EQUAL treatment

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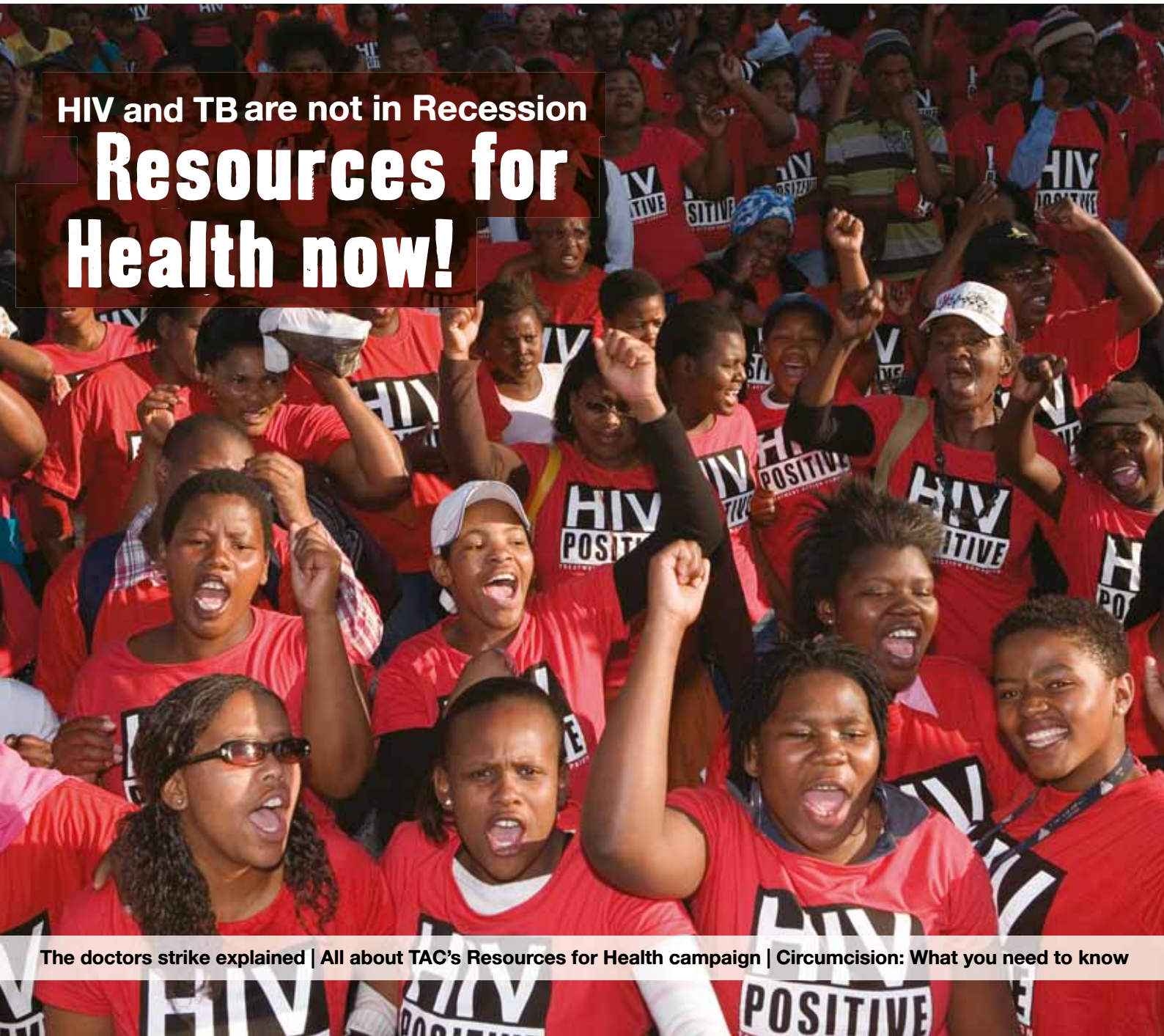

The doctors strike explained | All about TAC's Resources for Health campaign | Circumcision: What you need to know

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TAC is committed to providing people with HIV, their families and caregivers accurate information about life-saving medicines and treatment. TAC and its leaders are independent of the pharmaceutical industry as well as of the natural and alternative medicine industries and have no financial interests with them.

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CONTENTS

Issue 29 - September 2009

Editorial

For a long time now there has been an outcry in communities, both rural and urban, about the state of the public health care system in South Africa. These stories barely graze the surface in revealing the failures of government to make resources available and to budget properly. This mismanagement led to circumstances like the critical ARV shortages which occurred in the Free State in 2008–2009.

The most recent example of this is Edendale Hospital in Pietermaritzburg, which suspended its treatment programme in May this year because the HIV/AIDS treatment programme did not have enough human resources or space to cope with more patients. Kwazulu-Natal MEC for health Dr Sibongiseni Dhlomo has since removed district medical manager May Zuma-Mkhonza for failing to manage the issue of the antiretroviral treatment rollout at Edendale Hospital and treatment is being resumed with the help of international funders.

In the National Strategic Plan (NSP) 2007–2011, the South African government committed to reducing the incidence of HIV by 50% and to enrolling at least 80% of people who need antiretroviral therapy on ARVs by 2011. At the current rate of implementation, we are far from reaching this target. Recent figures suggest that there are more than 630,000 people on ARV therapy instead of 1.4 million as per the target.

Looking at the provincial HIV/AIDS budgets, it is possible to calculate that there will not be enough money available to put more people on treatment, let alone cover the costs of those already on ART. The Limpopo budget allows for 50,582 patients on ART. However, according to Department of Health numbers, there are already 49,421 people on ART and therefore a total of only 1,161 new patients will be provided for in this financial year. However, last year 22,000 patients in the province were initiated onto ART, and it is likely that as many will need treatment this year. Because there is only enough money for just under 1,500 patients to start treatment, over 20,000 will not have access to these essential, life-saving drugs. The blatant mismanagement of funds means that thousands of South Africans who cannot afford private health care will be left without treatment.

Another example occurred in May 2009 when the MEC for Health in Gauteng, issued an apology to mothers who had been unable to get formula milk for their babies. This happened because service providers had not been paid, which led to hospitals and clinics across Gauteng not receiving deliveries. This was not the first time, as TAC and the AIDS Law Project (ALP) reported similar circumstances in August 2008 with shortages in Mpumalanga. The risks of HIV transmission is higher for mothers who breastfeed their babies.

TAC has held meetings, marches and pickets in areas such as the Free State and Gauteng to demonstrate against the inefficiencies of planning. Planning has not been realistically based on need or on the burden of disease, and it has not led to efficient resource allocation.

This is not a problem endemic to South Africa. Examples of countries not budgeting properly for health can be seen in the choices some governments have made to bail out big businesses instead of increasing social spending. Health is a public good that also needs bailing out. There will be dire results, including more lives lost, if health and health care delivery are not budgeted properly. Costs cut now will be paid for in lives later.

Nonkosi Khumalo, TAC chairperson

Doctors and the human resource crisis

South Africa's struggle to attract health workers to the public sector – and to keep them there

By Catherine Tomlinson

A severe shortage of health workers is one of the greatest obstacles to improving health care in South Africa and to reaching the HIV treatment and prevention goals set out in the National Strategic Plan (NSP).

Task shifting

In order to address the human resource crisis government must take steps to increase the number of health workers in South Africa. This can be done by task shifting from doctors to nurses and from nurses to community health workers, as well as by attracting and retaining new doctors and nurses.

Task shifting from doctors to nurses and from nurses to community health workers is recommended by the World Health Organisation (WHO) in countries that have a shortage of health workers like South Africa. Task shifting would reduce the burden on health workers and increase the number of patients receiving treatment.

Task shifting from doctors to nurses would enable nurses to start new patients on treatment. Nurse-led initiation onto treatment for HIV is recommended in the National Strategic Plan (2007-2011) in order to scale up access to treatment. However this has not yet been put into practice by the Department of Health.

Task shifting must also be carried out from nurses to community health workers. Community health workers can perform tasks including: HIV testing, monitoring adherence, performing clinical follow-up, as well as, taking weight and vital signs. Community health workers can further increase access to treatment by making treatment more accessible in rural areas.

The doctors' strike initiated in March 2009, highlighted reasons for the country's low rates of attracting and retaining doctors. Addressing these grievances is vital to solving the human resource crisis.

South African doctors are demanding better working conditions. They are also seeking fair pay and improved opportunities for career path advancement through the Occupational Specific Dispensation, or OSD (see page 6).

An independent study commissioned by the South African Medical Association (SAMA) found that doctors were underpaid by between 50% and 75%. This figure has been used as a benchmark by striking doctors who are demanding increased pay. They are also asking for improved working conditions. Frustrations include long shifts, unpaid overtime, a lack of basic supplies and equipment, poor management and misallocation of resources by the Department of Health.

The human resources crisis in the health care sector is made worse by the unequal distribution of resources between the public and private sectors. It is further affected by emigration, and by the dual epidemics of HIV/AIDS and TB.

Human resource shortages mean that doctors in the public sector work extremely long hours. They serve an ever-increasing and often unmanageable patient load. This has a negative effect on the quality of care that doctors are able to provide to each patient. As a result, after completing their two-year internship and one-year community service, the majority of doctors do not wish to remain in the public sector.

The doctors' strike

In April 2009 many doctors began striking for improved pay and working conditions. On 25 April 2009 the Labour Court ruled that the strike was unlawful. However, the doctors continued to

A lack of resources and shortage of health workers results in poor patient care. Here cholera patients are minimally treated outdoors in Musina. Photo by Oupa Nkosi/ The Mail & Guardian.

Why do we have so few doctors in the public sector?

Every year there are 1200 medical school graduates in South Africa - 50% of them emigrate.

600 doctors are left - 75% of these go into the private sector.

150 doctors are left - 75% of these go to the Western Cape, Gauteng and urban areas.

This leaves just 35 doctors remaining in rural service for the rest of the country.

* This information was produced by Health Systems Trust and Africa Health Placements

- Roughly two thirds of South Africa's physicians work in the private sector, which serves just 14% of the population.
- The public health sector has suffered staff losses since the late 1990s. There are currently 11,000 vacancies for doctors in the public health sector.
- In the last 11 years, despite a massive rise in demand for public health services, and despite the burden of disease from TB and HIV, staff numbers in the public health sector have not increased.
- The Department of Health policy of freezing posts after a doctor quits or retires, has further weakened the health system. It adds to the burden on doctors remaining in the public sector.

Sources: Health Systems Trust, 'South African Health Review' (2006) p.475; 'A Roadmap for the Reform of the South African Health System', Draft final report, (8 November 2008) p.19-20.

Doctors took to the streets earlier this year, demanding increased pay and better working conditions. Photo by Samantha Reinders.

threaten strike action if their demands were not met.

Currently it is unlawful for doctors to strike because there is no agreement between doctors and government about minimum service levels during a strike. Government treats all medical services as essential services, making it illegal to strike under the Labour Relations Act 66 of 1995 (LRA). Section 65 (1) (d) of the LRA prohibits strikes and lockouts in essential and maintenance services. The Act defines an essential service as one which, if interrupted, endangers life, the personal safety or the health of the whole nation or any part of it, the parliamentary service and South African Police Service.

For doctors in South Africa to join in a strike legally they would need to reach an agreement with their employer to determine a minimum level of service provision throughout a strike. This minimum service level would ensure that a strike would not endanger life, the personal safety or the health of the nation. Public sector doctors would need to negotiate a national agreement with the Department of Public Services and Administration. This Department is the employer of all public sector workers for certain purposes, including negotiating wages. Any agreement about minimum services would need to be ratified by an Essential Service Committee. Government has resisted past attempts to come to such agreements. However during the strike most clinics and hospitals did not close down and operated with skeleton staff. Refusing to agree on minimum service levels is arguably a violation of doctors' rights to fair labour practices.

Working Conditions of Doctors

On April 22 2009 Equal Treatment interviewed a second-year medical intern, Colwyn Poole, working at an urban hospital in South Africa. He described poor working conditions and voiced concern that these poor conditions discourage doctors from continuing to work in the public sector after they finish their mandatory service.

What are a medical intern's work hours?

Due to a lack of human resources, interns form a large portion of all public sector doctors across the country. Public hospitals are staffed largely by interns and could not function without them. An assessment of working conditions carried out by 14 interns showed that they worked far more than the hours set by the Health Professionals Council of South Africa (HPCSA) in the 'Handbook of Internship Training' (2008).

Interns generally start a call at 07h30 and end the call shift 24 hours later. At the end of the call interns will often not be able to go home. They will immediately start the next day's work without taking any break. Interns can be on call for as long as 30 to 36 consecutive hours. During this time the intern and the senior doctor have little or no chance to eat, sleep or even use the bathroom. After about 20 hours, judgement and patient care can become severely impaired.

How are interns compensated for overtime?

Most interns exceed the HPCSA guidelines of overtime which are set at 80 hours per month. The majority of hospitals force interns to claim for only 80 hours of overtime. Of the 14 interns assessed, all had exceeded 80 hours of overtime by between 20 and 40 hours. The interns were not compensated for any overtime worked beyond 80 hours.

What is the patient load experienced by interns?

According to HPCSA guidelines interns should not handle more than 25 in-patients at a time. 'In-patients' are patients who are 'sick enough' to need admission for a combination of investigation, observation, treatment and specialist consultations. However in the survey of 14 interns, each reported handling 35 to 42 in-patients at one time. The interns noted that it was necessary to come in early and leave work late in order to cope with the patient load.

Colwyn Poole, a public sector intern, treats an infant in a Johannesburg hospital. Interns form a large portion of all public sector doctors across the country. Photo by Eugene Arries.

What is the impact on patient care and patient dignity?

Poor working conditions can create conflict in relationships between doctors and patients. Doctors may develop a negative attitude towards work that does not lead to good quality of care. This can have an impact on the patient's dignity. "What care can doctors offer within the setting of [the] hours that [are] worked?" asked Poole. Most junior doctors felt that, given working conditions, 'patient dignity was the first thing that got left at the entrance of every hospital'.

Do doctors have sufficient support?

The interview revealed that doctors are concerned about security at medical residences, where some have been assaulted and had their houses broken into.

Furthermore, in the hospital there are often no clean, secure places for doctors to rest during long shifts. They frequently find that on-call rooms, which are designated places for doctors to rest, have not been cleaned, are unlocked or have been burgled. There are no meals or snacks available

to medical interns at any time during their shifts. Staff toilets are often used as smoking venues. They are poorly maintained, and do not have door locks, which poses a security risk.

Dealing with preventable death

It is difficult to work in conditions where treatable diseases still cause deaths. Poole had experienced two avoidable and upsetting deaths during the previous shift. The first was the death of a child who passed away from Tuberculosis (TB). The patient was experiencing TB drug-induced hepatitis which caused bleeding in the brain. Because the Intensive Care Unit was full, doctors were unable to get the child to the unit in time.

The second death was that of an HIV-positive child. The child's mother had never received prevention of mother-to-child transmission (PMTCT) services, and her child had been mix-fed (formula and breastmilk). The patient, although known to be HIV-positive, had not received any follow up treatment.

Junior doctors carry the heaviest work load and encounter an enormous number of TB and HIV deaths. These deaths, especially when avoidable, are extremely demanding on medical interns.

What is OSD?

Doctors went on strike demanding the implementation of Occupational Specific Dispensation, or OSD. This is a scheme to introduce revised salary structures that are unique to each identified public service occupation. OSD was introduced in 2007 as part of a deal to end an earlier public sector strike by adjusting salaries and establishing career paths. Its aim was to keep health workers in the public sector.

In 2007 an OSD was implemented for nurses which was not properly budgeted for and was wrongly implemented, leading to massive extra costs for the health service. The Department of Health's attempts to later recover OSD over-payments have led to further disputes with nurses. OSD was supposed to be implemented for doctors, dentists, pharmacists and emergency care workers in July 2008.

A year later government signed a final offer for OSD for doctors on June 30th, 2009. SAMA did not accept the offer after a vote by doctors represented by SAMA. 91% of doctors surveyed rejected the offer. On July 24th the Health Sector Council (PHSDSBC) met with health unions to discuss the offer. The unions accepted the offer on August 11. The OSD agreement was accepted on the stipulation that certain salary scales would be reviewed within a reasonable timeframe. At the time of writing negotiations around these stipulations remain unresolved.

What is SAMA?

The **South African Medical Association (SAMA)** is a non-statutory, professional association for public and private sector medical practitioners. It represents most doctors in South Africa and is an affiliate of COSATU. It also includes the Junior Doctors Association (Judasa), the Rural Doctors Association (Rudasa) and the Registrar Association. SAMA represents the doctors on the Bargaining Council, which is the forum where doctors negotiate for fair pay and better working conditions.

What is UDF?

At the end of April 2009, the United Doctors Forum (UDF) was formed by doctors who broke away from SAMA. Members of the UDF complained that SAMA, which represents both public and private doctors, no longer represented their interests. The UDF also complained that SAMA was not making serious efforts to bargain for 50% pay increases for doctors. Currently, the UDF is not represented on the OSD bargaining council. The Forum claims to represent the majority of public sector doctors and has threatened a national strike if it is denied the opportunity to participate in the OSD talks. But UDF has been barred from the bargaining council because it is not a registered union.

the economic downturn and health

By Poppy Riddle

We hear a lot about 'the economic downturn', 'the financial crisis' and 'the recession' these days. On the street, on the radio, in the newspapers and on television, people are talking about it. But what exactly is this problem, and what does it mean for us and our health?

What is an economic downturn?

The formal word for an economic downturn is a recession. A country is usually considered to be in recession when its **Gross Domestic Product (GDP)** falls for six months or more in a row. GDP is the total value of all goods and services made within the borders of a nation in one year. Examples of goods include food, cars and computers. Examples of services include plumbing, teaching and entertainment. Other than a falling GDP, many economists also describe a recession as a 1.5% rise in unemployment in one year.

Essentially, a recession occurs when economic activity in a country or region slows down for more than six months.

What has caused the current recession?

Most economists agree that the current recession was sparked by a crisis in mortgage lending in the United States in 2007. Some American banks had been lending to people who found it very difficult to pay the money back. These banks began to lose money on the loans that they had made as people were unable to repay them. A panic about the economic health of banks arose, and banks were uneasy about lending to each other, and to companies. Banks and companies across the industrialised world faced bankruptcy and had to be given or loaned money by governments to save them. At the same time, food and oil prices rose, creating further problems for the economy.

Many economists argue that the longer term causes of this recession are that governments did not regulate banking practices enough. Regulation would have stopped the banks from engaging in risky practices,

like lending money to people who would not be able to pay the money back. Another key problem linked to regulation is that too many individuals and businesses were in debt. This meant that there was less money in the world than people thought.

What does this economic downturn mean for the developing world?

The recession has spread to much of the world because of globalisation. 'Globalisation' means that cultures, economies, politics, technologies and societies across the world are linked. As a result of globalisation, the recession, which started in the USA and Europe, has spread to other countries including South Africa. According to the Congress of South African Trade Unions (COSATU), the country's gross GDP dropped by 6.4% in the first quarter of 2009, far worse than the drop of 1.8% in the fourth quarter of 2008.

The global nature of this recession will create three main problems for developing countries:

1. Household incomes will fall.

Unemployment will rise, and for those still in work, salaries are likely to fall. People will have less money to spend. Governments will therefore collect less money in taxes and may cut spending on public services like health care, education and housing.

2. Trade with and investment in developing countries will drop as global trade and investment falls.

According to the South African Institute of International Affairs (SAIIA), developing countries are projected to lose over USD $750 billion in trade and investment revenue (income) in 2009. Furthermore, Sub-Saharan Africa is expected to be most severely affected by the downturn - with a total projected loss of $50 billion in revenue. This will lead to higher unemployment and lower income for households and governments.

Sub-Saharan Africa is particularly vulnerable because its economies are heavily dependent on trading in commodities. Commodities are things like raw

materials e.g. oil, iron and agricultural products such as cotton. As a result of the recession there is less demand from developed countries for commodities. For countries like Botswana, which relies heavily on its diamonds trade, the recession is a disaster.

3. Overseas aid will fall.

Many developing countries are very dependent on external (overseas) aid. For example, in Rwanda and Ethiopia, over 50% of total government budgeted health spending is financed by foreign donors. **It is expected that the global recession will cause developed countries to give less money in aid.** The Global Fund to fight AIDS, TB and Malaria is already experiencing funding problems. The Global Fund is financed by many different countries, individuals and organisations and is predicted to have a funding gap of at least $3.9 billion for the next year. Of the 3 million people in developing countries receiving antiretroviral treatment (ART), 2 million of those are funded by the Global Fund. A drop in donations to the Global Fund will therefore have serious consequences for health programmes. Many other similar aid programmes and organisations face spending cuts as a result of the global downturn.

What does all this mean for our health?

Poorer general health

According to the World Bank, previous recessions have caused a decline in the general health of populations in developing countries. There are many reasons for this. In countries without a public health service, people have less money to spend on visiting the doctor or buying medicines during recessions. They may not be able to pay for transport to get to a clinic or hospital. Even in countries with a fully-funded government health system, people still pay out of pocket for drugs and informal fees. In some countries (e.g. Tanzania), health facilities still charge user fees. With rising unemployment, poor people are likely to be the worst affected. Affordability might discourage them from seeking care, contributing to worsening health status. A decline in health budgets and overseas aid money would also cause problems – such as drug or equipment shortages.

Malnutrition

The recession is likely to cause widespread malnutrition in developing countries. As households experience unemployment and reduced earnings, people will have less money to spend on food, particularly nutritious food such as fruit and vegetables. This may result in widespread weight loss and severe malnutrition, especially in children. People living with HIV who are also malnourished are more likely to catch opportunistic infections and develop AIDS faster. As antiretrovirals (ARVs) sometimes need to be taken with food, people who can't afford to buy much food will find it harder to adhere to their medicines. Adherence is important if people are to stay healthy.

HIV/AIDS treatment programmes stalled

Worldwide, ARV treatment is keeping 3.4 million people alive and healthy. However, according to the World Bank, double that number need treatment urgently in order to survive. Declining health budgets and overseas aid could make it difficult for these people to access treatment.

Furthermore, budget cuts and drops in external funding would leave people in 15 developing countries at high risk of treatment interruption. Stopping treatment is dangerous because:

- If treatment stops, people soon become sick and die, leaving children orphaned and robbing society of its workforce.
- People who stop treatment become far more infectious.
- Disrupted treatment makes ARVs less effective.

The economic downturn may also cause HIV prevalence to rise because: 1) clinics may experience condom shortages; 2) malnutrition and treatment interruption make people with HIV more infectious; and 3) less money may be available for prevention literacy programmes.

Sources: Congress of South African Trade Unions (COSATU) Central Executive Committee media statement, 4 June 2009; The World Bank "Averting a Human Crisis During the Global Downturn" (2009); The South African Institute of International Affairs (SAIIA) "The Implications of the Global Economic Recession on Civil Society Advocacy, Aid and Policy Implementation" (2009) • Article reviewed by Veloshnee Govender, lecturer, Health Economics Unit, School of Public Health, University of Cape Town

TAC held its biggest direct action of the year in Cape Town in July 2009 to launch the Resources for Health campaign.

Campaign preparations

In preparation for the launch of TAC's Resources for Health campaign, staff from the organisation's six model districts (Ekurhuleni, Gert Sibande, Khayelitsha, Lusikisiki, Mopani, uMgungundlovu) compiled information about the state of the antiretroviral therapy (ART) rollout in their communities. They made some alarming discoveries. Long ART waiting lists, severe shortages of formula milk and essential drugs, and a lack of health workers in clinics are all damaging the health of communities. In many clinics, even the most basic pain and cough medicines were unavailable. These findings were written into a memorandum which was circulated widely to TAC staff. Briefings and workshops were held to discuss the research findings and decide how to run the provincial campaigns.

Launching the campaign: why the Western Cape?

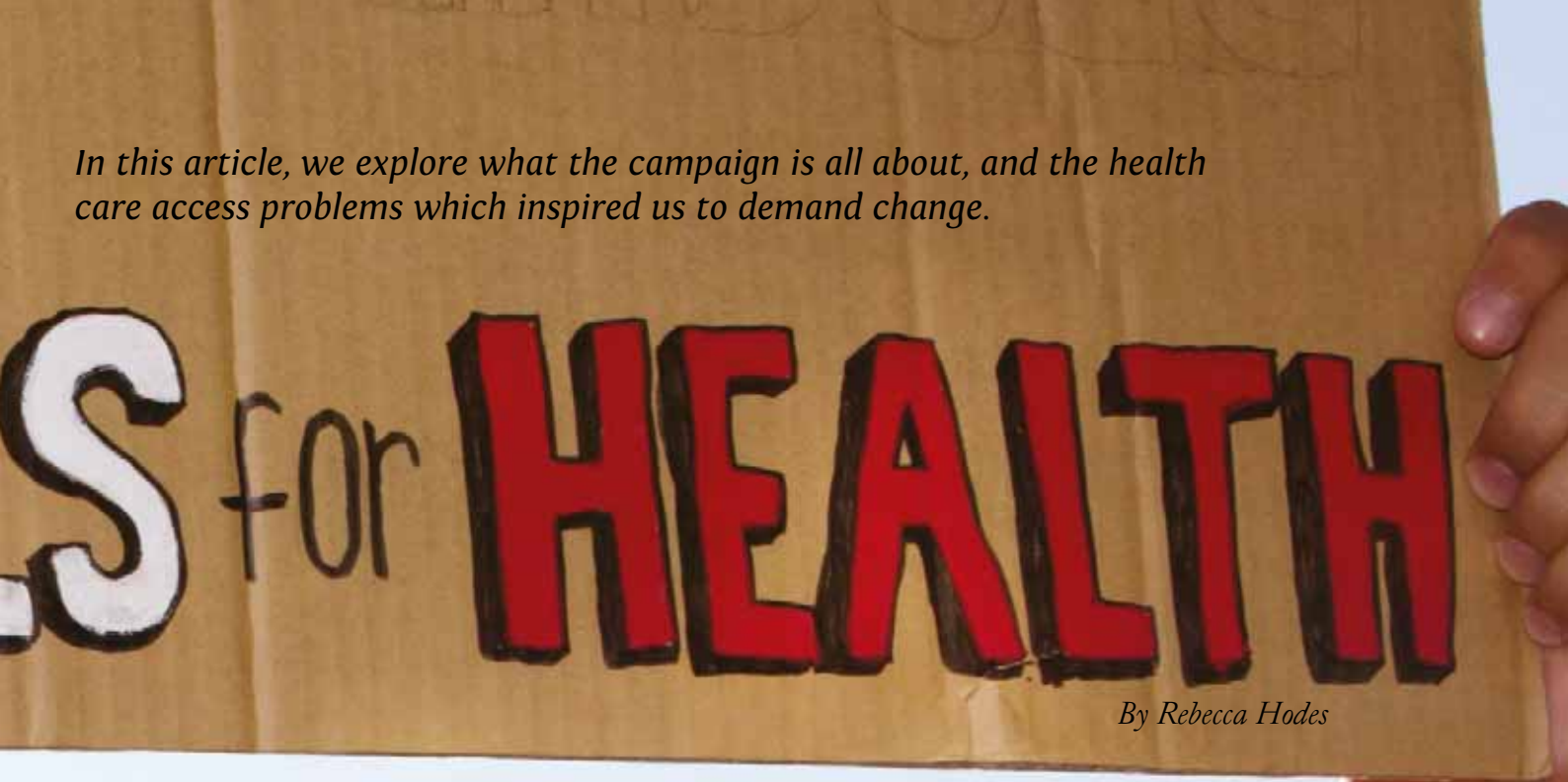
The 5th International AIDS Society (IAS) Conference on Pathogenesis, Treatment and Prevention took place in Cape Town, starting on 19 July. On this day, TAC launched the Resources for Health campaign. TAC and many other partner organisations marched through the centre of Cape Town to demonstrate to government, the public and to people attending the conference that our struggle for access to comprehensive health care is far from over.

It is notable that, despite Khayelitsha's supposed status as a model of community ART access, TAC's local research showed that the same problems experienced by clinics across the country are also seen in Khayelitsha and in nearby communities. Many clinics still have waiting lists of well over a hundred people, and the enrollment of new patients fell noticeably in the last three months of 2008 – proof that the ART rollout is slowing down in the Western Cape as well. The research suggested that, in Khayelitsha, many people are initiated onto ART with a CD4 count of less than 50. Khayelitsha also suffers ongoing condom shortages, and many lay counsellors have not been paid since November 2008. Some have therefore left their clinics, meaning that patients who go for HIV tests are often turned away.

The Free State ARV Moratorium: A sign of things to come

In November, an antiretroviral (ARV) moratorium was implemented in the Free State province. This meant that no new patients were to be initiated onto ARV therapy until further notice. TAC began receiving complaints from angry doctors and patients who had been told by the provincial Department of Health that for the time being, no new patients were to receive treatment. Many

In this article, we explore what the campaign is all about, and the health care access problems which inspired us to demand change.



By Rebecca Hodes

existing patients, including children, had their ARV regimens interrupted by drug shortages at clinics.

TAC quickly mobilised to have the moratorium lifted, but it still lasted for four months. The HIV Clinicians Society estimates that during this time an **additional** thirty people a day died from AIDS because they could not get ARVs.

TAC contacted the Free State Treasury and Department of Health to learn the reasons for the moratorium. We were told that the province had run out of money and had no other alternative but to stop providing life-saving medical services and drugs – including those for HIV, hypertension and diabetes. To initiate the target of 1,200 new people per month onto ART would have cost the Free State province roughly R800,000. A few weeks after the moratorium started, TAC learned that the province had given R30 million to political parties' election campaigns.

What happened in the Free State was a violation of the rights of people living with HIV and of others in need of essential health care which was denied to them during this time. In many cases, it continues to be denied. The Free State has the lowest levels of ART coverage in the country – hovering at around 26%, according to official figures.

TAC has tried to find out whether the province acted within the law in its decision to enact the moratorium. The Public Finance Management Act allows for emergency funding when people's lives are threatened by a lack of public funds. It is clear that serious mistakes were made and planning was non-existant; people died as a result.

Money matters

The moratorium in the Free State showed that provincial ARV rollouts were badly flawed – particularly in terms of their budget planning and oversight. Since then, ARV shortages have arisen in the Eastern Cape, Limpopo, KwaZulu-Natal and even in Gauteng, the richest province. Shortages of other essential medical supplies are also occurring with greater frequency. The **primary causes are improper and wasteful budgeting**, and the fact that government spending is poorly monitored.

Evaluations of the health system have found weaknesses at almost every level. Both hospitals and districts have shown poor service delivery and have failed to meet the health needs of their communities.

South Africa performs far worse than many other countries which spend less on health.

Health Minister Aaron Motsoaledi (right) with International AIDS Society president Julio Montaner (left) and TAC General Secretary Vuyiseka Dubula (back) at the launch of the Resources for Health campaign in Cape Town. Photo by Samantha Reinders.

South Africa has the skills and the capacity to achieve the National Strategic Plan (NSP) targets and to mobilise enough resources for health, but it must use these in the **right** way.

In October 2009, public health budgets are due to be adjusted. Any changes will need to take into account that there is currently a R1 billion shortfall to initiate the NSP's targeted number of people onto ART for 2009, and District Health Authorities are failing. TAC's Resources for Health campaign will fight for access to ART through

- the fulfillment of the NSP targets,
- the elimination of ART waiting lists,
- access to dual regimens for the prevention of mother-to-child transmission of HIV (MTCTP) and
- the integration of TB and HIV treatments.

Health rights, human rights, HAART rights

It is government's responsibility to make ART accessible and sustainable, as stated in the National Strategic Plan (NSP), to which government has committed. The NSP aims to treat 80% of people who need ART by 2011, and to reduce HIV transmission by 50% within the same time frame. But there is a crisis in the NSP's implementation, proven by the recent research in TAC's six model districts. This found sector-wide shortages of essential medicines and human resources in clinics.

As of June 2009, there are approximately 560,000 patients on ART in the public health sector. **But at least double that number need treatment urgently to survive.**

In the last few months, the ART rollout has lost momentum. Tens of thousands of people remain on waiting lists, and most patients have CD4 counts below 100 by the time they are finally initiated onto ART. This means that most of them have already suffered severe symptoms and have stage three or four AIDS.

This is both a moral outrage and a waste of precious health resources. The Constitution guarantees the progressive realisation of access to comprehensive health care. Long ART waiting lists and shortages of essential medicines violate this right. They sacrifice the lives and wellbeing of HIV-positive South Africans.

Late ART initiation is also costly because treating opportunistic infections requires more clinical care, which is expensive and time-consuming. Starting ART earlier would reduce both TB and HIV transmission by lowering the viral load and strengthening the immunity of people living HIV. The public view that HIV prevention and HIV treatment are separate needs to change. Making ART more accessible **is** HIV prevention.

South Africa may be facing a financial crisis, but the rights to health and to life are not for sale. TAC's Resources for Health campaign will mobilise communities across South Africa to fight for better access to TB and HIV medicines for all those in need.

Sources: J. Berger; 'A Roadmap for the Reform of the South African Health System' p. 20; M. Heywood, 'Key Targets of the NSP for 2009', (2009) • A. Violari et al., 'Early Antiretroviral Therapy and Mortality among HIV-Infected Infants', New England Journal of Medicine, 359: 2233 – 2244 (2008); 'A Roadmap for the Reform of the South African Health System', p. 43; N. Ford et al., 'Rationing ART in Africa'.

meet the NSP targets for HIV/TB

treatment prevention

universal access now!

Main objectives of the campaign:

1. **To demand early treatment of infants, dual treatment protocols and essential medical supplies for the prevention of mother-to-child transmission of HIV.** The NSP target for 2009 is to have 85% of facilities meet the quality standards for infant feeding. As research from districts proves, this target is failing outright. The Children with HIV Early Antiretroviral Therapy (CHER) study found that starting babies on treatment as soon as they are diagnosed HIV-positive substantially reduces mortality. Demanding polymerase chain reaction (PCR) tests for HIV and earlier treatment for babies will save thousands of lives, and increase the number of children on ART. This will bring us closer to the NSP target. Infants and children should be tested at vaccination sites. Mothers who need it must be given full HAART and access to PCR tests for their babies.

2. **To treat at a CD4 count of 350, not 200, as recommended by the WHO, and to end ART waiting lists.** The main reason that people die from AIDS is that ART is not available to those in need, and is started too late.

3. **To fight for integration of TB and HIV treatments.** All people with TB must be tested for HIV. Treatment must be offered at the same clinic to ensure that people can adhere to their regimens.

TAC aims to accomplish these campaign goals by:

1. Demanding needs-based budgeting, strict financial oversight and accountability at both national and provincial level.

2. Demanding a solution to the human resources crisis in the health sector.

3. Educating TAC members and the public about the current crisis in health care and the suffering and death that it causes.

4. Ensuring that government takes the lead to solve the health sector crisis.

5. Campaigning for resources for health worldwide.

The Backlash Against AIDS Funding

Even before the global economic crisis, a backlash against AIDS-specific funding had begun. Proponents of the backlash claim that more money has gone to AIDS than is necessary and that money would be better spent on a more general strengthening of health systems.

The backlash argument

Those supporting the backlash say that AIDS-specific funding has created the largest vertical* health programme in history. At the cost of other health spending and the strength of health systems, AIDS-specific funding has allegedly:

- eroded the public health sector,
- undermined government efficiency,
- removed national control over spending priorities and
- taken the focus away from maternal and child health.

Why the backlash makes no sense

The notion that we are overspending on HIV makes no sense. World Health Organization (WHO) funding for HIV is in line with the burden of disease caused by HIV. If anything, stock outs and threats to treatment programmes throughout Africa is evidence that spending should be increased dramatically. Cutting back on funding will result in more preventable deaths.

Whereas AIDS funding is blamed for creating a vertical health programme at the expense of health systems in general, the fact is that AIDS funding has created the largest horizontal health programme in history. It has gone beyond simply targeting HIV to further involve TB, hepatitis C, STDs and cervical cancer, as well as general health care. In addition to reducing and preventing other diseases such as TB, AIDS funding also directly lowers the mortality rates of mothers and children.

The evidence shows that funding for health care and for AIDS is complementary and that overall health spending has risen because of the AIDS response.Backlash supporters pit the United Nations' Millennium Development Goals 4 and 5 for reducing maternal and child mortality against Goal 6 of reducing HIV infection, when in fact, all three goals go hand in hand.

The reality is that in South Africa, 5.5 million people are living with HIV. Each day, 1,000 young, black women are newly infected with HIV. 27,000 children in stage four of infection are not getting treatment, and the rate of childhood AIDS mortality is four times higher than adult AIDS mortality. The antiretroviral (ARV) rollout has reduced infant mortality, raised life expectancy and lowered HIV incidence.

The ARV rollout has strengthened health systems by:

- empowering patients and health workers;
- strengthening distribution networks for medical services;
- pumping vital resources into pharmacies and diagnostics;
- preventing new HIV infections;
- reducing opportunistic infections;
- decreasing rates of disease and mortality.

The solution: Strengthening health systems on the back of the HIV response

While the international donor climate is changing and NGO funding is scarcer and more focused on health systems strengthening, it is important to note that the funding for general health systems strengthening has no obvious mechanisms to hold government accountable. Building better health systems on the back of the AIDS response makes perfect sense due to the strong systems already established by governments and activists responding to the HIV epidemic.

HIV/AIDS funding has helped to strengthen health systems in many parts of the world, providing much needed financing for health workers and medical supplies. Photo by © Francesco Zizola / Noor, couresty MSF.

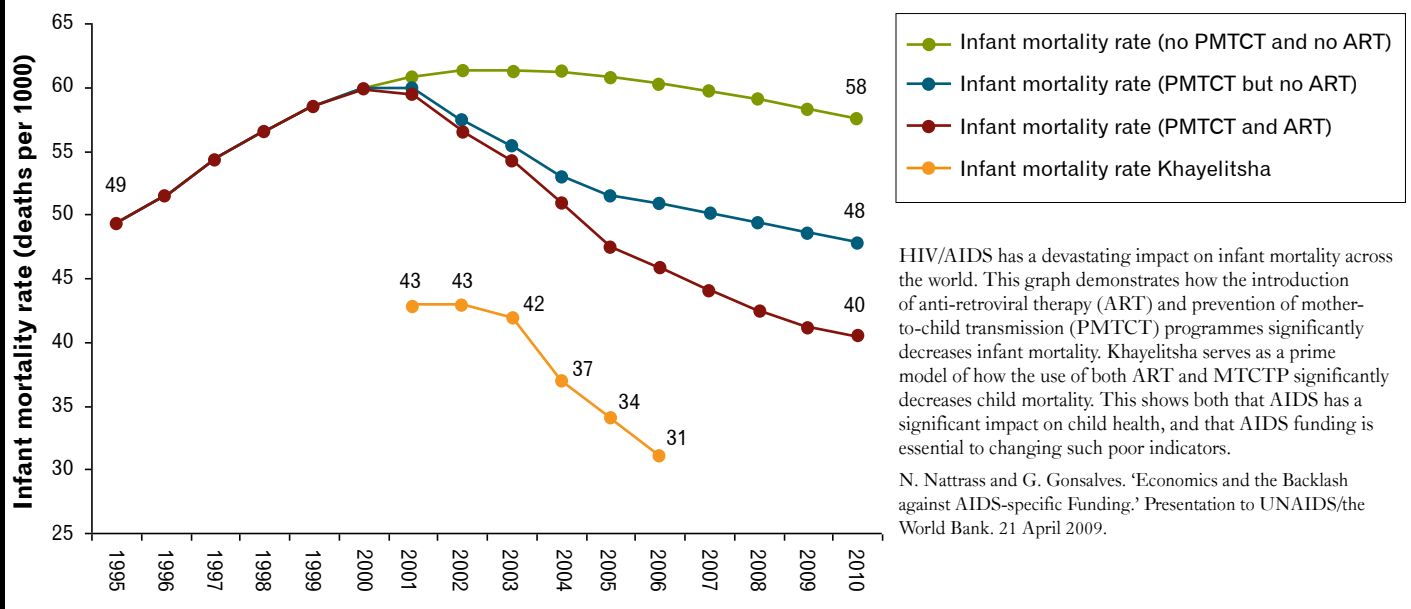
- Vertical health programmes refer to initiatives aimed at addressing specific diseases. Stop TB, for example, is a vertical programme aimed specifically at fighting tuberculosis.
- Horizontal health programmes focus on strengthening a health system as a whole, rather than focussing on specific diseases.

Sources: Natrass, N and Gonsalves, G. "Economics and the Backlash against AIDS-specific funding", Paper for the WHO/World Bank/UNAIDS Economics Reference Group (2009); Dubula, V. "South African politics post election, what do they mean for women and access to quality health", Women's leadership training, Booysens Hotel, Johannesburg 2009; Lynch, S and Hodes, R. "The Current Donor Landscape".

What is the Global Fund?

The Global Fund to fight AIDS, Tuberculosis and Malaria is an international financing institution that funds a wide variety of health programmes. To date, it has committed $15.6 billion in 140 countries to support large-scale prevention, treatment and care programmes. As of 1 July 2009, 2.3 million people are receiving antiretroviral treatment because of the Global Fund. However, the fund is currently facing a shortfall that will result in reduced support for programmes.

This issue of Equal Treatment was produced and distributed with financial support from the Global Fund.



HIV/AIDS has a devastating impact on infant mortality across the world. This graph demonstrates how the introduction of anti-retroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) programmes significantly decreases infant mortality. Khayelitsha serves as a prime model of how the use of both ART and MTCTP significantly decreases child mortality. This shows both that AIDS has a significant impact on child health, and that AIDS funding is essential to changing such poor indicators.

N. Nattrass and G. Gonsalves. 'Economics and the Backlash against AIDS-specific Funding.' Presentation to UNAIDS/the World Bank. 21 April 2009.

On Sunday 19 July 2009 approximately 2000 TAC members and allies gathered in Cape Town for a march to the city's convention centre where the 5th International AIDS Conference on Pathogenesis, Treatment and Prevention was being held. Traffic was brought to a standstill as protestors took to the streets, demanding that government meets its HIV/TB treatment and prevention targets as laid out in the National Strategic Plan (NSP).

TAC was joined by comrades from the South African Medical Association, the Democratic Nursing Association of South Africa, the Congress of South African Trade Unions, and the AIDS and Rights Alliance of Southern Africa. South African Minister of Health Dr Aaron Motsoaledi, International AIDS Society (IAS) Chairperson for South Africa Dr Jerry Coovadia, and IAS President Dr Julio Montaner also joined. Vuyiseka Dubula, TAC General Secretary, read the campaign memorandum which Motsoaledi signed after symbolically asking for his own HIV positive t-shirt. He voiced support for the memorandum and said that "most of" its demands would form part of government policy, asking for TAC to partner with the government on this work. Nonkosi Khumalo, TAC's Chairperson, accepted the Health Minister's offer but warned that if TAC's concerns were not considered, TAC members would be back to toyitoyi.

Concurrent activities took place across the country to launch the campaign at TAC district offices:

- In Mopani, Limpopo about 900 comrades marched from the Magistrates Court to the Mopani District Department of Health. The ANC Youth League and civil society organizations Fair Share and Ntshuxeko gave messages of support during the opening session. TAC's memorandum was accepted by a representative from the Mopani District Department of Health.
- In O.R. Tambo, Eastern Cape more than 500 TAC members marched down the streets of Umthatha to submit a memorandum to the Department of Health. The action occurred on Nelson Mandela's 91st birthday during the 67 minutes that South Africans committed to honour the former president.
- In Ekurhuleni, Gauteng approximately 1000 TAC members and partners marched to the Mayor's office to hand over a memorandum demanding resources for health. Councillor Ndolosi accepted the memorandum on behalf of the Mayor. Journalists from several major newspaper and radio stations attended.
- In uMgungundlovu, KwaZulu-Natal approximately 600 people marched from Market Square to Parliament. In addition to the Resources for Health campaign, the march was in response to the waiting lists and medicine stock-outs at Edendale Hospital. A vigil was held for those who had died while waiting for ARVs at Edendale.
- In Gert Sibande, Mpumalanga approximately 520 members marched from Mpumalanga stadium to the Department of Health. A memorandum of demands was received by the Director of Health in the District. After the march TAC received three invitations from hospitals previously antagonistic to the district's work.

To get involved with TAC's Resources for Health campaign, contact your nearest branch. Contact details on the Contents page of this magazine.

Sello Mokhalipi and the Free State stock-outs

By Olivia Adams

Sello Mokhalipi was working as a treatment preparedness counsellor in the Free State, when he saw an email from the MEC's office ordering antiretroviral (ARV) sites to stop initiating new patients from November 2008. He decided to take action. Soon after, the Free State stock-outs were making headlines across the country.

While working as a treatment preparedness counsellor, Sello Mokhalipi came across an email from the Free State MEC's office ordering antiretroviral (ARV) sites to stop initiating new patients in November 2008. Sello realised that the province was running out of ARVs and, after investigating the matter, he discovered that patients had been placed on waiting lists from as far back as August 2008.

That was when Sello decided to start corresponding with the Treatment Action Campaign's (TAC) National Office in Cape Town. His social mobilisation surrounding the Free State ARV stock-out had begun.

Towards the end of November, he wrote a letter to the Free State MEC for Health, Mr Sakiwo Belot, to complain about the ARV stock-out. The MEC's office did not respond. Despite this, in January 2009 Sello wrote another letter, this time requesting a meeting to discuss the issue. This attempt to make contact was also fruitless.

On 10 February 2009, Sello organised a march to the MEC's house in Bloemfontein. It was attended by TAC's chairperson, Nonkosi Khumalo, as well as by other activists from the Gauteng province. With TAC's help, Sello also organised a meeting in March of various activist organisations, which was attended by the then Minister of Health, Barbara Hogan. Out of this meeting, TAC and their partner organisations formed the Free State HIV Coalition, of which Sello was elected chairperson.

Sello also organised a picket outside Bloemfontein's City Hall which took place on 16 March 2009. The moratorium on ARVs in the Free State was lifted just weeks after the picket.

Sello's actions directly contributed to ending the moratorium in the Free State. He informed TAC of a crisis at a time when TAC was not operating in the province, and he made the problem more visible by mobilising local people and helping with media coverage.

Sello briefly left the Free State but has recently returned and is still involved with TAC and the Free State HIV Coalition. Thanks to his hard work, TAC's presence in the Free State persists and a fledging TAC branch continues to grow. (For more on the consequences of the Free State stock-outs, see page 11).

Stories from the Free State

Isaac Makamole is pictured here with his family. Isaac was unable to access ARVs during the Free State moratorium. He was so sick without this medicine that he had to be resuscitated with oxygen at a local hospital. Geoffrey York/The Globe and Mail.

For months, Evelyn Mapota was unable to get ARVs for her daughter during the Free State moratorium. She was repeatedly turned away from public hospitals, and continually told to "come back next week." Photo by Geoffrey York/The Globe and Mail.

WHY AFRICA MUST SPEND MORE ON HEALTH

At the start of the World Economic Forum (WEF) on Africa held in Cape Town from 10 – 12 June 2009, a coalition of African HIV and TB activists demanded that the region's leaders guarantee the right to health, ensure that it is financed as a priority, and mobilise the extra resources needed for universal access to TB and HIV prevention, treatment and care.

Without enough funding, promises for universal access ring hollow, and our communities will continue to be devastated by preventable and treatable illnesses.

For people with HIV in Africa, the effects of the economic crisis are clear: according to a recent World Bank report, in the next 12 months 70% of the 1.9 million people who are receiving antiretroviral treatment (ART) may see their access to treatment threatened by the economic downturn.

Despite global commitments to universal access to treatment by 2010, for the 3.9 million Africans with HIV who still need treatment, the likelihood of getting ART is now slipping even further out of reach. The situation is equally bad for maternal and child health. Across the continent, maternal mortality rates are only approximately 5% lower than 1990 levels. But the Millennium Development Goal calls for the rate to be 75% lower than 1990 levels by the year 2015.

The demands for resources to fight HIV and TB in Africa are not exaggerated. The availability of these resources is the key factor that will decide whether or not millions of people will live or die. TB is a leading cause of death in many countries in the region, especially among people with HIV. It claims more than half a million African lives every year. All HIV-related deaths on the continent are estimated to total 1.5 million a year.

Spend now, save later

Failure to invest enough money in managing TB and HIV shows a disregard for the lives of people with these diseases. It also burdens the continent with the social and economic consequences of the unmanaged epidemics.

African activists call on leaders at the 2009 World Economic Forum on Africa to prioritise health financing and close the resource gap to secure universal access to HIV and TB care. Photo by Samantha Reinders.

A 2007 World Bank paper estimated the economic cost of not treating TB in Africa at $519 billion, more than 25 times the cost of managing TB properly over the same period. Several studies have also proved convincingly that initiating HIV treatment at higher CD4 counts reduces transmission rates significantly. As such, universal access to treatment is a valuable preventative measure that could end up saving governments billions of dollars.

As financial resources become increasingly scarce, it is more important than ever for regional leaders to make sure that their priorities meet the needs of the people they serve. In 2001, African heads of state said in the Abuja Declaration: 'We are fully convinced that containing and reversing the HIV epidemic, tuberculosis and other infectious diseases should [be] our top priority for the first quarter of the 21st century'.

Many other regional and international commitments have echoed this statement and recognised the importance of increasing funds to fight HIV and TB in Africa. But few of these words have translated into action. Furthermore, 'expert' dialogue worldwide has now started to turn against HIV-specific funding, arguing that it has weakened health systems. This backlash is happening despite the fact that millions of people are alive today only because billions of dollars were invested in ART and health systems (see page 14 for more on the backlash against AIDS funding).

We refuse to have this progress undone. Activists across the region will be keeping a close eye on leaders for proof of their commitment to the rights of people with HIV and TB, and will mobilise to ensure that these rights are protected.

The future of the continent is bleak if its health is not secure, and the health of the continent cannot be secure unless we deal with the challenges of HIV and TB. Great progress has been made in response to these co-epidemics – but the battle is far from over, and the casualties continue to rise.

At the WEF, TAC and the AIDS and Rights Alliance for Southern Africa (ARASA) demanded that leaders recognise and respond to the current health resource crisis by:

Honouring their existing commitments, including:

- The 2001 Abuja Declaration, in which African heads of state pledged to devote 15% of national budgets to health;
- International agreements to commit 0.7% of high-income countries' revenue to Overseas Development Assistance (ODA); and
- The promise to ensure universal access to TB and HIV prevention, treatment and care.

TAC and ARASA also demanded that leaders close the gap for health resources by:

- Discouraging fiscal policies that limit social spending in low-income countries;
- Committing 15% of middle- and low- income countries' total revenue (excluding grants) to health;
- Ensuring that 15% of ODA, or 0.1% of high-income countries' revenue, is given to health;
- Introducing a global currency transaction tax, as recently suggested by France, which could generate an extra $30 – $60 billion each year for global health; and
- Improving transparency and accountability in the way that health resources are allocated and spent, including stopping illegal outflows of capital from low-income countries.

Article adapted from ARASA press release.

Where the $MONEY$ goes

Compiled by Pouya Gharavi and Lynn Elharake.

The Wars in Iraq and Afghanistan

At the time of writing, the United States government has made $830.2 billion available for the wars in Iraq and Afghanistan. A further $77.1 billion has been requested to fund these conflicts, bringing the total to $907.3 billion since 2001.

In comparison, AIDS spending by the G8 group of wealthy nations, the European Commission and other donors was only $6.6 billion in 2007. In 2006, it was even less: $5.6 billion. As a result, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), an $8.1 billion funding gap remains for essential HIV/AIDS programmes world wide.

South Africa is one of the 15 focus countries of the United States government's President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR funding for South Africa was only $397.8 million in 2007. The US also provides support for HIV/AIDS efforts worldwide through its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund has approved five HIV/AIDS grants (including HIV/TB grants) for South Africa, totalling just $228.7 million dollars in confirmed funding.

Photo by Campaign Against Arms Trade

Domestically, South Africa's HIV/AIDS response is mainly financed through the national health budget. In 2007, the national HIV/AIDS budget was estimated to be only R3.4 billion (approximately $480 million).

Sources: http://www.nationalpriorities.org/cost_of_war_counter_notes; http://www.plusnews.org/Report.aspx?ReportId=79150; http://www.kff.org

The 2010 World Cup in South Africa

South Africa is spending R8.4 billion to build five new stadiums and renovate a further five for the 2010 World Cup finals, according to the event organisers. Government's total contribution to infrastructure and stadia stands at R17.4 billion.

By contrast, in 2008/09, the national Department of Health's overall budget was just R15.1 billion.

Sources: http://www.sa2010.gov.za/en/funding; http://www.sa2010.gov.za/en/printpdf/524; http://www.gcis.gov.za/docs/publications/yearbook/2009/chapter12.pdf; "How Much Does It Cost to Provide Antiretroviral Therapy for HIV/AIDS in Africa?", Center for International Health and Development Boston University.

While South Africa has invested R17.4 billion on the 2010 World Cup, the country annually spends only R3.4 billion on HIV/AIDS

A stadium for the 2010 Soccer World Cup, Green Point, Cape Town, 17 August 2008. Photo by David Goldblatt.

Electioneering vs. lives

Earlier this year the Free State passed legislation giving R30 million to political parties to spend on their election campaigns. Experts described it as illegal and unconstitutional. Only national government can award funds to political parties.

This announcement was made after the Free State had stopped putting new patients on ARVs in November 2008 – reportedly because the province didn't have enough money to buy the medicines. The ARV moratorium cost 30 lives per day, according to a conservative estimate from the South African HIV Clinicians Society.

While money was available to political parties, it was witheld from patients. It would have only cost the Free State R800,000 to continue treatment during the four months of the moratorium.

The Bailout

The US government is spending more than $7.76 trillion in an effort to ease the economic downturn.

This spending comes as international donors and African governments announce that they are likely to cut health budgets due to the crisis. Health experts are afraid that rising unemployment and poverty will mean less food security and poorer nutrition, which will further strain weak health care systems.

The Global Fund to Fight AIDS, Tuberculosis and Malaria recently announced that it is at least $4 billion short of the money it needs to continue funding essential services in 2010. The Global Fund coalition believes that there is a $10.7 billion funding gap for regional implementation of the Global Plan to Stop TB alone.

[This shortfall could create an even greater need for funds in future.]The South African government spends R400 on treating a patient with ordinary TB, but when a person develops a multiple drug-resistant form of TB, the cost of treatment balloons to R24,000.

Male circumcision and HIV prevention

The scientific evidence is overwhelming: in a society in which many people have HIV, there are clear health benefits to male circumcision. These benefits far outweigh the small risks if the procedure is carried out safely. However, there are ethical and practical questions to think about when setting up a public health circumcision programme.

What is male medical circumcision?

Male circumcision is a procedure done to remove the foreskin of a man's penis. This practice has been carried out for religious and cultural reasons for thousands of years. Male circumcision must be distinguished from female genital mutilation (FGM), which is still carried out in some countries. FGM is when parts of the woman's vagina, including her clitoris and inner lips are cut off. FGM is condemned as an abuse of human rights and has a very negative impact on women's health, dignity and independence.

By medical circumcision we mean that the foreskin is surgically removed under hygienic conditions and anaesthetic by a trained person using surgical tools and techniques accepted by the medical profession.

Health benefits of circumcision

Circumcision reduces a heterosexual male's risk of contracting HIV by 50-60%. This has been shown clearly in three studies. These studies, all carried out in Africa, randomly divided a large group of uncircumcised heterosexual HIV-negative male volunteers into two groups, one of which was then circumcised. In all three studies the circumcised men had a much lower risk of HIV infection. (The current evidence only relates to heterosexual men. As yet, we do not know whether circumcision offers protection to men who have sex with men.)

Current research also suggests that:

- Circumcised men are less likely to become infected with herpes (herpes simplex virus type 2). Circumcised men also seem to be less likely to get some other sexually transmitted infections, such as genital ulcers and gonorrhoea.
- Circumcised men are less likely to get penile cancer than uncircumcised men.
- Circumcised boys are less likely to get urinary tract infections.
- Female partners of circumcised men seem to have a lower risk of cervical cancer. Circumcised men are less likely to become infected with or to infect their partners with human papilloma virus (HPV). Some types of HPV are linked to cervical cancer.

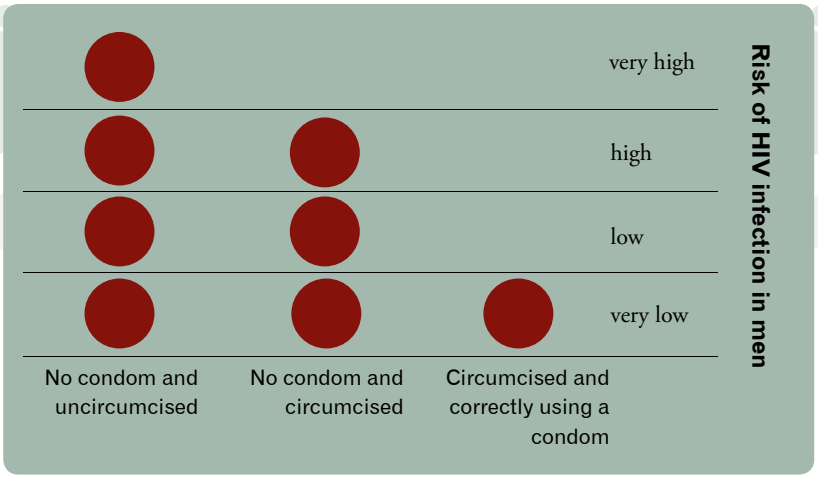
Preliminary studies seemed to suggest that female partners of circumcised HIV-positive men may be less likely to get infected with HIV than female partners of uncircumcised HIV-positive men. New, more reliable, findings suggest that this is not the case, and they are equally likely to be infected. Women are nevertheless expected to benefit from circumcision programmes because circumcision offers some protection to men and should therefore lead to lower HIV prevalence overall.

The World Health Organisation recommends male medical circumcision as an important part of HIV prevention efforts.

Health risks of circumcision

Complications happen in a small percentage of medical circumcisions because it is a surgical procedure. In the vast majority of cases these complications are resolved. In very rare instances deaths have occurred.

- Some men who are circumcised say that their sexual functioning has decreased, or that their penises are less sensitive after circumcision. However, some men also report improved satisfaction after circumcision.
- While the penis is healing after circumcision (which takes about six weeks), the risk of transmission from an HIV-positive man to an HIV-negative female partner might be higher than for uncircumcised men. This shows how important it is to counsel men not to have sex during this time.



What are the ethics of circumcision?

Circumcision cannot be reversed once it is done. It permanently changes a man's body, causes temporary physical pain and, at least in some cases, reduces penile sensation.

This raises some questions: Is it ethical to promote circumcision? Is it fair to carry out circumcisions on children who might later regret being circumcised? The health benefits are clear, but there is still some debate around these questions.

South Africa's Children's Act includes a section on male circumcision which bans circumcision of males under 16 except when:

- performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or
- performed for medical reasons on the advice of a medical practitioner.

We recommend that children under 16 and older than infants should only be circumcised after proper counselling and with their agreement. For children over 16, the law demands informed consent and proper counselling.

Circumcision in the public health system

Heterosexual men who are circumcised remain at high risk of getting HIV if they do not use condoms during sex. Even though the risk is diminished, all protective measures must continue to be used. Circumcision must be promoted in such a way that it does not lead men to think that they can have riskier sex once they are circumcised.

Voluntary circumcision in the public health system is an opportunity to counsel and test men for HIV. Because of the threat that circumcision might be seen as a license to have unprotected sex, it is important that the counselling is very good and standardised.

Many boys and young men in South Africa are circumcised as part of religious or traditional ceremonies. These circumcisions are seldom done by medical experts and often they are performed under non-hygienic conditions. They are hardly ever done under anaesthetic and there have been many reports of incompetence that resulted in boys being hospitalised. It is not clear if the health benefits outweigh the risks for boys who have been circumcised in this way.

Traditional and religious male circumcision rites should be allowed, but the state must make sure that they are carried out safely and in accordance with the laws on circumcision. They must be done using hygienic surgical equipment and by people who have been properly trained.

Although circumcision is a relatively safe procedure, complications can occur. Circumcision should therefore be offered by the state at surgical facilities that meet acceptable standards. The Department of Health must make sure that these facilities are developed in districts where they do not currently exist.

Voluntary medical circumcision should be offered free of charge at health facilities across the country. It must be provided together with the highest standard of HIV counselling and testing.

Original factsheet by Nathan Geffen with assistance from Mark Heywood. Adapted for Equal Treatment by Marcus Low. Sources: World Health Organization information package on Male Circumcision for HIV Prevention. (www.who.int/hiv/topics/malecircumcision/en/) • Auvert et al. 2005. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med. 2005 Nov;2(11):e298. Epub 2005 Oct 25.• Bailey et al. 2007. Lancet. Feb 24;369(9562):643-56. Malecircumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial.• Gray et al. 2007. Lancet. Feb 24;369(9562):657-66. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial.• Siegfried et al. 2009. Cochrane Database Syst Rev. 2009 Apr 15;(2):CD003362. Male circumcision for prevention of heterosexual acquisition of HIV in men.

Latest TB science

By Nathan Geffen

There have been important new scientific developments regarding TB.

Please note: All the patients who participated in the clinical trials described in this article did so of their own free will. These trials were approved by ethics committees and the Medicines Control Council. You should never be forced to take part in a clinical trial and you should never be put onto a trial without knowing it.

New TB drug looks promising

A TB drug called TMC207 is currently being tested, and so far results are promising. TMC207 was compared to a placebo in a small randomised blinded clinical trial on patients with multi-drug resistant TB (MDR-TB) in a South African hospital.

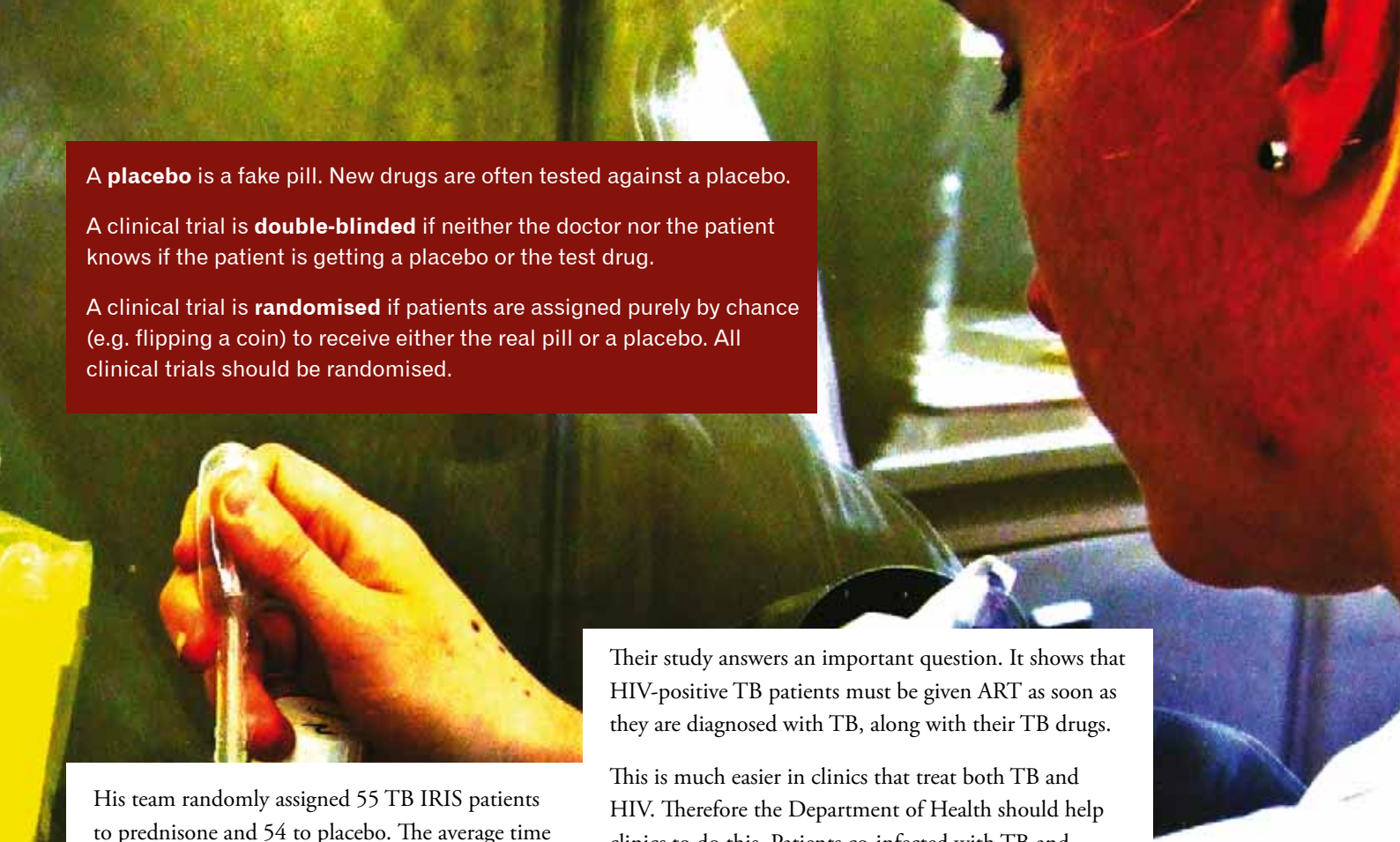
10 out of 21 patients who took TMC207 became TB-negative as opposed to 2 out of 23 who took placebo. This means that TMC207 was effective at curing MDR-TB in this trial. However, some side effects occurred. More patients who took TMC207 became nauseous than patients who took placebo. Nevertheless, TMC207 was well-tolerated by most patients.

Based on these results, TMC207 looks promising. However, this was a very small, early trial. More testing is being done. It might take another two years before we can say with confidence whether or not this is a safe and effective drug. In the meanwhile, TMC207 should be made available in some cases to people with drug-resistant TB who have no other options.

Steroid effective at treating TB IRIS

Some patients who start antiretroviral treatment (ART) with very low CD4 counts develop a dangerous condition called immune reconstitution syndrome (IRIS). Despite being on treatment, patients with IRIS can have opportunistic infections like TB. This happens because the immune system recovers (due to ART) and reacts to already existing infections in the body.

Dr Graham Meintjes is a doctor at Jooste Hospital in Cape Town. He ran a study to see if patients with TB IRIS do better if they are given a steroid called *prednisone*.



A **placebo** is a fake pill. New drugs are often tested against a placebo.

A clinical trial is **double-blinded** if neither the doctor nor the patient knows if the patient is getting a placebo or the test drug.

A clinical trial is **randomised** if patients are assigned purely by chance (e.g. flipping a coin) to receive either the real pill or a placebo. All clinical trials should be randomised.

His team randomly assigned 55 TB IRIS patients to prednisone and 54 to placebo. The average time in hospital spent by prednisone patients was one day, while for those on placebo it was three days. Altogether, the number of hospital days among the prednisone group was 282 versus 463 days for the placebo group. There were also fewer hospital procedures in the prednisone set (29 versus 38). Overall, patients on prednisone did better than those on placebo.

This study shows that prednisone should be given to patients with TB IRIS. Prednisone is already available in the public sector.

HIV-positive people with TB must be given ART immediately

Salim and Quarraisha Abdool Karim's research institute, CAPRISA, ran a clinical trial in Durban to see when it is best to put HIV-positive patients with TB onto ART.

They randomly divided their patients into two groups. One group received ART immediately, along with TB treatment. The other group was given ART only after completing their TB treatment. The death rate in the immediate ART treatment group was less than half that of the delayed group.

Their study answers an important question. It shows that HIV-positive TB patients must be given ART as soon as they are diagnosed with TB, along with their TB drugs.

This is much easier in clinics that treat both TB and HIV. Therefore the Department of Health should help clinics to do this. Patients co-infected with TB and HIV should not have to go to two different clinics for treatment of TB and HIV. Separate care is expensive, inefficient and inconvenient. It also means that all patients with TB must be tested for HIV, and all patients with HIV be tested for TB.

Disturbing news about XDR TB

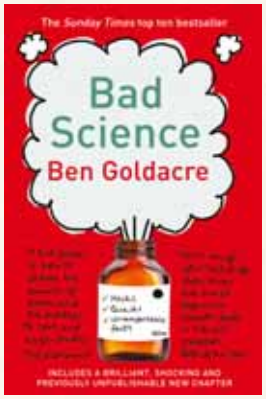
The news on extremely drug-resistant TB (XDR-TB) in South Africa continues to be disturbing.

A study by Max O'Donnell in King George V Hospital in Durban showed that 25 out of 60 patients his team treated for XDR-TB died. A further six defaulted on their treatment. At the end of six months, fewer than half of these patients were known to be alive. This is despite being given relatively good medical care, including ART for HIV-positive patients. Only twelve patients were cured by the end of the study period.

This study shows how difficult it is to treat XDR-TB successfully.

It is also worrying that the patients were referred from 26 different health facilities in Kwazulu-Natal. This means that XDR-TB has spread quite widely in the province.

Recommended reading



Bad Science

By Ben Goldacre

In South Africa we know very well that a poor understanding of science and how it works can lead to preventable deaths. We know that vitamins cannot cure HIV, and that ARVs are the only treatment that can suppress the virus. Nevertheless, our former Minister of Health tragically failed to recognise these proven facts.

In *Bad Science*, medical doctor and acclaimed science writer Ben Goldacre explains in easy-to-understand language how we can make sense of scientific claims in the media. He shows convincingly how the media often engages in fear-mongering, how public relations companies push pseudo-science to benefit their clients, and how many journalists make basic mistakes when writing about science and health.

Goldacre doesn't just point the finger, though: he gives you the tools to spot bad science and pseudo-scientific fear-mongering for yourself. As such, *Bad Science* is a hugely empowering book and a highly recommended read. If only some of our former leaders could have read it before taking office.

Note that the 2009 edition of the book contains a chapter on Matthias Rath. This chapter was left out of earlier editions because Rath took legal action against Goldacre for comments Goldacre had made in *The Guardian* newspaper. The court has since ruled in Goldacre's favour. The Rath chapter is also freely available online at this address: http://www.badscience.net/2009/04/matthias-rath-steal-this-chapter/

The Virus, Vitamins and Vegetables

Edited by Kerry Cullinan and Anso Thom

The Virus, Vitamins and Vegetables provides an insightful history of the years of state-endorsed AIDS denialism under former President Thabo Mbeki and former Minister of Health Manto Tshabalala-Msimang. Put together by the award-winning team of journalists at *Health-e News Service*, the book features contributions by, amongst others, Pregs Govender, Ashraf Coovadia and Zackie Achmat.

At the launch of the book in Durban, former Deputy Minister of Health Nozizwe Madlala-Routledge said that it "chronicles the tragedy that unfolds when leaders choose to play with people's lives by ignoring evidence and science and embrac[ing] untested remedies and [the] theories of those on the lunatic fringe."

As a history of AIDS denialism, the book is well worth reading. From the Virodine affair to TAC's long struggle with Matthias Rath and the campaign's success in convincing government to roll out antiretrovirals (ARVs), all the bases are well covered.

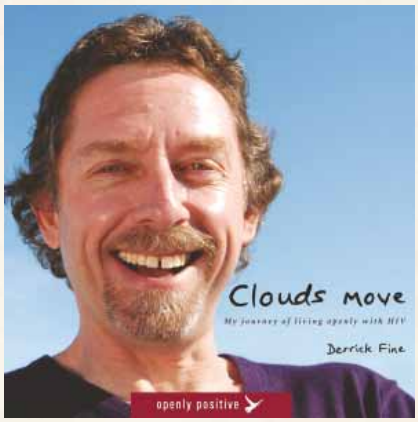
Not all of the essays are equally good, though. The article on TAC, for example, focuses almost exclusively on gender politics internal to TAC. Whereas this is certainly a valid topic to investigate, the reader is never shown why it matters in the context of denialism.

Even so, *The Virus, Vitamins and Vegetables* is essential reading for anyone with an interest in HIV/AIDS in South Africa.

Both books reviewed by Marcus Low.

Books from Openly Positive

The Openly Positive Trust (Openly Positive) helps to build a supportive environment for people living with HIV through its story-telling series. Derrick Fine's Clouds Move *(2007) and Elaine Maane's* Umzala *(2009) will be followed by a collection of short stories about living with HIV, from South Africa and the African continent. If you would like to contribute your story, you can contact Openly Positive on opositive@iafrica.com or www.openlypositive.com*



Clouds Move

By Derrick Fine

Clouds Move is a poignant and revealing memoir of living with HIV in South Africa. This is Derrick Fine's life story expressed through words, poems, photos and Zapiro's wonderful cartoons. Yet it is also the story of many people who are fighting for access to treatment and searching for light in a bleak political landscape.

Through flashbacks to his early years, the challenges of coming out as a gay man, his gradual disclosure of living with HIV and the joy of finding love, Derrick's personal journey celebrates life and calls for the greater visibility of people living with HIV.

Clouds Move encourages us to reflect on our own life, with its useful lessons, questions for discussion and positive language guidelines to help reduce HIV stigma. You can use these learning tools on your own, in awareness workshops and in support groups.

Umzala

By Elaine Maane

Umzala (isiZulu for *cousin,* which Elaine uses to refer to HIV) is a hearty tribute to the challenges of living positively with HIV, told with tears and laughter. Elaine shares the path charted by many of us who have felt like an island at some point in our lives.

From her Zambian roots, Elaine's story reflects on her life journey as a young mother who discovers that she has HIV and then loses her husband to the virus. Her journey will touch you with her refreshing insights as she shares the lessons she learned as a single parent, as a lover, and as a woman constantly rocked by the loss of loved ones.

Umzala inspires us to rise above seemingly impossible odds and to make our mark. Elaine encourages us to heal, to love and be loved, and to live life fully to the best of our ability. Together with her, we discover that HIV should not be a barrier to reaching our dreams.

branch NEWS

Oscar Mabela of the Limpopo branch facilitating a discussion on ARV regimens available within the public health sector at the Lenyenye Y Centre. Photo by Adam Malapa.

Goso Forest, Lusikisiki branch members march as part of their campaign on human rights and access to comprehensive health services. As part of the campaign, TAC has encouraged the community to be regularly tested for HIV and TB, and given out copies of Equal Treatment and over 800 condoms. The branch will continue to provide HIV/AIDS and TB education to schools and plans to form a support group for rape survivors. Photo by Tandeka Vinjwa.

Creamy Tuna Noodles

The ultimate budget friendly dish to warm your family's bellies on a rainy day.

NUTRITION PROFILE: High Fiber • Low Cholesterol • Low Saturated Fat • High Calcium • High Potassium • Heart Healthy
This dish is packed with the vitamin powerhouses, spinach and red bell peppers. For added fibre use whole wheat noodles.
MAKES: 6 servings TIME: 40 minutes PREPARATION: Easy

What you need

1 package instant Chinese noodles (or regular noodles)
1 tablespoon vegetable oil

3 cloves garlic, finely chopped
1 medium onion, chopped
1 bell pepper, chopped

1 bunch spinach, chopped

1 teaspoon salt
470ml nonfat milk

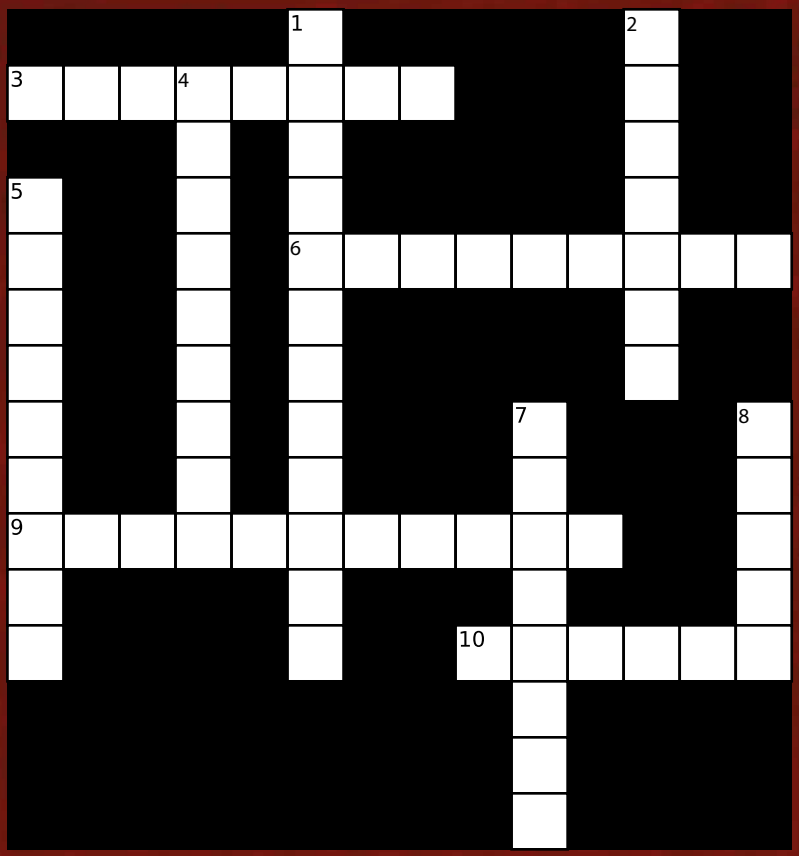
2 teaspoons freshly ground pepper
2 cans canned chunk light tuna (see Tip), drained
180ml grated Cheddar cheese

Method

1. Put instant noodles in a pot. Pour boiling water to cover and let stand till tender. Alternativley, boil regular noodles according to package directions. Drain.
2. Heat oil in a large skillet over medium-high heat. Add onion, garlic, bell pepper and salt and cook, stirring often, until the onion is softened but not browned, about 5 minutes. Add spinach and cook until wilted, 4 to 5 minutes. Add milk and pepper and bring to a simmer, stirring constantly. Stir in tuna and cheese until evenly incorporated. Then, stir in the noodles. Remove from the heat and serve.

TIP: Tinned fish is a good, cheap source of protein. You can substitute any tinned fish for tuna in this recipe.

Equal Treatment's Crossword Puzzle



We will give a R200 Pick n' Pay gift voucher to the first crossword drawn from a hat with all the correct answers. The answers can be found in this issue of *Equal Treatment*.

Last month's winner will be announced in a future issue.

Fax or post your completed crossword, with your name, address and contact number.
Address: Equal Treatment, PO Box 2069, Cape Town 8001
Fax: 021 422 1720

Across

3 When nurses take over some of the functions of doctors it is called task___

6 Medical circumcision reduces, but does not ... the risk of contracting HIV.

9 According to new research, HIV-positive people with TB must be given ART___

10 From which African country is Elaine Maane?

Down

1 OSD stands for Occupational Specific___

2 The chairperson of TAC is Nonkosi___

4 In November 2008, an antiretroviral moratorium was put in place in which province?

5 When a country's **Gross Domestic Product** falls for six months or more in a row, that country is considered to be in___

7 The book 'Bad Science' was written by Dr Ben___

8 In the 2001___ Declaration, African heads of state pledged to devote 15% of national budgets to health.

Show us the Money for Health!

- **President Robert Mugabe** of Zimbabwe spent $250 000 on his 85th birthday party, which could fund 10 501 courses of tuberculosis treatment.
- **King Mswati III** of Swaziland has a luxury vehicle worth $500 000, the cost of 21 001 courses of tuberculosis treatment.
- U.S. **president Barack Obama** has spent $700 000 000 000 on the country's economic bailout, which is more than 100 times the 2009 budget for the President's Emergency Plan for AIDS Relief (PEPFAR).
- The cost of the U.S. war in Iraq, headed by former **President George Bush** and former **Vice-President Dick Cheney,** is pegged at $686 880 390 658, which is more than 140 times the money needed to close the Global Fund's gap for HIV and TB.

ARASA AIDS & Rights Alliance for Southern Africa

Sign our petition and check out the 'Lords of the Bling' video for more information on where our money is going and how it should be spent.

www.arasa.info