TAC
TREATMENT ACTION CAMPAIGN

Annual Report

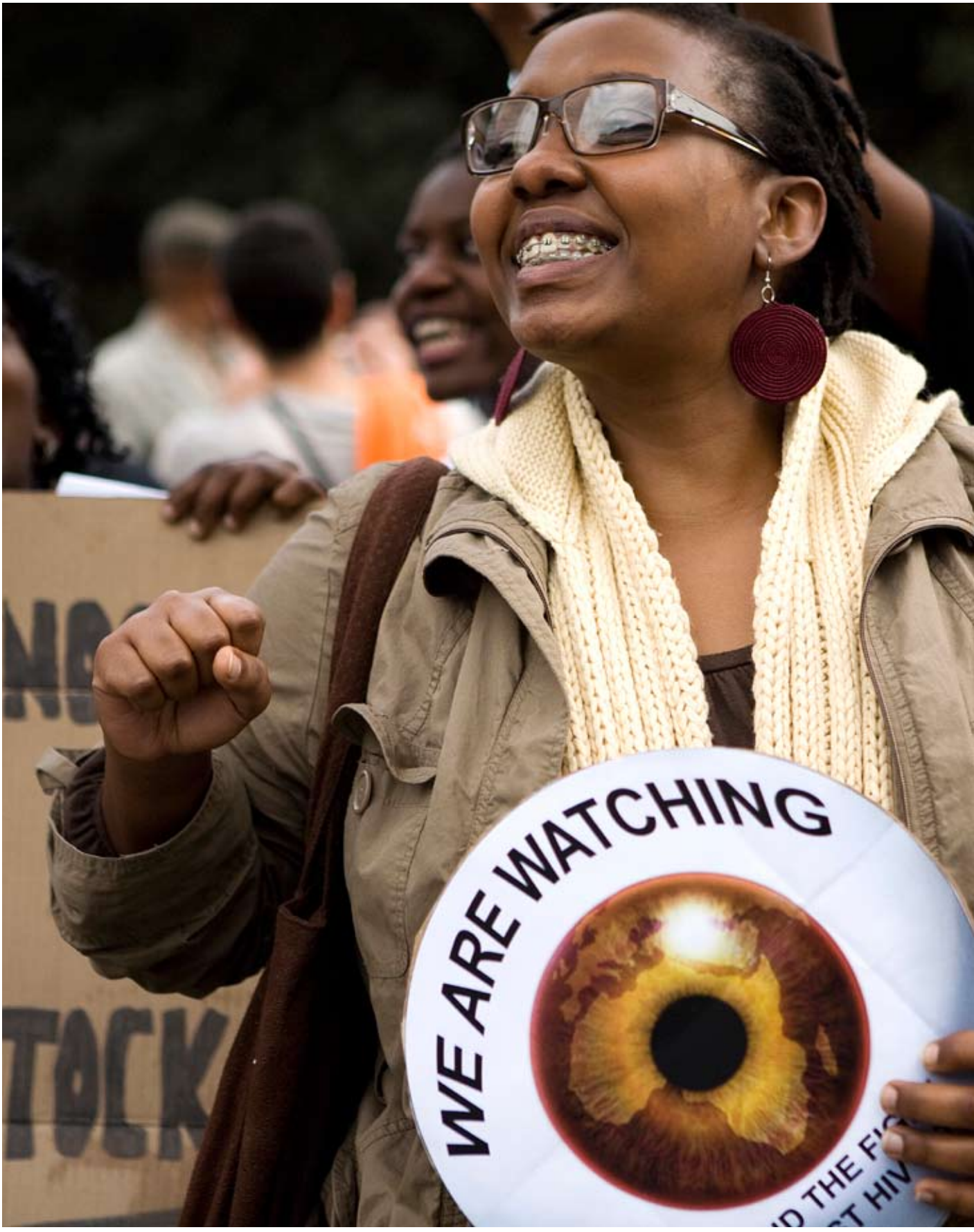
1 March 2009 to 28 February 2010

meet the NSP targets for HIV/TB

treatment prevention

universal access now!

Content


WE ARE WATCHING

Overview of year

With the effects of the global economic crisis still lingering and high-level talk about scaling down HIV funding in favour of broader health system strengthening, AIDS activists faced a dramatic shift in focus going into 2009. The era of state-sponsored AIDS denialism might have been over, but it had been replaced by a lack of urgency from many international donors and the rise of an invalid argument pitting HIV against other health concerns. Just as everything was in place to start rolling back the tide of the HIV epidemic, it seemed the funds were drying up.

Of course, on the ground, where many hundreds of thousands are still struggling to access treatment, the need for prevention, treatment and care has not abated. Less than half of South Africans in need of antiretroviral medicines were receiving it in 2009. Other sub-Saharan African countries that are more dependent on international donors faced the plug being pulled on existing HIV programmes – let alone scaling up treatment toward universal access. The incredible human cost of this still pending resource gap cannot be underestimated.

Another challenge is that available funding often is being sub-optimally spent. In recognition of this, TAC and a number of partner organisations started paying more attention to and equipping local activists to analyse health budgets.

In the light of the resource crisis then, TAC's major campaign for 2009 was our resources for health campaign. This umbrella campaign gave us the space to campaign on a number of issues ranging from the lack of human resources in the South African health system, to antiretroviral drug stock outs, outdated treatment guidelines, and the wider international HIV funding crisis.

Of course, TAC itself has not been untouched by the changing economic environment. It was becoming clear that funding would become more difficult to come by – and that TAC needed to improve its own management and strategic focus to remain sustainable in a changing funding and policy environment. In this light TAC underwent a further period of restructuring toward the end of 2009.

By the end of 2009/early 2010 TAC was leaner, more streamlined and had become more professional and accountable than at any time in its history. The restructuring saw increased autonomy being given to TAC's six model districts. This was in accordance with our strategy of supporting the HIV&AIDS and STI Strategic Plan (2007-2011), commonly known as the National Strategic Plan (NSP), through model interventions in selected areas with high HIV prevalence.

Apart from all the excellent treatment literacy and community health advocacy work done in these model districts, they also help keep TAC's ear to the ground and helped us identify various delivery problems in the health system. In these districts we responded to poor service delivery, antiretroviral stock outs, helped bring cases of gender based violence to the courts, and supported government in its testing campaigns.

On a national level, our campaigns helped bring about a number of important improvements to South Africa's treatment guidelines – some announced by President Jacob Zuma on World AIDS Day 2009 and others announced early in 2010. Improvements included updated treatment guidelines, the launch of a national HIV Counselling and Testing campaign, the rollout of voluntary medical male circumcision as well as TB/HIV service integration.

However, we are aware that national policy does not always translate into on the ground reality and service delivery. Monitoring and supporting the implementation of the improved HIV guidelines and policies will be one of TAC's main priorities in the upcoming year. In our six model districts, we will work with government to implement these changes and advocate around gaps identified.

Finally, threats to international funding continue to undermine universal access targets globally. In 2010 we will work closely with international partners to pressure governments to meet their commitments to universal access. Now is the time for governments and funders to build on the successes of the last decade and expand access to antiretroviral treatment to all who need it.

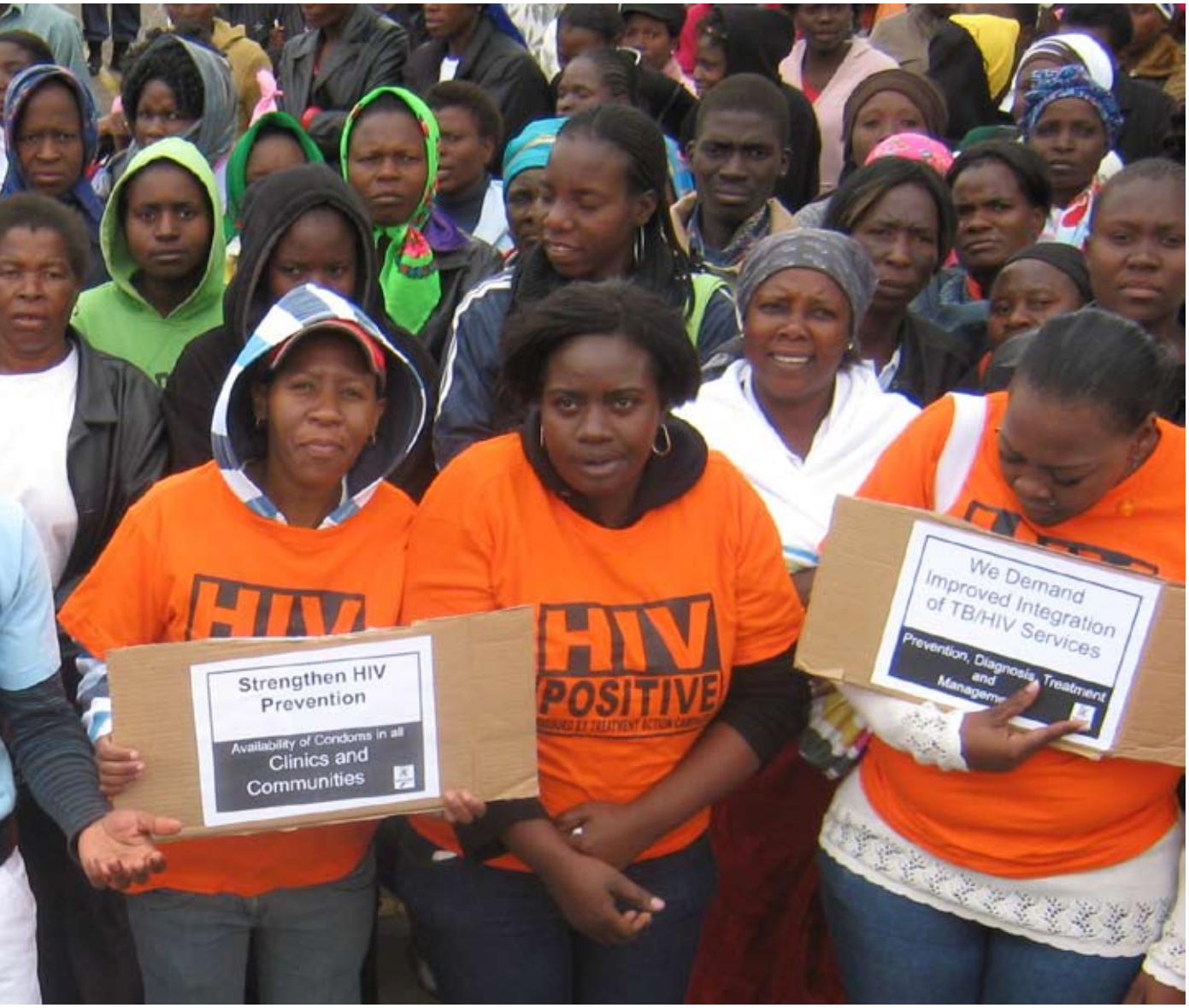
A new political climate

After years of poor management and AIDS denialism, 2009 saw a return to sanity in South Africa's response to HIV. The break from the past that had occurred with the leadership changes of September 2008 was built upon by new leadership in the Presidency and the department of health. TAC responded to the new atmosphere of openness and realism by committing to work with government to ensure the success of the National Strategic Plan (NSP).

On 11 May 2009 President Jacob Zuma appointed Dr Aaron Motsoaledi as South Africa's new Minister of Health. Motsoaledi replaced Barbara Hogan, who had been in the job since Manto Tshabalala-Msimang was removed from the post on 25 September 2008.

TAC had a good relationship with Hogan and initially there had been some uncertainty as to whether Motsoaledi would continue her progressive efforts in rehabilitating the health system after the years of mismanagement under Tshabalala-Msimang. However, Motsoaledi soon allayed what fears there might have been around his leadership and showed himself to be a reasonable and approachable leader.

When 5,000 TAC members marched to the Cape Town International Convention Centre on 19 July



2009 as part of our resources for health campaign, Motsoaledi was there to receive our memorandum. In a hugely symbolic moment Motsoaledi put on one of TAC's HIV Positive T-shirts. He also met with TAC's leadership to discuss a range of pressing issues.

In the following months both Zuma and Motsoaledi made a number of important speeches in which they spoke clearly and realistically about HIV. On 29 October 2009, Zuma openly distanced himself from the denialist policies of the past and signalled a clear end to state-sponsored AIDS denialism in a landmark speech to the National Council of Provinces. The year culminated with a series of important changes to South Africa's treatment guidelines announced by Zuma on World AIDS Day 2009. Though these policy changes did not go quite as far as TAC would have wanted, they all directly related to areas in which TAC had been campaigning and were all based on reliable evidence.

Even though we are now working more closely with government than ever, particularly through the South African National AIDS Council, TAC's primary responsibility remains to the millions of people living with and affected by HIV. We will therefore keep holding government accountable and continue to campaign for universal access to HIV treatment and care.

Resources for health campaign

As we entered the financial year, South Africa faced rampant problems of drug shortages and waiting lists. We were just coming out of the deadly moratorium in the Free State. At the same time, we faced immediate shortages of funding for HIV that would only deepen as international governments and donors began to back away from funding HIV. In response to this we launched our resources for health campaign.

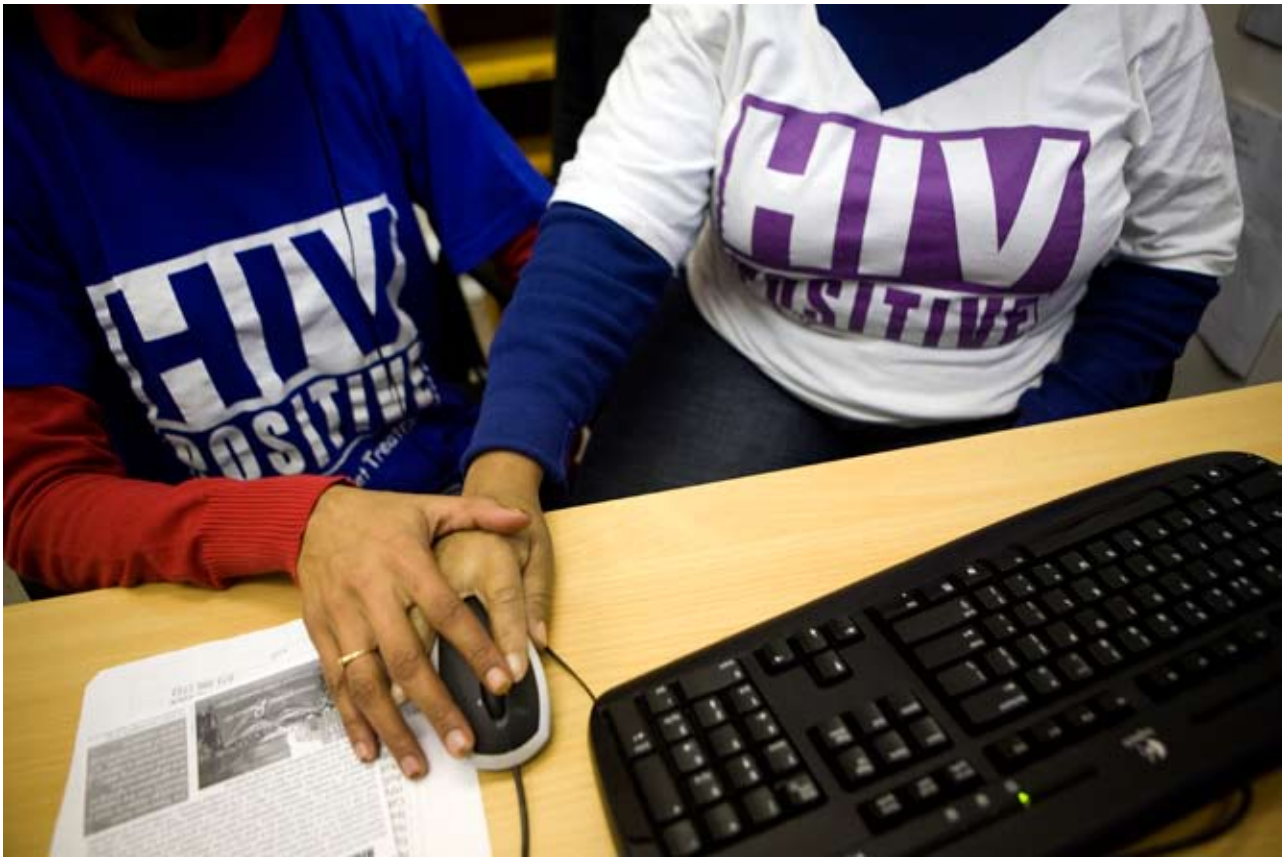
TAC initiated the campaign by carrying out research in six districts on the state of HIV programmes and health service delivery. We found that provincial waiting lists for antiretrovirals were in the thousands with a waiting list of 60,000 in KwaZulu-Natal. It was further identified that patients were only being initiated onto treatment very late when they were already very sick. For instance, in Ekurhuleni, a patient on the waiting list at Emthonjeni Clinic had a CD4 count of just 25. All of the districts also identified ongoing stock-outs of antiretrovirals, TB medication, chronic illness medication, formula milk and condoms. The districts further identified the shortage of human resources and the lack of integrated services as a serious challenge to meeting the NSP targets.

As part of our resources for health campaign, TAC carried out a number of demonstrations with partners. On 2 April, TAC and partners protested at the 4th Southern African AIDS Conference in Durban. Protesters held banners stating 'HIV is not in recession!' On 10 June TAC, the AIDS Rights Alliance of Southern Africa and other partner organisations picketed outside of Cape Town's International Convention Centre during the World Economic Forum on Africa. We demanded that the right to health is properly financed.

In July TAC held six protests around the country demanding that government meet the NSP targets to reduce new infections by 50% and increase access to treatment to 80% by 2011.

Our demands

- Scale up treatment to all those in need
- Improve the monitoring and evaluation of the prevention of mother-to-child transmission and antiretroviral programmes
- Update the HIV and TB guidelines and regimens
    - Provide early treatment to all HIV positive infants
    - Initiate treatment at CD4 counts of 350
    - Provide tenofovir as a first line regimen
    - Integrate TB and HIV care
- Proper financing and management of the health system and the NSP
- Implement task-shifting



Learning to monitor budgets

As the financial year began, the NSP treatment targets were facing a funding deficit of R1 billion. It was also identified that available funding was being spent sub-optimally and budgets were not being properly managed. Funding shortages and lack of capacity to manage budgets were undermining the department of health's ability to scale-up treatment and improve service delivery. Therefore, TAC mobilised to capacitate ourselves to engage with health budgets.

We started by working with SECTION27 (incorporating the AIDS Law Project) to learn about the Public Finance Management Act (1 of 1999) which regulates the use of public finances. TAC also partnered with the Centre for Economic Governance of AIDS in Africa (CEGAA) to develop local budget monitoring and expenditure tracking projects in Lusikisiki (Eastern Cape) and uMgungundlovu (KwaZulu-Natal). Through these projects TAC aims to build the capacity of TAC districts to understand budget processes so that we can engage more actively with the planning and budgeting aspects of the health system. The TAC/CEGAA project also aims to strengthen the capacity of communities and local health authorities to engage with budgets.

This year SECTION27, TAC and several other organisations also launched the Budget and Expenditure Monitoring Forum. The Budget and Expenditure Monitoring Forum brings together civil society organizations, doctors, lawyers and economists to engage with health and HIV budgets and respond to issues when necessary. The first meeting, held on 21 August 2009, highlighted the mismanagement of health finances and explained how civil society could intervene to improve the situation. The second meeting, held on 5 February 2010 looked at the 2010 antiretroviral tender and aimed to capacitate civil society to monitor and engage with this process effectively.

Through our resources for health campaign, we called on government to cover the funding deficit for treatment and to take steps to strengthen the department of health's capacity to budget and manage finances.

While TAC cannot take the credit for this, at the end of the financial year we began to see significant increases in funding for HIV and antiretroviral treatment in South Africa. On 1 December 2009, PEPFAR announced that it would give South Africa R900 million over two years to cover the funding shortfall for treatment and strengthen procurement and supply chains. In February 2010, government announced an increase to the comprehensive HIV&AIDS grant of R1.7 billion for the 2010/2011 financial year.

The increased funding allocations for HIV are necessary to meeting the treatment targets. Yet, shortages of funding for health in general, as well as, poor financial management continue to plague the health sector and threaten to undermine HIV and TB programmes. TAC will continue to work to strengthen our capacity to meaningfully engage with these issues and respond when necessary.

Declining funding for HIV and the backlash

As the global economic downturn deepened in 2009, it became clear that it threatened to undermine universal access targets, particularly, as governments were using it as an excuse to backtrack on their commitments to HIV and health. On 6 July 2009, the World Bank and UNAIDS released a report stating that the global economic downturn would result in disruption of HIV prevention and treatment programmes in 22 countries in Africa, the Caribbean, Europe and Central Asia, and Asia and Pacific over the course of the year.

The situation was worsened by a backlash away from funding HIV and AIDS treatment programmes identified in a working paper by Nicoli Nattrass and Gregg Gonsalves, *Economics and the Backlash Against AIDS-Specific Funding* (2009). The backlash identified that donors and international policy makers priorities were shifting away from HIV. Policy makers argued that cheaper, more cost-effective interventions should be prioritised over HIV. Also policy makers began to pit health interventions against each other, arguing that HIV-focused funding was undermining health system strengthening and maternal and infant health.

AIDS activists internationally mobilised against the backlash, aiming to demonstrate to policy makers that their arguments against HIV funding were fatally flawed. HIV/AIDS continues to be a leading cause of maternal and infant mortality in sub-Saharan Africa. A move away from HIV funding will worsen these health outcomes. Research by Médicins Sans Frontières has shown that HIV programmes can strengthen health systems and, at the same time, a move away from HIV funding will lead to more opportunistic infections and AIDS related diseases, increasing the burden on health systems.

Throughout the year TAC developed and disseminated materials and held workshops to educate members and partners on the challenges to HIV funding. TAC and partners lobbied international policy makers through our resources for health demonstrations. TAC and partners called for expanded and sustainable funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan for AIDS Relief (PEPFAR). We also called on African governments to meet their Abuja commitment to spend 15% of their annual budgets on health care.

This campaign will continue into next year as funding for HIV and TB remains threatened. The United States has signalled that they will cap funding for HIV treatment programmes and will move away from funding direct care, focusing instead on 'technical assistance'. The Global Fund is struggling to secure funding for its upcoming round and only 6 out of 52 African countries have met their Abuja commitments.

Stock-outs and waiting lists

The South African Constitution guarantees the progressive realisation of access to comprehensive health care. Long antiretroviral treatment waiting lists and stock-outs of antiretrovirals and other essential medicines violate this right and sacrifice the lives and wellbeing of HIV-positive people. Late treatment initiation is also costly because treating opportunistic infections requires more clinical care and is therefore expensive and time consuming. Timely initiation of treatment would prevent both TB and HIV transmission by reducing the viral load and strengthening the immunity of people living with HIV.

Following the antiretroviral stock-outs and treatment interruptions in the Free State toward the end of 2008, TAC paid specific attention to monitoring ARV availability in 2009.

After a deadly ARV stock-out at Edendale hospital in Kwazulu-Natal, TAC uMgungundlovu and partners organised a march attended by more than 700 people on 16 July. The march slogan was "WAITING LISTS = DEATH". After more pressure from TAC, from partner organisations and from the media, the situation was resolved and the district medical manager May Zuma-Mkhonza was fired.

In October TAC Gert Sibande alerted TAC national office to urgent stock-outs at Piet Retief hospital in Mpumalanga province. The matter was escalated through TAC and the AIDS Law Project to the national department of health and the situation was resolved.

TAC continued to monitor stock-outs in all six model districts. A number of stock-outs of medicines and formula milk were reported and responded to by TAC at local level.

Access to medicine campaign

TAC continued to advocate for affordable access to treatment throughout the year as part of our access to medicine campaign. This year TAC focused on improving access to and affordability of the antiretrovirals, abacavir and tenofovir, as well as fixed dose combinations.

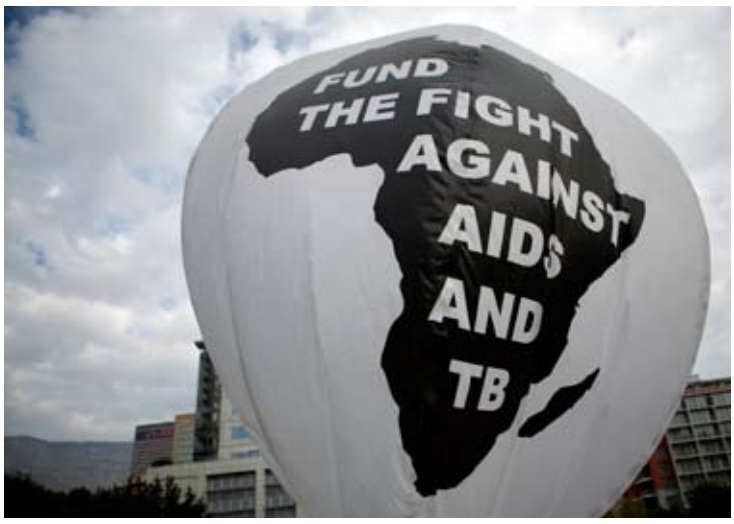
TAC, the Centre for the AIDS Programme of Research (CAPRISA) and the Southern African HIV Clinicians Society (SAHCS), assisted by SECTION27 (incorporating the AIDS Law Project), took successful action resulting in increased availability of the antiretroviral drug abacavir. SECTION27 made a submission to the competition commission on behalf of TAC and partners explaining how the pending merger of GlaxoSmithKline and Aspen Pharmacare would impact competition for antiretrovirals.

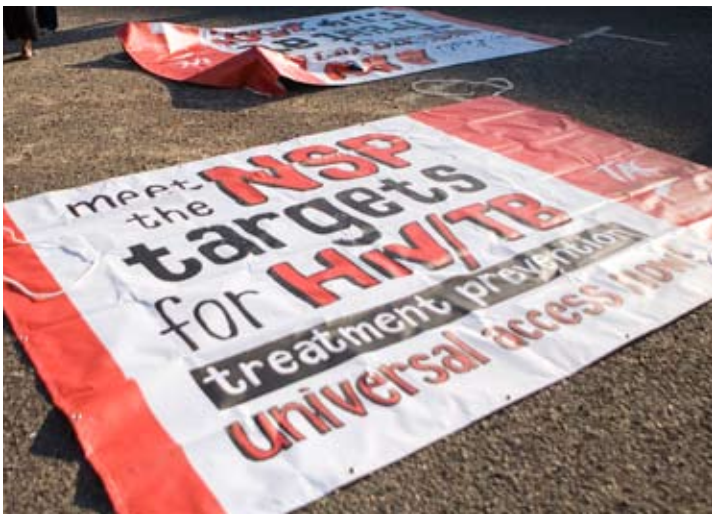
In September 2009 the merger of the two companies was approved on the condition that GlaxoSmithKline grant local generic manufacturers licenses to manufacture or import abacavir. This will increase competition to drive down prices of abacavir products. Abacavir is particularly important for the treatment of infants and children and, subsequently, in April 2010, the treatment guidelines were updated replacing stavudine with abacavir for infants and children.

Throughout the year TAC also advocated for better first line regimens for adolescents and adults including the replacement of stavudine and zidovudine with tenofovir and the expanded use of fixed dose combinations. Stavudine and zidovudine are associated with high rates of serious side effects. Tenofovir is a superior drug to stavudine and zidovudine – it has fewer side effects and requires fewer treatment switches.

Advocacy efforts around tenofovir included the development and dissemination of materials and policy briefs. TAC educated members, branches and communities on tenofovir and its benefits. Throughout the year, TAC wrote a series of letters to generic producing companies urging them to submit generic tenofovir products to the Medicines Control Council for registration and to market these products at prices competitive with stavudine and zidovudine.

This year TAC also focused on the need for expanded access to fixed dose combinations. Fixed dose combinations combine all of the drugs in a regimen into a single pill. Fixed dose combinations





can improve adherence because they are simpler for patients. Fixed dose combinations are also simpler for healthcare workers and procurement and supply chains.

On 5 February 2010, the Budget and Expenditure Monitoring Forum looked at the antiretroviral tender to capacitate civil society to monitor and engage with the process. Following this meeting, the forum drafted letters and statements calling for the Medicines Control Council to speed up registration of antiretrovirals and particularly fixed dose combinations to ensure that improved regimens are made available through the 2010 antiretroviral tender.

Out of date guidelines

Going into 2009, antiretroviral treatment guidelines in the South African public health system lagged far behind those of developed countries and those prescribed by the World Health Organisation. This was mostly a legacy of the distrust and lack of interest in antiretroviral treatment in the department of health under Tshabalala-Msimang, but also related to concerns over the cost of treatment and the capacity to roll it out.

As part of TAC's Resource for Health campaign, we campaigned for earlier initiation of treatment for infants and adults and urgent improvements to the first-line antiretroviral treatment regimen.

Earlier HIV treatment

While most developed and many developing countries were starting HIV-positive people on treatment at CD4 counts of 350, people in South Africa were only started on treatment once CD4 counts dropped below 200. TAC campaigned to have the threshold pushed up to 350 in accordance with international standards and World Health Organisation recommendations.

On World AIDS Day 2009 President Jacob Zuma announced that HIV-positive pregnant women and people co-infected with HIV and TB would be initiated at 350. Whereas these changes represented a partial success, they do not go far enough and TAC will continue to campaign for all HIV-positive people to be started at 350.

Earlier treatment for infants

Also on World AIDS Day, Zuma announced that all HIV-positive infants would be provided with treatment immediately. This had also been a campaign point and a topic featured in TAC's Equal Treatment magazine and in TAC workshops. Our campaign for the earlier initiation of treatment followed strong findings from the CHER (Children with HIV Early Antiretroviral Therapy) trial which found that early treatment substantially reduced mortality.

Inclusion of tenofovir in first-line treatment

The last time prior to 2010 that South Africa's antiretroviral treatment guidelines were updated was in 2004. This meant that the guidelines did not allow for the use of better tolerated medicines that had become viable alternatives since then.

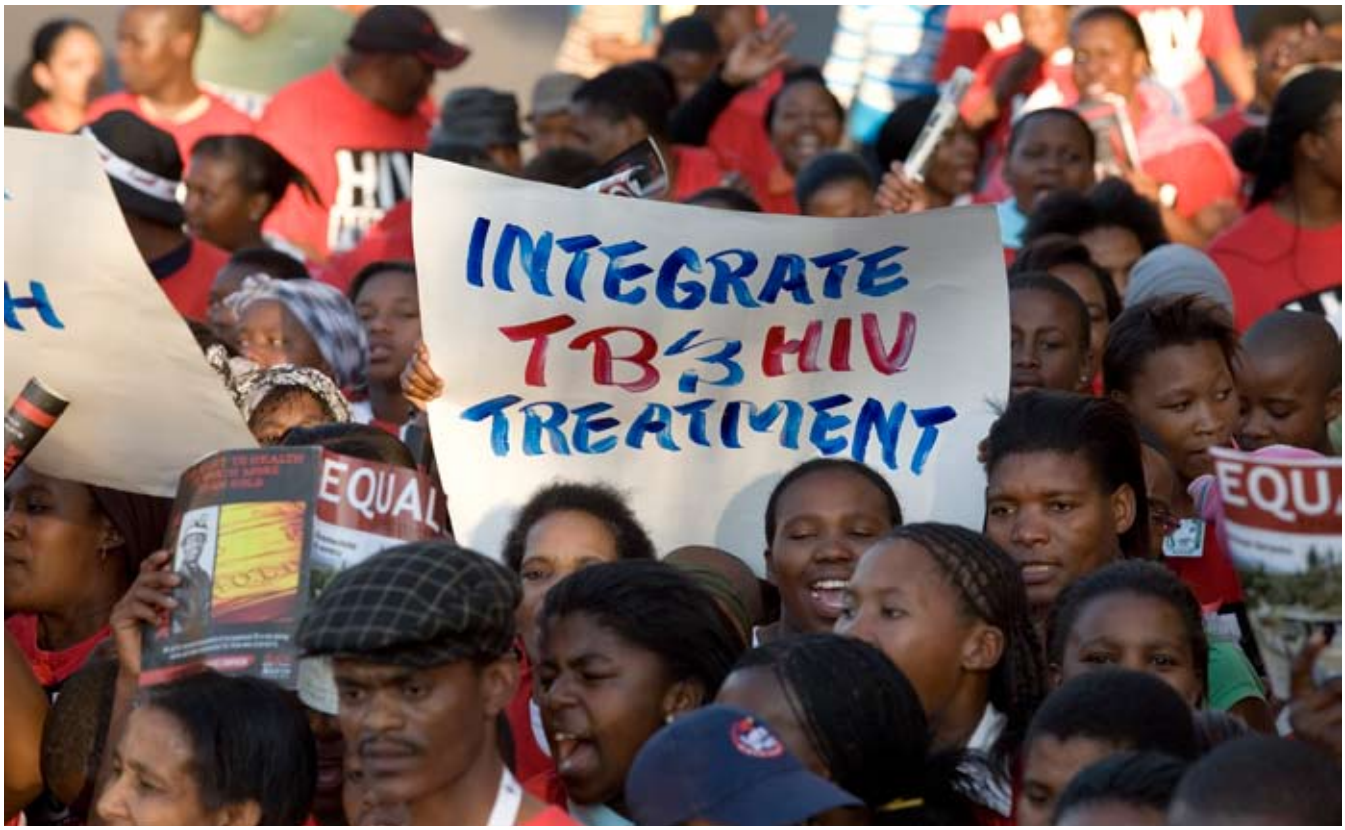
TAC campaigned for the antiretrovirals stavudine and zidovudine to be replaced with tenofovir in first-line antiretroviral treatment due to tenofovir's much better side effect profile. (See access to medicine campaign page 7). Shortly after the period covered in this report, the 2010 antiretroviral treatment guidelines were announced in which stavudine and zidovudine were finally replaced with tenofovir for new patients and patients experiencing side effects.

Human resources shortages

The shortage of human resources is felt in all districts, leading to poor service delivery and public sector burn-out of doctors and nurses. Pharmacists are particularly scarce and patients must wait for hours to be served or come back another day if the pharmacist is absent.

The human resources shortage is a significant challenge but one that government can meet partly through task-shifting. We are more likely to meet the NSP targets if healthcare is decentralised. This means making antiretroviral therapy more widely available at primary care level facilities and expanding the roles of all health workers and particularly community health care workers. The task-shifting models used in Khayelitsha and Lusikisiki have demonstrated that this can work.

In April 2009, at the 4th South African AIDS Conference, TAC and partners campaigned and released statements calling on government to implement task-shifting. Through our resources for health campaign, TAC advocated for the department of health to formalise the role and employment of community health workers to engage them in task-shifting, and make the



necessary policy changes to empower nurses to initiate and manage ART.

TAC is currently engaging with the development of a community health care worker policy through the South African National AIDS Council. In Khayelitsha, TAC worked to educate community health care workers on task-shifting and the policy so that they could engage in its development.

In the following year, allowances were made for nurses to initiate and manage antiretroviral therapy. This is an important and necessary step that will ensure that more people are able to access antiretroviral therapy. Although there is still more to be done, far too many posts remain vacant – particularly in rural areas. TAC will continue to advocate for government to address the shortages by filling the posts, finalising the community care giver policy and further implementing task-shifting.

Bringing services under one roof

Poor integration of health services affects many people's ability to access the care and treatment that they need. A person that is co-infected with TB/HIV may have to travel long distances to different facilities to access care. Many people cannot cover transportation costs or get time off work to visit multiple clinics. This is a major barrier to treatment adherence and is having a negative impact on treatment outcomes.

TB is the leading cause of death of people living with HIV. Co-infection with HIV is more than 50%, and as high as 75% in some areas. Further, due to poor treatment outcomes we are facing increasing cases of drug resistant TB. In Khayelitsha Médicins Sans Frontières, TAC, the City of Cape Town and the Western Cape Department of Health have demonstrated that integration of services can improve treatment outcomes.

TAC and partners called for integration of health services and prioritising the integration of TB/HIV services in a march to parliament on World TB Day 2009 and again during our resources for health campaign. TAC also developed materials, including a policy paper, and carried out workshops on the need for the integration of TB and HIV care.

In line with the need for expanded access to integrated care, TAC called for more facilities to be accredited to provide antiretroviral therapy.

TAC Gert Sibande supported Amajuba Memorial Hospital and Driefontein Clinic in becoming accredited to provide antiretroviral therapy. TAC

Gert Sibande also held a door-to-door campaign to rally support for accreditation of the Driefontein clinic.

TAC Khayelitsha met with the Western Cape MEC for Health in 2008, calling for the Brooklyn Chest Hospital to be accredited to provide antiretrovirals. In 2009, after our intervention, the site was accredited and a doctor was placed at Brooklyn Hospital to administer antiretroviral treatment.

On World AIDS Day (1 December) 2009, TAC and partners celebrated when Health Minister Aaron Motsoaledi announced that from April 2010, TB and HIV would be treated under one roof.

Prevention

In 2009 TAC continued to campaign for evidence-based prevention interventions. Our massive condom distribution programme went from strength to strength, we did education and campaigning around the benefits of voluntary medical male circumcision, we had some concrete successes in relation to the prevention of mother-to-child transmission of HIV, and new research confirmed that treatment is a crucial part of prevention – due to the lower infectiousness of people who are stable on treatment.

Voluntary medical male circumcision (VMMC)

By the beginning of 2009 the evidence was already very strong that medical male circumcision reduces a heterosexual man's chances of contracting HIV by approximately 60%. TAC produced a factsheet on VMMC, included an article on VMMC in Equal Treatment and produced workshops on VMMC in districts. We called for the rollout of VMMC services in the public health system.

In late 2009 government indicated its commitment to rolling out VMMC and soon after the first VMMC services were made available in KwaZulu-Natal province with more provinces scheduled to follow in 2010.

Prevention of mother-to-child transmission (PMTCT)

As part of our resources for health campaign, we campaigned for better monitoring and evaluation of the PMTCT programme. We also called for increased HIV testing and improved treatment guidelines to replace outdated and suboptimal PMTCT guidelines. Through our prevention and treatment literacy programme, we provided education to pregnant women on testing and prevention.

On World AIDS Day 2009 President Zuma announced important updates to the PMTCT guidelines. HIV-positive pregnant women with CD4 counts above 350 were now to be provided with PMTCT from 14 weeks, while positive women with CD4 counts under 350 would be started on antiretroviral therapy immediately. These changes represent a major step forward in protecting infants from infection.

Condom distribution

In 2009 we continued our massive condom distribution drive. Condom distribution has long been a cornerstone of TAC's work. TAC Khayelitsha distributed more than 8 million condoms in the year.

In uMgungundlovu condoms were distributed to most partner organizations, branches, at clinics and at hospitals. TAC uMgungundlovu also ran a prevention campaign where members did door-to-door distribution of condoms and materials like Equal Treatment magazine. Other TAC districts also routinely distributed condoms as well as on special occasions such as the Global Day of Action and on World AIDS Day.

After receiving reports of condom stock outs in the Free State, TAC conducted research on condom availability in the province in order to gauge the severity of the problem. Of 41 clinic surveyed, 11 stated that they had no male condoms at all. Four additional clinics reported condom shortages. This information was then used as part of our campaigning against stock outs in our resources for health campaign.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Gender based violence

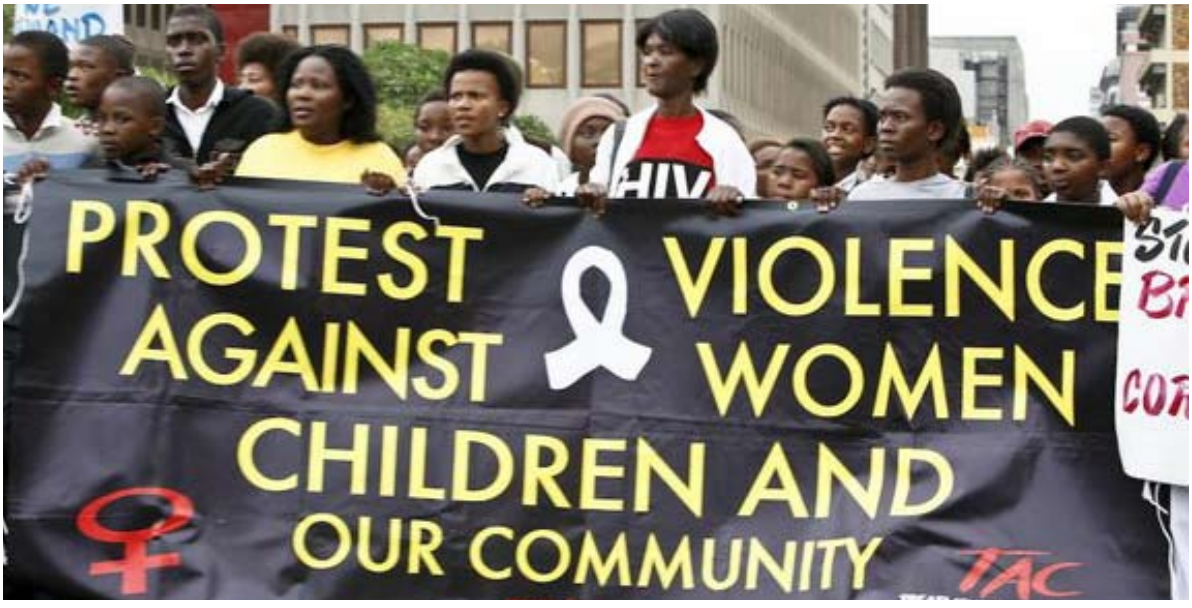
TAC aims to reduce gender based violence and expand access to health and justice services for rape survivors. We aim to do this through increasing awareness of abuse and rape and by providing education on human rights. This is done through workshops, engaging with communities, disseminating material and door-to-door campaigns. In Lusikisiki, TAC spoke out against the abuse of the custom ukuthwalwa where young girls are forced to marry older men by their families. These girls were subsequently raped and some fell pregnant and/or became HIV positive. TAC Lusikisiki also supported and provided HIV and human rights education to girls that were able to escape from forced marriages.

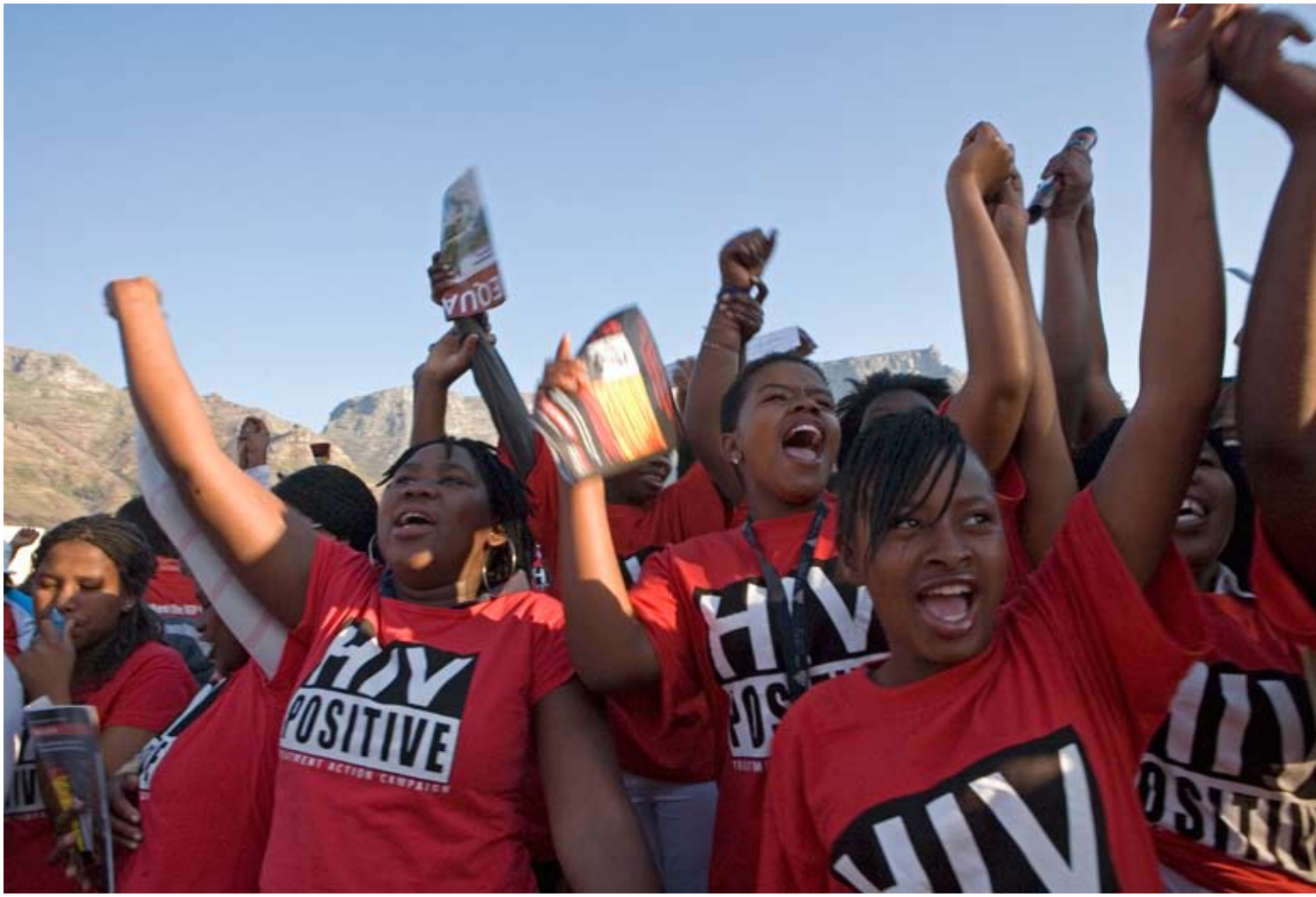
TAC aims to increase access to health services by increasing awareness of the rights of rape survivors. Rape survivors are entitled to post-exposure prophylaxis and sexual health services but many women are not informed of or offered these services. TAC aims to empower survivors to demand these services by teaching communities about the services they are entitled to through material distribution and door-to-door campaigns. In cases where rape is reported to TAC, we will accompany survivors to access these services.

Many rape survivors are unable to access justice services as police often do not take these cases seriously and they are not properly investigated. Also often the case will face repeated delays due to police missing court dates, the loss of dockets or other incompetencies in the justice system. Therefore TAC is monitoring a number of cases to ensure that perpetrators of gender based violence are brought to justice and survivors are able to get justice.

In uMgungundlovu, TAC picketed outside of the court house as a man faced charges for raping his nephew. In Lusikisiki, TAC put pressure on the police and department of justice to investigate the case of a school girl that was raped. TAC also demanded that the police bring in rape kits from another station when the station that the case was reported to said the kits were out of stock. In Cape Town, TAC and partners picketed outside of the courthouse calling for the murderers of Zoliswa Nkonyana to be brought to justice. Zoliswa was murdered, allegedly because she was openly lesbian.

As part of our efforts to reduce gender based violence and expand access to justice and health services, TAC developed materials including: a pamphlet; a number of Equal Treatment articles and a draft curriculum on gender based violence.





Women's Health

TAC mobilised around women's health issues through TAC's women's rights campaign. Through this campaign we advocated for increased access to and uptake of human papillomavirus (HPV) and cervical cancer prevention services.

Cervical cancer is the most common form of cancer in women in South Africa. Women living with HIV are more vulnerable to cervical cancer and there is evidence that women living with HIV may get cervical cancer at a younger age and that the illness may progress more quickly. TAC's campaign aims to increase access to the HPV vaccine as well as pap smears. TAC also worked in communities to encourage uptake of pap smears.

TAC developed and disseminated educational material for women which was incorporated in workshop and trainings throughout the year. TAC published a pamphlet on preventing cervical cancer and numerous Equal Treatment articles on women's health issues. Further, TAC presented a position paper at the 5th International AIDS Society conference on HIV/AIDS and Cervical Cancer Prevention in South Africa.

During December 2009, TAC Lusikisiki and TAC Khayelitsha carried out door-to-door campaigns, educating women on the importance of pap smears. TAC also partnered with the department of health clinics in the area to open its doors, allowing women to walk in for pap smears.

As part of the women's health campaign, TAC also called for universal availability of post-exposure prophylaxis for rape survivors and educated women on the health services that rape survivors are entitled to and must demand. (See gender based violence, page 12)

Wrapping up cases

Two of TAC's major cases came to an end early in the year – the Westville Prisoners' court case and the Matthias Rath affair.

In 2005, TAC sued the Department of Correctional Services on behalf of 15 prisoners who were unable to access treatment in prison. The court ruled in TAC's favour but government continued to drag its feet and subsequently one of the prisoners, prisoner 'MM' died. TAC and SECTION27, incorporating the AIDS Law Project, brought a case against the Minister of Correctional Services to be given access to the report of the Judicial Inspectorate of Prisons regarding the premature and unnecessary death of 'MM'. The Pretoria High Court ruled in TAC's favour but the Minister appealed this decision. On 13 March 2009, the Minister's appeal was dismissed. Further, the Minister's application for leave to appeal was described as ill-conceived, and government was ordered to pay the legal costs incurred by TAC and SECTION27.

The Matthias Rath affair also appears to have finally come to an end. TAC, the Legal Resources Centre and SECTION27, led a court battle to stop Matthias Rath from distributing unregistered medicines and conducting unauthorised clinical trials. On 13 June 2008, the Cape High Court ordered the former Minister of Health, Manto Tshabalala-Msimang to take steps to prevent Rath and his agents from conducting unauthorised clinical trials and from publishing advertisements about the medicinal effects of Rath's product VitaCell. The state was also ordered to investigate these unlawful actions by Rath. The court also interdicted Rath and several of his agents from continuing the above activities. Following the Cape High Court verdict, Rath lodged an appeal. Matthias Rath however failed to file further court papers before the March 2009 deadline and is now out of time. The appeal process is therefore over and this court case is now complete.

TAC Programmes

Community Health Advocacy (CHA)

Community Health Advocacy aims to strengthen advocacy and leadership in order to improve access to and uptake of health services and to realise health and gender rights; to improve knowledge and literacy on health rights and policy; to develop leadership among women and people living with HIV/AIDS to advocate for their rights; and to realise the right to access quality health and social services with a particular focus on HIV treatment and prevention services.

The CHA programme collaborated with TAC branches to identify; recruit and appoint 42 Community Health Advocates (CHAs) within the 6 model districts. 41 CHAs were appointed in April 2009, with the last CHA being appointed in Khayelitsha in May. The focus at national level was the development of the CHA training curriculum and development of a training plan for the newly appointed CHAs.

The first national CHA training was held on the 27th - 30th of April 2009 in Cape Town. CHA coordinators and 12 CHA provincial trainers attended. Subsequently, the second training was held on the 16th - 20th of August 2009 in Cape Town attended by 42 CHAs. The training aimed at identifying gaps in access to services at national, provincial and district level and at formulating possible interventions by women and people living with HIV from within TAC at all levels.

Prevention and Treatment Literacy Programme (PTLP)

The Prevention and Treatment Literacy programme is one of TAC's primary community outreach programmes. The programme began when antiretrovirals were introduced into the public health care system in South Africa to assist in disseminating necessary information about ARVs, their side effects, benefits and the need for adherence as well as other important information about health and patient rights. The programme continues to address the debt of scientific and evidence-based knowledge on HIV/AIDS prevention, treatment and care that exists among the South African general public.

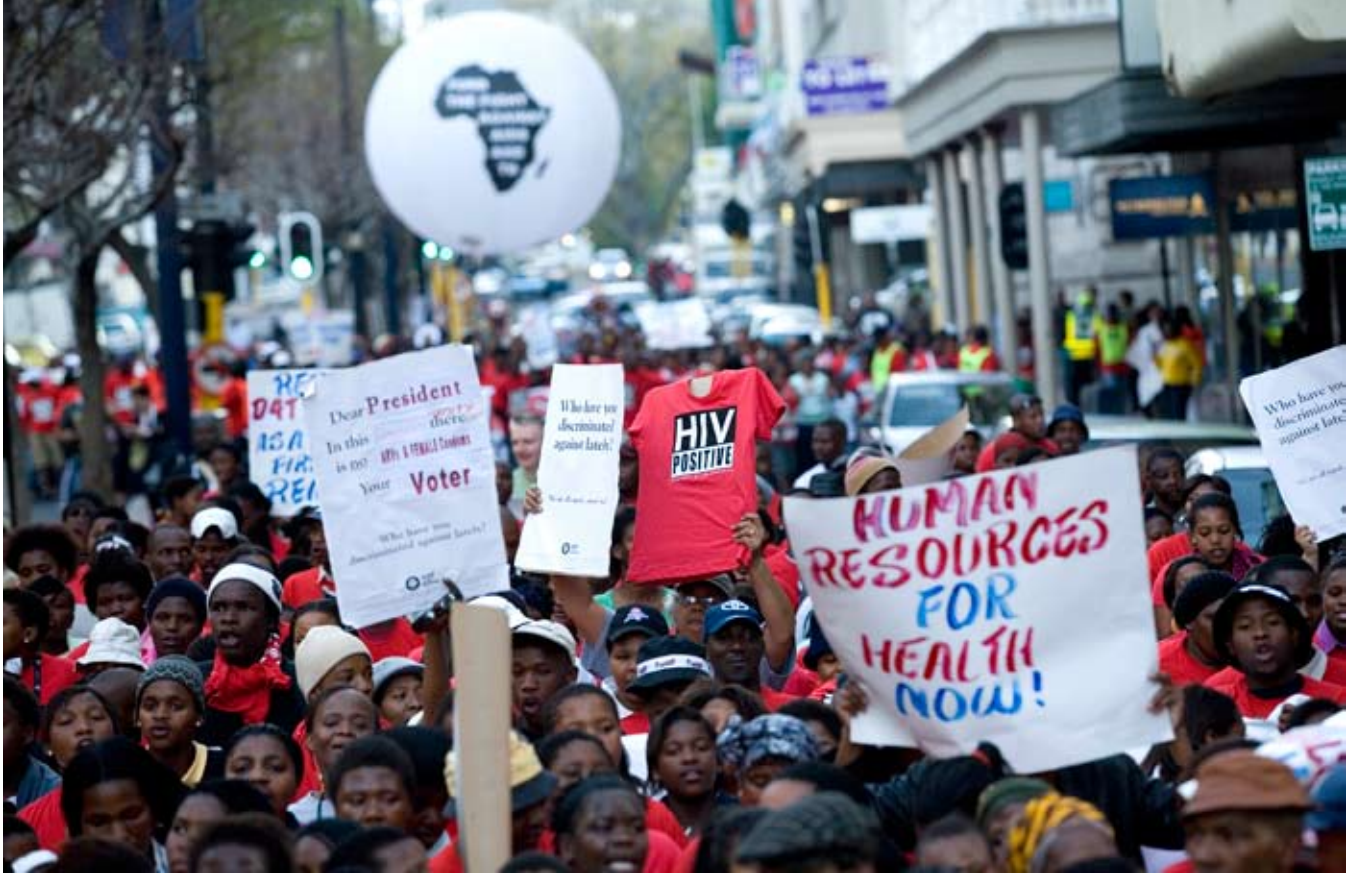
The main focus area for the programmes includes training a cadre of people to disseminate simplified health information in a form of Prevention and Treatment Literacy Practitioners (PTLPs). PTLPs are then placed within public health care facilities within TAC focus districts to address the human resource constraints by providing capacity in selected areas to support prevention and treatment literacy.

Currently the programme deploys over 120 PTLPs across the six health districts including 6 provincial trainers and 6 district coordinators. With support from the Global Fund, the programme employed a senior trainer who was responsible for designing the training programme for PTLPs and two national PTLP trainings were held in 2009.

Policy, Communication and Research (PCR)

The policy, communications and research (PCR) department currently employs 6 district PCR Coordinators as well as a Senior Researcher and an Equal Treatment Editor in the national office. PCR is responsible for: monitoring and engaging with health policy processes at the national, provincial and district level; disseminating information on the science of HIV and TB through the production of materials; communicating developments in HIV and TB policy and science to TAC's staff and membership base; and, liaising with media to promote TAC's advocacy and campaigns work.

At a district level, PCR coordinators are responsible for publicising the activities of TAC in the district through articles, stories and reports; researching and investigating successes and challenges in meeting the targets of the NSP at a district level; and reporting on TAC's work in line with supporting the NSP. The first national PCR department training took place during March 2009.



Organizational overview

In mid-2008, TAC underwent a period of retrenchments as a consequence of the Global Fund to Fight AIDS TB and Malaria grant stoppage. Payments were put on hold as a result of the principal recipient's work plans not matching the agreement signed with the grantor (TAC is a sub-recipient of Global Fund funding.) In 2009 TAC continued to face major funding cuts. The context of the cuts was the global economic recession as well as a backlash against funding HIV programmes by funders with shifting priorities.

At the end of 2008 TAC also underwent an organizational strategic review and a consultative process with TAC staff, members and partners. This process demonstrated that TAC's financial and management capacity would be better applied through focusing TAC's resources in one 'model district' in each TAC province.

Following retrenchments in 2008, TAC's second phase of the restructuring was completed in 2009, resulting in the closure of the provincial offices, and consolidating resources in one model district office in each province. This was to ensure greater organisational efficiency, financial sustainability and increased manageability of the organisation.

The model districts selected were: Ekurhuleni (Gauteng); Gert Sibande (Mpumalanga); Khayelitsha (Western Cape); Mopani (Limpopo); Lusikisiki (Eastern Cape); and uMgungundlovu (KwaZulu-Natal). TAC offices in Braamfontein, Durban, East London, Nelspruit, Salt River, Polokwane, Queenstown, Stranger and Klipfontein were closed.

This was an extremely sad and difficult period for TAC as many staff members were retrenched. However many former staff members remain active in TAC and continue to work without stipends.

Following the adoption of the NSP in 2007, TAC aligned its activities with monitoring and supporting the implementation of this plan. It is intended that TAC model districts will develop a successful 'model' for achieving the NSP targets that can be replicated by government and partners. The lessons learnt through model districts also inform our national campaigns and advocacy. Outside of model districts, TAC activities and advocacy are carried out by members and volunteers through branch structures.

In 2010, raising sufficient funding remains an uphill battle in the context of current economic conditions, but TAC is very fortunate to enjoy the support of quite a number of loyal funders.

Funding

See below a list of institutional donors who have contributed to TAC this year. TAC also receives many donations from private individuals and organisations throughout the year. TAC is very grateful for the support and would like to thank all individuals and organisations for their contributions.

AIDS Vaccine Advocacy Coalition

Atlantic Philanthropies

Bill & Melinda Gates Foundation

Bread for the World

Broadway Cares

Centre for Economic Governance & AIDS in Africa

Comic Relief

Department for International Development

Embassy of Belgium

Ford Foundation

Friends of TAC/ Comic Relief

GESSO Foundation

Global Fund to Fight AIDS, Tuberculosis and Malaria

HIVOS/ European Union

John M Lloyd Foundation

Levi Strauss Foundation

Médicins Sans Frontières

Open Society Foundation

Open Society Initiative

Oxfam Australia

Oxfam Great Britain

Royal Netherlands Embassy

South Africa Development Fund

Stephen Lewis Foundation

Swedish International Development Agency

Statement of Financial Position

Assets			Reserves and Liabilities		
	2010	2009		2010	2009
Non Current Assets - Equipment	631,592	507,864	Operating Fund	–	79,754
Current Assets	17,792,072	28,200,518	Equipment Fund	631,592	507,864
			Sustainability Fund	5,912,370	
			Current Liabilities	1,730,535	1,266,077
			Deferred Income	10,149,167	26,854,687
Total Assets	18,423,664	28,708,382	Total Liabilities	18,423,664	28,708,382

Revenue and Support			Expenses		
	2010	2009		2010	2009
Grants	50,374,762	48,303,585	General and Administrative	21,701,950	22,470,288
Donations	497,840	1,691,890	Programmes and Projects	27,626,980	28,655,249
Investment and Sundry Income	4,757,427	1,130,062			
Total Revenue and Support	55,630,029	51,125,537	Total Expenses	49,328,930	51,125,537

TAC's full 2009/10 financial statements are available at: http://www.tac.org.za/community/finance