially amongst children – mainly as a result of the lack of proper building materials, and the lack of access to basic services like sewerage, electricity and running water as well as lack of food security.”

In addition to identifying the conditions which increase vulnerability to HIV, TB and STIs, the NSP also stipulates that the state should identify and address “structural barriers to accessing HIV, STI and TB services to residents in informal settlements”.

Furthermore, the NSP requires that a national plan be developed to achieve this goal and identifies specific government departments that are responsible for making this happen.

STRATEGIC OBJECTIVE 3:

Sustain Health and Wellness

The focus of this objective is to achieve a “significant reduction in deaths and disability as a result of HIV and TB infection through universal access to accessible, affordable and good quality diagnosis, treatment and care.”

The Department of Health’s plan to ‘re-engineer primary health care’ will see a radical expansion of primary health care services with an emphasis on community-based care services. Community-based services, are crucial to expanding the quality and reach of health and wellness services, which will help to improve diagnosis, follow-up, adherence and retention in care.

In addition to bolstering primary health care services, this objective places great emphasis on early treatment, in line with mounting evidence that earlier treatment

is both beneficial for patients and reduces onward transmission. The following key steps are identified in order to ensure earlier treatment:

- All ART must be started within 2 weeks of staging and adherence eligibility being confirmed;
- All ART must be started within 8 weeks of starting TB treatment;
- All TB treatment must be started less than 2 days after confirmation of TB at screening site (<5 days for MDR-TB);
- All primary care, antenatal, TB and mobile outreach health facilities must become fully functional nurse-initiated ART and MDR-TB initiation sites for adults, children and pregnant women;
- Unless clinically indicated otherwise, all patients started on ART and

MDR-TB treatment should be managed at the primary health care level;

- Ensure 90% treatment success rate for drug susceptible TB (60% for MDR-TB).

Other interesting targets include:

- 70% of all TB patients and pregnant women must be initiated on lifelong antiretroviral treatment by 2012. This target rises to 100% by 2016.
- 20% of clinics must provide services on weekends and after hours by 2012. This target rises to 90% by 2016.
- Refugees, legal foreigners and undocumented migrants must have equitable access to TB screening, HIV testing and appropriate treatment in line with Department of Health policies and guidelines.

STRATEGIC OBJECTIVE 2: Prevention of HIV and TB Infections

The new NSP places great emphasis on combination prevention. This means that a combination of different interventions is required to slow the rate of new infections. These interventions can be structural (like increasing access to nutrition and transport), medical (including voluntary medical male circumcision), social (such as changing social norms that discriminate against homosexuals), or behavioural (like promoting correct and consistent condom use and reducing multiple and concurrent partnerships). The strategic objective to prevent HIV and TB infections has eight sub-objectives.

Amongst others, Sub-Objective 2 aims to: “prevent vertical transmission of HIV to reduce mother-to-child transmission to, at least, less than 2% at six weeks and less than 5% at 18 months by 2016.”

This will require the proper integration of prevention of mother-to-child-transmission services into primary health care and effective post-natal follow-up, including strengthening infant feeding practices.

Other interesting targets which flow from the ‘prevention objective’ include:

- **10 million people to be both tested for HIV and screened for TB in 2012.**

This target rises to 30 million for 2016.

It is only through knowing one’s status that appropriate interventions and services can be accessed. Furthermore, evidence that early treatment initiation can decrease the risk of transmitting HIV and keep people with HIV healthy, should encourage early testing and screening in order to initiate treatment as soon as possible.

- **500 million male condoms and 9 million female condoms to be distributed in 2012. These targets rise to 1 billion and 20 million respectively by 2016.** The low targets for female condoms are disconcerting given that new and better female condoms are due to be approved by the World Health Organization (WHO) in the coming months. Female condoms are one of the few female-initiated prevention interventions available to us and efforts for increased roll-out should be strongly supported.
- **500,000 males to undergo voluntary medical male circumcision in 2012. This target rises to 800,000 by 2016.** New evidence showing that the risk of HIV transmission amongst circumcised men is reduced by up to 60% resulted

in the roll-out of a national medical male circumcision programme in 2010. The new NSP aims to scale-up these efforts to reach 80% of men between 15-49 years of age by 2016.

- **Reduce new TB infections by 50% against 2010 levels by 2016.** This will require prompt diagnosis, improved infection control and a seamless link between screening, diagnosis and treatment.
- **Provide antiretroviral treatment to 58% of those in need by 2012. This target rises to 85% by 2016.** At the end of 2009, an estimated 37% of people with HIV were receiving treatment for HIV, according to the latest WHO guidelines (2010). Antiretroviral programmes must increase in size, accessibility and efficiency in order to provide these life-saving medicines to all who need them. In the wake of growing evidence that ARV treatment dramatically reduces onward transmission of HIV and decreases the risk of opportunistic infections which cause a spike in viral load, the scale-up of antiretroviral treatment is key to prevention efforts.

STRATEGIC OBJECTIVE 4: Protection of Human Rights and Promotion of Access to Justice

The law has played a key role in ensuring access to treatment in South Africa. However, many legal challenges remain. The NSP takes as a starting point the constitutional recognition that access to health care and other social services – which includes reproductive health care – is itself a fundamental right. In fact, it could be argued that the state has a constitutional obligation to implement many of the legal reforms suggested under this objective of the NSP. This objective has four sub-objectives.

Amongst others, this section calls for reform of South Africa’s Patents Act 57 of 1978, which may unconstitutionally limit access to medicines by providing patent protection in excess of what is required under international trade law, thereby preventing the market entry of generic competition necessary to bring medicine prices down and ensure sustainability of supply. TAC has recently launched a campaign calling for such patent reform.

The NSP also requires a process that must result in the tabling of a bill to

decriminalise adult sex work by no later than 30 June 2013.

Unlike the previous NSP, the new NSP identifies responsible government departments for many of the proposed legal reforms and sets concrete deadlines for specific steps to be taken. It is essential that we hold government departments accountable in this regard over the coming years.

THINGS TO WATCH

TAC and SECTION27 made a number of submissions during the development of the new NSP. The submissions have had some impact on what the final NSP looks like, but they also flagged various issues that will require continued monitoring. In the following pages we look back at some key submissions and the implications for the way forward.





TB IN THE NEW NSP

Early on in the new NSP it states: "One of the key decisions of the consultations was to develop a single integrated strategy for HIV, STIs and TB for 2012-2016. This is primarily due to the high co-infection rate between HIV and TB." Thus, the NSP crucially recognises that HIV and TB affect not only the same communities, but often the same patient. At the same time, however, TB itself appears to be the weaker partner in this integrated NSP.

In a submission on an early draft of the new NSP, TAC wrote: "Insufficient emphasis is placed on TB throughout the current draft, particularly in the main text. Although paid lip-service throughout the document, it often appears that TB has been simply inserted into an HIV document. For instance, where examples of interventions are provided, they focus primarily or entirely on HIV. While in some cases the same intervention will be appropriate for both conditions, TB also requires specific action."

While some specific improvements around unique TB interventions and populations have appeared in later drafts, this observation retains some broad truths. This can be seen most obviously in the fact that the new NSP discusses at length how it builds upon the previous NSP (HIV), but almost completely overlooks the NSP (TB) to which it is also heir. This lack of attention comes despite the fact that TB is the number one killer

of adults in South Africa, that recorded deaths tripled between 1997 and 2005, and that the world's first widely publicised outbreak of extensively drug resistant (XDR) TB was reported in South Africa in 2006. The latter case is particularly instructive given that drug resistant TB exists mainly as a result of an inadequate health system response to TB. Through the consultation process, TB has been integrated more deeply into each successive draft of the NSP, but often still seems overwhelmed by HIV.

This imbalance is heightened by the fact that, despite the promise of the early reference to co-infection mentioned above, the NSP ultimately never truly drives home the most important reason for addressing both diseases under the same strategy: that HIV/TB co-infection poses a risk greater than the sum of its parts, as the two diseases reinforce each other, making the patient with one more susceptible to the other while making treatment and diagnosis more difficult. Thus, integration of services for education, diagnosis and treatment of HIV and TB is crucial not because it is convenient or cost-effective to address the conditions at the same time, but because it is no longer possible in South Africa to tackle one without also tackling the other. Addressing HIV and TB under the same strategy is a crucial step for health care in South Africa. What is also crucial is that TB, and TB activists, not be the silent partner in the relationship.

TIME FOR A TB REVOLUTION

On 10 August 2011, TAC, Médecins Sans Frontières (MSF), the HIV Clinicians Society of Southern Africa (HIVSOC) and SECTION27 hosted an historic meeting of scientists, clinicians, policy makers, government and activists to ignite South Africa's response to the tuberculosis (TB) epidemic.

Photo by Chelsea Maclachlan.

Recorded TB deaths in South Africa tripled between 1997 and 2005. TB is the country's number one cause of death in adults. Yet despite the health crisis posed by TB, the disease is neglected. Political will, accountability, access to new drugs and diagnostics and expanded funding are urgently needed to strengthen the response.

The meeting participants agreed that we must take bold steps: new diagnostics like the GeneXpert must be rolled out while also investing much more money in research for highly sensitive and specific point-of-care tests; HIV co-infected patients must be initiated on antiretroviral treatment regardless of their CD4 counts; patients with drug-resistant TB should have access to experimental drugs like bedaquiline (formerly TMC207) and delamanid (formerly OPC-67683).

We also need a different approach to finding and treating TB. We need a campaign encouraging TB screening, similar to the campaign for HIV testing. By treating people with active TB much earlier, we can reduce the time that people are infectious.

People co-infected with HIV should be treated by the same health care team for both conditions. The paternalistic Directly Observed Treatment (DOTS) model must be phased out and replaced with adherence models similar

to those used for HIV. Treatment for drug resistant (DR) TB must be decentralised and must respect the constitutional rights of patients. Facilities treating TB must have working infection control and implement contact tracing.

As with HIV, there needs to be a TB budget. The government's response to TB can be adequately planned and funded if government develops a needs-based budget.

Miners and former miners are disproportionately affected by TB. It is critical for the mining industry to improve working and living conditions, including the replacement of hostels with decent housing and lowering dust levels. The industry has to assist with regular check-ups of former miners, because they remain at very high risk of developing lung disease.

Prisoners are also at very high risk of TB. This risk is mainly due to overcrowding. The Department of Correctional Services must therefore take steps to reduce overcrowding in prisons.

The special needs of children at risk of TB are often neglected. Efforts to prevent, diagnose and treat TB in children in South Africa are poor. Diagnostics and drugs are seldom tested as well in children as they are in adults. Children's needs must be prioritised.

TB: WHAT NEEDS TO BE DONE?

The August 2011 meeting came up with the following list of steps required to ignite South Africa's response to TB:

1. Protect the rights of people with TB and reduce TB vulnerability

Poor people are much more likely to become sick with TB. But it is also much more difficult for poor people to access quality health care so that TB can be diagnosed and treated. People with TB also face stigma and discrimination. This is why the response to TB must be consistent with the protection and promotion of human rights. This must be reflected in the new NSP and all other Department of Health TB policies.

2. Expand screening for and diagnosis of TB

By screening more people for TB and diagnosing them earlier, we can treat more people, reduce mortality and reduce new TB infections. Through the HIV Counselling and Testing (HCT) campaign, more people have been screened for TB. Referral and follow-up systems must be strengthened so that people are not lost to follow-up and those diagnosed with active TB start treatment. TB screening must be increased to the scale of HIV testing by launching a TB-specific testing campaign.

Contact tracing of TB patients is another essential intervention. During the 2011 Budget Speech, Health Minister Aaron Motsoaledi announced that the Department of Health had begun rolling this out in some areas. This must urgently be expanded to all health facilities that treat TB.

3. Implement the GeneXpert and invest in better diagnostics

TB diagnostics are far inferior to diagnostic tools developed for HIV. Today the gold standard for diagnosing TB is to grow it in culture from a patient's sputum. This is an expensive process that takes weeks. Because of cost in both time and money, most TB diagnoses is therefore carried out by looking for TB bacilli in sputum under a microscope. The turnaround time for this is about a day, but it is not very accurate. Many people with active TB, especially people with advanced HIV disease, have very few bacilli in their sputum and are therefore not diagnosed. By comparison, fast, accurate tests are widely available for HIV, a virus that was unknown 30 years ago.

A new tool called the GeneXpert is able to detect TB in many of the false negatives given by smear microscopy. Also, unlike smear microscopy, the GeneXpert is able to diagnose both drug susceptible TB and resistance to rifampicin. Resistance to rifampicin is highly correlated with resistance to isoniazid in South Africa and therefore with Multi-Drug Resistant (MDR) TB.

The GeneXpert provides test results in two hours. However the planned roll-out of the GeneXpert in South Africa is largely at district-level laboratories and not decentralised at primary health care facilities where people with TB present. Slow laboratory turnaround times and reliance upon transport systems will continue to delay results.

A costing in South Africa demonstrated that placing the GeneXpert in health facilities will increase the costs of rolling out the GeneXpert by 70%. (Source: G Meyer-Rath) But the test will only realise its true value if it is decentralised. While it is therefore essential to put pressure on the manufacturer, Cepheid, to reduce costs further, the roll-out to primary care facilities must still be budgeted for.

GeneXpert is not the only diagnostic tool that is needed. Diagnosing TB in infants and young children is very difficult and under-researched. Many children cannot produce a sputum sample. Private care facilities and NGOs generally use a nebuliser (mist machine) to produce a sputum sample from a child. Nebulisers are urgently needed in public health facilities to scale up diagnosis of TB in infants and children. Nebulisers can also help adults to produce sputum.

Finally, while we must rapidly roll out the GeneXpert, which is possibly the best available TB diagnostic tool, we still need an affordable, rapid, electricity-free point of care TB diagnostic tool. Further investment in the development of such tools is strongly needed.

4. Treat all people with drug resistant (DR) TB and decentralise DR-TB care

South Africa is failing to diagnose many cases of DR-TB. According to Médecins Sans Frontières, in Khayelitsha only 54% of cases of DR-TB are detected. This figure is likely lower elsewhere in the country. Of those diagnosed nationwide, we are failing to retain and initiate many of them onto treatment. Beyond that, treatment targets are far lower than the number of patients diagnosed.

In 2010, nearly 10,000 cases of DR-TB were diagnosed but only a little more than 5,000 were started on treatment. By the end of 2011, the Department of Health estimates it will treat 6,500 DR-TB patients.

Without treatment, most patients with DR-TB will die. Delaying treatment also increases the risk of transmitting DR-TB. With the roll-out of the GeneXpert we can predict a large increase in the number of patients diagnosed with DR-TB and therefore save many lives. It is estimated that the roll-out of the GeneXpert will lead to the detection of 21,250 new cases of DR-TB by 2013. But in order to save these lives, it is essential to set ambitious treatment targets to provide treatment to all people diagnosed.

With ambitious treatment targets, treatment must be decentralised to reach all people in need. Currently there is not enough space in clinics to treat all patients and treatment is highly centralised. The Department of Health estimated that as of April 2011, there was a shortage of over 750 beds for DR-TB patients. Decentralisation can help address this issue.

A properly costed and budgeted-for Community Health Worker policy is needed to scale up decentralised DR-TB treatment.

5. Improve access to **second-line TB medicines**

Treating patients with DR-TB is expensive and costs are expected to rise. In South Africa the average cost of treating an MDR-TB patient is R1,200 per month during the injectable phase and R900 per month during the continuation phase. For XDR-TB patients the prices rise to R6,000 per patient per month during the injectable phase and R4,000 per month during the continuation phase.

The shortage of suppliers of active pharmaceutical ingredients and finished DR-TB medicines drives up the costs of these medicines and makes them vulnerable to shortages.

Capreomycin, an injectable used in South Africa to treat XDR-TB, provides an example of some of the cost drivers in the TB medicines market. There is currently a worldwide shortage of the medicine as there is only one supplier of the active pharmaceutical ingredient.

Another problem is delayed regulatory approval of TB medicines. Para-aminosalicylic acid (PAS) is used to treat XDR-TB, costing an average of R2,000 per patient per month. The medicine was not registered until 8 August 2011 and was being purchased via Section 21 authorisations. The price is expected to drop by around 20% now that the medicine is registered, but will remain extremely expensive.

For most DR TB medicines, South Africa is paying higher prices than are available through the Global Drug Facility (GDF), which is the procurement arm of the WHO for DR-TB medicines. South Africa should consider procuring

medicines at lower prices through the GDF. It is vital that government take steps to reduce the costs of DR-TB treatment.

There have been several stock-outs of standard first-line TB drugs. Breaks in the drug supply-line endanger the lives of patients and cause drug resistance. They must be prevented.

6. **Compassionate access** to experimental TB medicines

There are a number of new TB medicines in the pipeline. They need further testing and are not yet ready to be registered. However, patients with MDR- and XDR-TB have to take treatment for approximately two years and they have a poor prognosis. They should be offered compassionate access to promising experimental medicines.

Bedaquiline (formerly TMC207) is the most advanced in clinical trials. It has been in development since at least 2004 and must be made available for compassionate use. A phase II trial demonstrated that the addition of bedaquiline to MDR treatment regimens resulted in more patients converting much quicker to sputum-negative culture.

Clinicians in South Africa must apply to the Medicines Control Council for Section 21 authorisations to use bedaquiline. These types of authorisations were used to procure PAS prior to its registration, a far less effective and harder to tolerate medicine.

7. Scale up **infection control measures**

Infection control is crucial if we are to address the TB epidemic, particularly the prevention of transmission of TB in health facilities. New facilities must be designed to reduce nosocomial transmission. All health care facilities must be provided with the resources for effective infection control. There must be an uninterrupted supply of N95 masks and this must be budgeted for. Patients and visitors should be educated on the importance of infection control. Community education programmes must be strengthened. Health care workers exposed to nosocomial TB infection should be supported by the trade unions, the Department of Health and the Department of Labour to ensure they are properly looked after and receive the compensation they are entitled to.

8. Addressing the **TB/HIV co-epidemics**

In South Africa, TB/HIV co-infection is estimated at 73%. On 12 August 2011, Deputy President Kgalema Motlanthe announced that all patients with CD4 counts at or below 350 cells/mm³ will now be eligible for antiretroviral

treatment (ART). Expanding ART eligibility is important for reducing the number of active TB cases and government should be congratulated on taking this step. However the WHO recommends that all people co-infected with HIV and TB should be offered ART regardless of CD4 count. The latest version of the NSP now includes this intervention, aiming to initiate 70% of patients co-infected with TB and HIV onto lifelong ART in 2012, reaching 100% coverage by 2016.

Isoniazid preventative therapy (IPT) is now available in public health facilities for people living with HIV. IPT can reduce a person's risk of developing active TB. However, concerns were raised that IPT is being implemented in South Africa without the condition that it only be offered to patients who are tuberculin skin test-positive (TST-positive). There is abundant evidence that IPT only benefits such patients. Moreover, it is potentially harmful to give IPT to TST-negative patients. As there are conflicting views on the use of IPT there needs to be further consultation involving clinicians and people living with HIV on its use and roll-out.

9. Reduce TB in the mines

Miners are at very high risk for active TB because of their exposure to silica (causing silicosis) and heavy dust levels, as well as the crowded living conditions that many miners experience. The risk of contracting TB is 2 to 5 times higher if you have silicosis. The risk of contracting TB is 3 to 5 times higher for people living with HIV. An HIV positive miner with silicosis is 16 times more likely to develop TB than a miner without these risk factors. For miners with silicosis or exposed to heavy dust levels, the increased risk of contracting TB is lifelong. The high prevalence of TB in the mining population also exposes their families and communities to TB infection.

SANAC must convene a stakeholders' summit to consider solutions to the crisis of TB in the mines. The mining industry should take responsibility for improving living and working conditions, reducing this group's risk of contracting TB and supporting better access to health care. All miners should have access to decent, lifelong health surveillance and health care.

10. Address the barriers to scaling up access to antiretroviral therapy

Expanding decentralised TB treatment that is integrated with HIV care affects human resources. Policies addressing specific groups of health care workers, such as the Nurse Initiation and Management of ART (NiMART) and the Community Health Worker policies, must be consistent and monitored, taking into account the state's aim to revitalise primary care.

NiMART is a necessary intervention that will improve patient access and quality of care if our health systems are simultaneously strengthened. While much progress has been made in the past year, there are still significant barriers to standardised, efficient, effective expansion of HIV services in South Africa. Barriers to the expansion of NiMART must be addressed urgently by finalising regulations governing scope of practice of all cadres of nurses, clarifying minimum standards for training and mentorship related to NiMART as well as clarifying standards for determining competency, relieving nurses of other time-consuming tasks that can be shifted to community health care workers, disseminating information on government decisions relevant to health care workers' roles and removing the barriers to nurses prescribing ART and for pharmacists and pharmacy assistants to dispense their prescriptions.

11. There needs to be political will from all government departments to deal with TB

TB is intimately linked to poverty. The government departments responsible for improving access to safe drinking water, adequate nutrition and housing are also essential to the response to TB.

We need budgets that are evidence-based. There needs to be better accountability for TB spending at all levels of government, especially national and provincial. We currently do not know how much we are spending on TB. A conditional grant would be beneficial for monitoring TB expenditure. But the reporting mechanisms for TB expenditure must be improved.

The Department of Health and the National Treasury should work closely together, while cooperation between other departments should be improved. People must be identified who would take responsibility for TB in their respective departments.

All policies, whether for the decentralised treatment of MDR-TB or for the integration of HIV and TB services, should be costed and budgeted. All policies should be properly communicated so that they are understood and complied with.

TAC and SECTION27 thanks all the scientists, researchers, policy makers, government officials and civil society representatives who attended and contributed to the August 2011 TB meeting.

- A new TB website for doctors, activists and patients was launched in August 2011. The site is called TB Online and can be found at www.tbonline.info.
- In September 2011 TAC published a TB-themed issue of its *Equal Treatment* magazine. You can download it for free from www.tac.org.za/community/equaltreatment.

WE NEED EXCELLENT COSTING AND BUDGETING

Given that the scale of South Africa's HIV response is set to expand substantially over the next five years, the need to cost the NSP properly and then budget for its implementation to ensure the adequate, efficient and sustainable funding of interventions cannot be ignored.

A failure to ensure that costing and budgeting processes are properly managed from the start is likely to result in an NSP that is not fully implementable.

Unfortunately, the government's ability to do this in the past has been severely lacking. For example, the 2010 Mid-Term Review of the previous NSP was particularly critical of the way in which the NSP 2007–2011 was costed and budgeted. The review highlights incomplete costing, diverse and uncoordinated

sources of funding, and the lack of coordinated budgets for implementation as significant challenges; these have resulted in a 'scatter gun' approach to the financing of the NSP.

We cannot afford to repeat these inefficiencies.

Ensuring that the NSP 2012–2016 is appropriately costed and then budgeted is not simply about adhering to good financial management principles; it is about ensuring that available resources are allocated and used in ways that ensures that the right to have access to health care services, as entrenched in section 27 of the Constitution, is progressively realised. The Constitution makes it clear that "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of (this) right".

HOW DO WE ENSURE EFFECTIVE COSTING AND BUDGETING?

- All aspects of the NSP 2012–2016 and the nine Provincial Operational Plans (POPs) must be costed.
 - Provision must be made periodically to review the costing to allow for adjustments to be made as new implementation data becomes available or as interventions are adjusted and revised.
 - Contingencies must be put in place to ensure adequate budgets for the implementation of the NSP and nine POPs in 2012/13.
 - Consideration must be given to the funding mechanisms to be used in transferring resources to departments and agencies responsible for implementing interventions.
 - Government must consider options for sourcing additional resources, using those funds that are available more efficiently and reducing input costs – such as medicines and diagnostics – where possible.
 - The way in which SANAC and other AIDS councils are financed must be reviewed; over the medium-term funding should be channelled through an integrated conditional grant.
 - Aggregated implementation budgets must be developed at the national and provincial levels that clearly outline available resources, what they will be used for and who will be responsible for expenditure.
 - SANAC must introduce a structure that will be responsible initially for costing the plans and then periodically reviewing this costing.
 - Budget monitoring and expenditure tracking should form part of monitoring and evaluation (M&E) structures and processes.
- Read SECTION27's full submission on costing and budgeting in the first draft of the new NSP on www.section27.org.za.



Photo by Samantha Reinders.

CIVIL SOCIETY WILL BE WATCHING

TAC and SECTION27 are members of the Budget and Expenditure Monitoring Forum (BEMF), a group of civil society organisations that monitors budgeting and expenditure for the NSP and health service delivery in the country. On 21 and 22 November, BEMF convened partners to look at the costing of the NSP and what is planned for provincial plans. The meeting aimed to capacitate civil society to better engage with and monitor the budgeting and expenditure process for the new NSP. The meeting also looked at the financing of our response and how we can better engage with the mobilisation of resources for HIV and AIDS. We will report back on this meeting in an upcoming issue.



“The NSP must resist the temptation to be everything to everyone; it cannot – and should not – become the focal point for dealing with all social ills that undermine the response to HIV & AIDS, TB and STIs.”

Photo by Alon Skuy.

WHAT IS A STRATEGY?

In a submission on the first draft of the new NSP, SECTION27 argued that the NSP must resist the temptation to be everything to everyone. That submission was important because of the way in which it attempted to define the role of the NSP.

Over the following months it became clear that that submission had identified a key point of contention. While some (SECTION27, TAC and others) were arguing for a streamlined NSP focussing on strategy, other stakeholders argued for a broader NSP that would include many more targets – some of which are very difficult to measure. Every stakeholder seemed to want his/her specific point of interest reflected in the NSP. The worry was that this could make the NSP unwieldy and ultimately harder for wider South African society to rally around.

While keeping the NSP streamlined and focussed was crucial, it was important from the outset to recognise that even if this wasn't fully achieved, the new NSP would still be an important step forward. The specific SECTION27 submission started: “The

new NSP represents a significant advance in South Africa's response to the epidemics. It marks closure on our history of conflict, recognising the importance of evidence-based underpinnings, the value of meaningful consultation and the centrality of constitutional values and human rights. Importantly, it starts to give expression to recent government commitments regarding HIV/TB integration.”

Many of the interventions identified in the first draft of the new NSP fell outside of an NSP's appropriate mandate. In our view, it is not for SANAC to coordinate these interventions that are central to the mandates of various government departments.

By definition, an NSP must be focussed; it cannot be the sum of all parts of the country's response. In addition to providing the basic framework in terms of which all stakeholders – government at all three spheres, business, labour and civil society – are to develop their detailed operational plans, an NSP must also provide the basis upon which it will be assessed and stakeholders held to account. Importantly, it must provide some

degree of coordination in relation to identified priorities; it should not seek to replace stakeholders' plans and programmes.

In particular, it needs to recognise the roles and responsibilities of organs of state, such as the National Planning Commission (NPC), as well as a wide range of line-function departments with primary responsibility over a number of HIV-relevant – but not necessarily HIV-specific – interventions.

The fact that an NSP does not expressly address all HIV-relevant issues does not mean that these issues are unimportant; it is simply to state that it is neither feasible nor appropriate to include every possible intervention under the rubric of an overarching national framework for HIV. That said, there are numerous important policies, programmes and structures – including many that are already in existence – that should be developed and implemented by relevant government departments.

Amongst others, these include the following:

- Health: primary health care revitalisation; national health insurance; enforcement of quality control through an Office of Health Standards Compliance; and a human resources for health strategy;

- Social Development: prevention and treatment of substance abuse; regulation of alcohol use and advertising; and social assistance; and
- Police, Justice & Constitutional Development and Correctional Services: prevention of sexual violence and the successful prosecution and incarceration of offenders; and an efficient and effective criminal justice system that protects the vulnerable.

So how then should the NSP deal with such issues, if at all?

Consider the example of gender-based violence (GBV), in particular rape. In our view, the NSP could focus attention on providing a range of key stakeholders – police officers, correctional services members, prosecutors, health care workers, their respective departments – with a strategic framework that provides the basis for ensuring access to post-exposure prophylaxis (PEP) services. For this to happen the identified stakeholders would also have to work on a broader range of interventions necessary to ensure access; but for the purposes of the NSP, the focus would be much narrower with clearly defined indicators.

THE WAY FORWARD

The final NSP was neither quite as streamlined as what we would have liked it to be, nor was it as broad as we feared it might be. Some stakeholders may feel aggrieved that their specific contributions were not included in the final NSP, but this is inevitable with such wide and extensive consultation. The writing team did an impressive job of taking the many various inputs and still producing a relatively concise final document.

Now that the NSP is out there, it is up to government departments, civil servants, and civil society to make it work. As all these stakeholders do their bit in their particular sphere, we encourage everyone to take a step back from their daily grind to consider how their work fits into this national plan. As argued in the SECTION27 submission, the NSP is not only a long list of targets, but the single strategy around which we can galvanise a renewed push to fight HIV, STIs and TB. If the popular rhetoric about fighting these diseases together is to mean anything, it has to mean aligning all of our efforts with the NSP.

The SECTION27 submission referred to in this article can be found at www.section27.org.za.



Photo by Jose Cendon/
Médecins Sans Frontières.

TAC FIGHTS FOR ACTIVE AIDS COUNCILS



Photo by Chelsea Maclachlan.

For the new NSP to be a success, it is essential that provincial, district and local AIDS councils (PACs, DACs, LACs) start playing a more active part in the fight against HIV, TB and STIs. These structures are essential to strengthening the partnership between government, various stakeholders and communities. They are the mechanisms by which national strategy can trickle down to communities, and community-level concerns can be escalated back up to the South African National AIDS Council (SANAC).

Unfortunately, many of these structures are not yet fully functional. Reasons for this include: a lack of understanding of the mandate of AIDS councils; lack of coordination and management skills; unbalanced representation of sectors; resource shortages; and lack of accountability.

During 2011 TAC aimed to play a leading role in reviving the PACs and DACs in the six model districts across South Africa where TAC has district offices. TAC district leadership used the HIV counselling and testing (HCT) campaign as a vehicle to revive AIDS councils, requesting meetings with provincial premiers and health authorities during planning for the launch of the HCT campaign. Through such engagements, the Eastern Cape PAC, the Mopani DAC, the Mpumalanga PAC, the Gert Sibande DAC, the Tzaneen LAC and the multi-sectoral action team (MSAT) in Cape Town conducted planning meetings in which TAC participated.

In August 2011 TAC and SECTION27 held a three-day workshop for 30 key TAC leaders representing TAC and

people living with HIV/AIDS in either the local, district, provincial and/or national AIDS councils.

The aim of the meeting was to evaluate and give recommendations on:

- the roles and responsibilities of AIDS councils;
- financing and measurable performance indicators;
- the role of civil society and TAC's allies; and
- the role of TAC in AIDS councils.

The workshop made substantial recommendations on restructuring SANAC and strengthening AIDS councils. These recommendations were later submitted to the drafting team for the new NSP. Subsequent to the workshop, TAC has been requested by district mayors to conduct training on the roles and responsibilities of AIDS councils in Gert Sibande, Mopani, Umgungundlovu and OR Tambo.

TAC will continue to advocate for well-functioning provincial and district AIDS councils.

Time to get to work

**01 DECEMBER 2011:
WORLD AIDS DAY**

Launch of South Africa's 2012-2016 National Strategic Plan for HIV and AIDS, STIs and TB.

The NSP will provide a framework to guide the activities of partners whose work is relevant to the three epidemics of HIV, STIs and TB in South Africa.

In order for the new NSP to make a meaningful impact, it must move beyond a mere policy document and into our clinics, institutions and communities. This will require that provinces take the necessary steps towards ensuring that implementation commences by the April 2012 deadline.

Implementation planning should be as inclusive as possible. Once provincial strategic implementation plans have been produced, these plans should be made available to the public so that civil society can engage with the implementation process and offer feedback on proposed implementation plans.

Progress towards meeting the targets of the NSP will need to be rigorously monitored and regular reporting should be encouraged.

Efforts to hold the state, other institutions and ourselves accountable to the vision of the new NSP must continue beyond the document's release on December 1st.

JANUARY 2012

National AIDS Council Task Team Reports

In September 2011 the Chairperson of SANAC, Deputy President Kgalema Motlanthe, appointed a high-level task team that will make recommendations on how the South African National AIDS Council must be strengthened and restructured. Members of the task team include: Dr Ayanda Ntsaluba and Judge Thabani Jali.

The efficient functioning of SANAC is essential to the success of the new NSP. We will carefully monitor the work and recommendations of this task team and report back in our next issue. The task team is due to report in January 2012.

01 APRIL 2012

Implementation commences

**24 MARCH 2012:
WORLD TB DAY**

Launch of the provincial strategic implementation plans.

The NSP itself is not an operational plan. Provinces and other partners will need to develop their own operational plans in advance of the NSP implementation date. Provincial AIDS Councils and National Government Departments will draw up strategies and implementation plans that describe exactly how they will implement the four strategic objectives of the NSP. The costed implementation plans must be complete by the end of March 2012.

SUPPORT TAC

WE NEED YOUR HELP

For more than a decade, TAC has campaigned for all South Africans to have better access to HIV/AIDS treatment, care and prevention programmes. TAC has received world-wide acclaim and numerous international accolades, including a nomination for a Nobel Peace Prize in 2004. In 2006 the New York Times called TAC "probably the world's most effective AIDS group".

FUNDING IS IN CRISIS

Funding for HIV/AIDS has been negatively affected by the global recession. The funding gap is growing fast and is now estimated to be over \$7.7 billion globally. In 2009, UNAIDS released studies on the impact of the economic crisis on HIV prevention and treatment programmes. The summary report states "the negative impact of the crisis on AIDS programmes is real and getting worse".

THE EPIDEMIC CONTINUES

People with HIV and TB continue to depend on TAC's education and campaigns - but we can't continue our work without your help. Be part of our struggle. Support TAC's work.

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