EQUAL TREATMENT

NEWSLETTER OF THE TREATMENT ACTION CAMPAIGN DECEMBER 2005

Health workers speak out

ZipZap Circus entertained Khayelitsha as part of a youth HIV awareness day on 29 October. Photos by Eric Miller, courtesy of MSF.

Thembisa Khwethala of TAC, Lusikisiki. This Eastern Cape rural town celebrated over 1,100 people on treatment on 28 October 2005.

Brandvlei prisoners read Equal Treatment *during a workshop held by TAC.*

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TAC is committed to providing people with HIV/AIDS, their families and caregivers accurate information about life-saving medicines and treatment. However TAC and its leaders are independent of the pharmaceutical industry and have no financial interests with it.

editorial

WE NEED MORE HEALTH WORKERS!

Long queues starting before dawn, dirty clinics and hospitals, rude and uninterested nurses, short consultations, poor medical decisions. That's the experience many of us have with the public health system.

But don't blame the nurses or other health workers. They work in very challenging environments. There is a crisis of human resources in South Africa. We have a shortage of health workers, poor working conditions that lead to burnout, and an unequal distribution of staff between the urban and rural areas and the public and private sectors. For example, the public sector serves 82% of the population but has only 27% of the country's general practitioners. Not only are there shortages of doctors and nurses, there are also shortages of skilled managers, administrators and support staff, such as porters and cleaners.

These problems are a result of historical inequalities and skills shortages from colonial and apartheid rule. They are made worse by insufficient investment in the public health system, job freezes (i.e. not replacing health workers when they resign) and poor leadership from the Minister of Health.

Why are our health workers leaving the public sector? There are 'push and pull' factors. Nurses are attracted by the private sector and overseas jobs because of better working conditions. For example, 12% of foreign nurses in the UK are South African. The shortage of staff often means that one nurse has to do the job of many. Lack of equipment, medical supplies and appropriate training mean that nurses often cannot do their job properly. This results in frustration. Public health managers have little incentive to address the shortage because government views health workers as a cost burden, not an asset.

Illness due to HIV/AIDS also places a heavy burden on the health system – because of increased work for health workers, but also because of a high HIV infection rate amongst health workers. A survey of health workers in four provinces by the Human Sciences Research Council found over 15% were HIV-positive. Although the HIV operational plan promises an additional 22,000 public health workers by 2008, little is being done to make this happen.

In the past few months the Department of Health has released two important documents. One is the *Strategic Framework for the Human Resources for Health Plan*. The other is the new Nursing Bill. Both documents have serious problems and fail to address sufficiently the human resources crisis. They are discussed in this month's *Equal Treatment*.

Adequate health human resources are essential for achieving the constitutional rights to life, dignity and health care. For TAC, resolving the human resources crisis is a priority. But it is the nursing unions that will have to be at the forefront of this campaign. It is their members who struggle against the odds to make our public health system work.

Sipho Mthathi
TAC General Secretary

HUMAN RESOURCE CRISIS IN THE HEALTH SYSTEM

Sources for this issue's focus: ASSA2002, AIDS Law Project, Health Systems Trust's South African Health Review 2005, HPCSA, DENOSA, SAMA, IDASA, Inside Labour, Department of Health, ASSA, OECD, Statistics South Africa

Unlike in most countries, the number of years South Africans live has been falling over the past decade. The number of people getting sick has increased dramatically. This is due to the HIV epidemic. Those most affected are children under the age of four and young adults aged 20 to 44.

Patients wait to be treated at a clinic in Khayelitsha. Many of them have to stand. Long queues are a symptom of the shortage of human resources in the public health system. Photo by Brenton Geach.

To cope with this increased burden of disease, we need a well staffed, efficient and accessible public health system. Unfortunately we have a long way to go to achieve this.

There is a human resources emergency in the health system. The public sector in particular has serious staff shortages. Nurses and doctors work under enormous stress, enduring poor working conditions, long hours, uncompetitive salaries and often physical threats.

Therefore lots of health workers look for better opportunities in other countries or in the private sector. Many also leave to work in other professions. South Africa has 35,000 registered nurses documented as being in the country who are inactive or unemployed, despite 32,000 vacancies in the public sector.

To stop this "brain drain" from our public clinics and hospitals will require political will and action by government, civil society and the international community.

FACTS ABOUT HEALTH IN SOUTH AFRICA

- In 1996 the average person in South Africa could expect to live until over 60. In 2005 this has dropped to less than 50. (Source: ASSA)
- Over 5 million South Africans live with HIV. About 500,000 to 800,000 have AIDS and need antiretroviral treatment now. (Source: ASSA)
- More than half of all deaths in 2005 were due to HIV/AIDS. Most adults die between the ages of 35-39. (Sources: ASSA, Statistics South Africa)
- Nearly 16% of health workers in four provinces (Mpumalanga, Free State, Kwazulu-Natal and North-West) were HIV-positive in 2002. (Source: HSRC)

FACTS ABOUT HUMAN RESOURCES IN THE HEALTH SYSTEM

- There are over 120,000 health practitioners working in the public sector in South Africa. About 43,000 of these are professional nurses.
- Over 70% of doctors in South Africa work in the private sector but less than 20% of South Africans have medical aid. This means most people have to use the public sector.
- Between 1996 and 2004, South Africa produced just over 34,000 nurses. But over 27,000 have been lost to the system. There is no research showing what has happened to them.

BUT BEWARE! The information system keeping track of the above human resource statistics in the public health system has many problems. Therefore they cannot be considered reliable.

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THE BURDEN OF STAFF SHORTAGES ON PATIENTS

Patients speak out

Waiting for a health worker. Photo by Danielle Kuczynski.

"In the queues of Natalspruit Hospital, you will find old people in wheelbarrows due to the shortage of stretchers and porters to help them. Some people sit on the floor looking very weak."
Nokhwezi Hoboyi,
Equal Treatment *Co-editor.*

"I joined the march [to Frontier Hospital in Queenstown] because I was sick of being on a waiting list. I wanted treatment."
Nozuko Smile, *Queenstown.*

"Blood samples were taken [from me] but [I was] never told the results. The next thing, without explanation, they gave me a letter to go and get formula milk and that I should not breastfeed."
Monatho Mafumbuka, *Queenstown.*

"I'm sick and I'm not working. I went to the hospital. They told me I must go and talk with the social worker. The social worker was not there. Now I am struggling to get food."
Thomas Munyayi,
Limpopo.

"I spent the whole day yesterday waiting at the clinic but I was sent home because my turn came too late, so I'm back today even earlier. Maybe someone will see me today, but I will have to come again tomorrow to the pharmacy."
Patient at clinic in Khayelitsha,
as told to Equal Treatment.

"I expect to spend the week here. I have not been able to tell my work that I am sick yet."
Patient at clinic in Khayelitsha
as told to Equal Treatment.

"In February 2005, I was referred to a social worker that took down my personal details. She promised to get back to me before the end of February. I am still waiting for her. I am not sure if I was put on a waiting list or not. I cannot walk long distances or carry heavy objects because I am always tired. I would appreciate it if the social worker could come and see me so that I can know when I will be getting my treatment."
Grace Ngobeni,
Magorho, Limpopo.

Grace Ngobeni, Photo by Joel Ntimbani

HOW STAFF SHORTAGES AFFECT A CLINIC

An example: Msogwaba Clinic in Mpumalanga Province

by Sibongile Mashele

Msogwaba Clinic in Mpumalanga

- One sister in-charge
- Two doctors once a week
- Four professional nurses
- Three assistant nurses
- Two health promoters
- Two loveLife volunteers
- **2,500 patients a week!**

Msogwana Clinic in Mpumalanga Province. Photos by Sibongile Mashele.

Msogwaba Clinic operates in a rural area of 800,000 people. It offers many services including voluntary counselling and testing for HIV, mother-to-child transmission prevention, CD4 counts and antiretroviral treatment.

The staff includes a sister in charge, four professional nurses, three assistant nurses, two health promoters and two lay counsellors. There are also two loveLife volunteers.

The clinic operates five days a week, nine hours a day. Yet it sees about 2,500 patients a week. *[This works out to at most few minutes that any staff member can see a patient. - Editor]*

The clinic has lost four nurses to the private sector this year. Volunteers also assist the staff. There are two doctors who come only once a week. One of them attends HIV-positive patients.

The antiretroviral programme started in October. It has 20 patients. The lay counsellor, partly trained by TAC, gives treatment literacy education at the clinic every Tuesday.

The clinic has a schedule for various types of friendly clinics every day. These include youth, elderly, antenatal care, paediatric and TB.

Msogwaba Clinic offers critical life-saving services, but it is clearly severely understaffed.

It serves too large a population and consequently too many patients. The staff have to do their best under very difficult circumstances.

Health workers speak out: Matron I.D. Mahlalela

"I became a nurse because I love working with people and helping them. Health workers are overworked, underpaid and there is a shortage of staff.

My clinic serves about six thousand patients a month and we only have nine nurses. Each of the nurses attends to about 45 patients a day. They usually have to work overtime because the clinic is the only one that operates 24 hours in the area. We service a population of about 35,000, so it is difficult to satisfy everyone.

We test about 20 people for HIV a week and eight out of ten test positive and most are women. We need a full-time nursing sister who is trained on voluntary counselling and testing (VCT) to work with the counsellors. We also only have one nurse trained in mother to child HIV transmission prevention and there is no one trained to do VCT full-time.

We also lack someone who is trained on antiretrovirals and can help us understand how they work. We have community volunteers that are a great asset and the clinic should hire them full time.

I hope that the Department of Health will someday soon address the problem of human resources because the shortage of health workers affects the quality of our work."

Matron Mahlalela works at Mangweni Clinic, Mpumalanga.

Report and photo by Sydney Masinga.

Health workers speak out: Sister Mashudu Mudau

"The conditions at our clinic are such that I am ready to work in the private sector or go overseas. There is a lack of staff. We are overworked. There is a lack of privacy and equipment and the building is too small. The number of patients with HIV is growing daily and I have been trained only to provide counselling and HIV tests. There is a need to develop more clinics, hospitals, health centers and visiting points. Health workers must be trained on how to use CD4 tests, antiretrovirals, fluconazole, contrimaxizole, HIV tests and viral load tests."

Sister Mudau works at Shayandima Clinic, Limpopo.
Report and photo by Joel Ntimbani.

"This is a gender issue too. Nursing is still largely a profession of women and so it is undervalued in our society."

Thembeka Gwagwa,
General Secretary of the Democratic Nursing Organisation (Denosa) as quoted in
Inside Labour

Health workers speak out: Busisiwe Nota

"There are many obstacles that prevent us from providing proper quality service. One of the main ones is the shortage of staff. There is a high death rate as a result of the fact that health personnel are not replaced. It results in nurses being exploited by having to do the work of the nurses who are not yet in place. The workload brings both physical and emotional stress.

There are also inequalities in how nurses in rural areas and urban areas are treated. The conditions we work under are much worse than in urban areas: there is no running water, no homes for nurses in place and the distance between a nurse's home and the clinic is long. The clinic is usually in a village and a nurse's home in another and there arex few ways of transport.

Security is not provided and as a result there are few nurses that are interested in working in the rural areas and the government is not creating mechanisms to attract more nurses to go to these areas. It can be said that the shortage of staff and the lack of training may have led to more deaths than were necessary, especially when it comes to HIV/AIDS.

I think HIV/AIDS should be included in the nursing curriculum just like any other chronic disease."

Nota works in an Eastern Cape public health facility.

Report and photo by Masizole Gonyela.

Health workers speak out: Dr Gcina Mavuso

"I began my career in 1999 when I was 25 years old. I face many challenges at work. There is a shortage of staff since many professionals leave after they have done community service. As a result, the job is becoming harder because I have lost eight doctors in the hospital which forces me to do a lot of ward work and prevents me from doing my administrative work. HIV/AIDS has increased our workload because the hospital is full of people living with the virus and they come in large numbers needing serious help. It makes it difficult for the hospital to admit new patients.

I have had offers to work in the private sector as well as work in Canada and the UK. I refused because I knew it would create an even bigger human resources gap in the hospital. Going abroad as well does not appeal to me since there is nothing better than working at home in South Africa, and also I could not live without my family nearby.

To overcome these challenges the Department of Health must try to provide accommodation to all the staff that has been relocated away from their homes, and they must make sure that doctors have the equipment they need. Priorities in order to develop a people's health service would be to improve employment conditions and making sure that everyone enjoys his or her job. The government should also improve the packages it offers doctors."

Dr Mavuso works at Themba Hospital, Mpumalanga.
Report and photo by Sibongile Mashele.

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BURDEN OF INEQUALITY

Compared to most African countries, the number of health workers in South Africa is large. Yet in some areas, one doctor may have to service over 30,000 people.

The problem is that health workers are distributed unevenly. There are too few health workers in South Africa, but there is also inequality between urban and rural areas, the public and private sector, as well as rich and poor provinces.

A consequence of this is that many posts in the public sector are vacant as the table on the right shows.

PERCENTAGE OF UNFILLED POSTS PER PROVINCE

PROVINCE	% UNFILLED POSTS
Mpumalanga	67
Free State	41
North West	33
Gauteng	32
Eastern Cape	28
Northen Cape	27
Kwazulu-Natal	25
Western Cape	14
Limpopo	13

Source: South African Health Review 2005

Rural versus urban

Rural areas account for 46 percent of the South African population, but only 12 percent of doctors and 19 percent of nurses. A well-resourced mainly urban province like the Western Cape has one doctor per 2,800 people. Eastern Cape, which is predominantly rural, has one doctor per 6,300 people. Also, if you look at the table on the right, Limpopo has only 13% vacant posts, which is much better than the Western Cape. But what this fails to show is that there are far fewer posts in Limpopo because there are fewer facilities. Limpopo only has one doctor per 7,100 people. The World Health Organisation recommends a minimum of one doctor per 5,000 people.

This should not give people the false impression that the Western Cape and South Africa's other major urban province, Gauteng, are well off. There are unacceptable inequalities here too. Khayelitsha, one of Cape Town's biggest townships has only three clinics serving half-a-million people. The World Health Organisation would recommend at least ten clinics in Khayelitsha, (one clinic per 50,000 people), but there are staff shortages for even the current clinics.

Public versus private

The conditions of work are much more favourable in the private sector. Though salaries are often higher in the private, this is not necessarily the case when housing and other benefits offered to public sector workers are taken into account. There is also less job security in the private sector. But the private sector has much lower patient loads, better-stocked equipment and safer working conditions.

Therefore doctors and nurses are more likely to work in private care which often means that even if there are a lot of doctors working in the country many of them are working in the private sector. But less than 20% of South Africans have medical aid. Therefore they either have to use the public sector or pay private fees that they struggle to afford. It is estimated that 76% of specialist doctors and 73% of general practitioners in South Africa work in the private sector. Often this means that shortages of staff exist in the national health system yet parts of the private system have more health workers than they need.

The brain-drain

Migration of health workers to overseas has become particularly worrying. This is a global phenomenon: health workers leave poorer countries, where they were trained, for wealthier countries.

Indeed, South Africa receives many health workers from poorer countries. But we lose many highly skilled health workers to

rich countries. We are subsidising Britain, Canada, Saudi Arabia, the United States, Australia and others by training and educating nurses and doctors who then move abroad for better posts. The loss of public subsidies through medical education for South Africa is estimated at more than R6 billion per year.

Emigration also worsens the rural–urban divide, as vacancies in urban areas left by emigrating workers are filled by those leaving rural areas.

Training colleges are not able to train enough people fast enough to compensate for the loss of workers who have left the country. A 2003 World Health Organisation report found that 60% of South African institutions had trouble replacing nurses who had emigrated. In Gauteng for example, the province loses about 800 to 850 nurses a year and it can only train up to 600 in return even though it received 100,000 applications for its first year course intake in 2001.

This points to the need to increase the number of training colleges, but also to find ways to encourage health workers to stay in South Africa.

Patients wait despondently in a long queue at a public health clinic. Photo by Paula Magalhaes.

MIGRATION OF HEALTH WORKERS TO PRIVATE SECTOR AND ABROAD

- Nearly one in three public health jobs in South Africa are vacant.
- 300 trained nurses leave South Africa each month.
- 6% of all health workers in the UK are South African.

NUMBER OF SOUTH AFRICAN BORN HEALTH PROFESSIONALS WORKING OVERSEAS

	PRACTITIONERS*	NURSES/MIDWIVES	OTHER HEALTH PROFESSIONALS**	TOTAL
Australia	1,114	1,085	1,297	3,496
Canada	1,345	330	685	2,360
N. Zealand	555	423	618	1,596
UK	3,625	2,923	2,451	8,999
USA	2,282	1,082	2,591	6,956
Total	8,921	6,844	7,642	23,407

Source: OECD 2003

** Doctors, dentists, veterinarians, pharmacists and other diagnostic practitioners*

*** Including Assistants*

Health workers speak out: Sister Ricardo du Preez

"I have ten years experience working as a nurse in the public sector and have been at the Wallacedene Clinic since January 2001. I sometimes think of leaving the public sector but not my profession.

I have already considered starting my own business that would deal with health issues. I have on occasions been approached to work overseas and in the South African private sector where there are better services available.

The public sector has many complications and there are many challenges that I experience at work. These include waiting two to three hours for an ambulance, a lack of medication with which to treat patients, low salaries and understaffing. Because of all these factors it is difficult for me to carry out my work effectively.

My work is becoming harder because we lack the appropriate medication to treat new diseases as well as HIV related illnesses.

The situation could be improved by more involvement of the community in the clinic. It is also necessary to end political party conflicts which often lead to failure of community involvement in the clinic.

> "The situation could be improved by more involvement of the community in the clinic."

Priorities that need to be addressed include developing a safer work environment, increasing the availability of medication and establishing realistic patient-staff ratios."

Sister du Preez works at Wallacedene Clinic, Western Cape.
Report and photo by Vuyokazi Majali.

> "Ek geniet dit om mense te help wat siek is.
>
> My werk word moeiliker as gevolg van die tekort aan profesionele verpleegpersoneel.
>
> Daar is ook 'n tekort aan toerusting en vergoeding."

Verpleegster Melvina Stollie werk by Seawind Kliniek, Wes-kaap.
Verslag en foto deur Rodrick Clarence.

Health workers speak out: Dr Khumalo

"I work in the antiretroviral roll out clinic at Rob Ferreira hospital. At the moment I have 116 patients on antiretroviral treatment and all of them are still on regimen one. There are about 100 patients on the waiting list, and we usually treat about 15 patients a week. When a patient passes away while still on the waiting list, it is emotional and it feels terrible but there is nothing we can do because we rely on the resources that are available to us.

It does not help that government takes away the grant once a person becomes better on treatment. Personally I don't approve because most people on antiretrovirals are poor and they need the grant to survive.

With the grant they are able to buy basic food that is necessary to complement antiretroviral treatment. After the twelve month deadline of the grant expires, patients start to become depressed and they also start developing side effects to their treatment since most of them have to take their medication on an empty stomach.

Without the grant you find that patients' CD4 counts drop and they start becoming very ill again.

To improve the roll out program at Rob Ferreira we need full support from the National Government and Department of Health so as to supply medication on time. We also need more staff. The antiretroviral clinic itself must also be improved since at the moment it is dirty, crowded and small."

Dr. Khumalo works at Rob Ferreira Hospital, Mpumalanga.

Report and photo by Sydney Masinga.

Health workers speak out: Carol Molotsi

"I am a voluntary counselling and testing coordinator for the clinic and I have 16 years experience as a nurse. I became a nurse because I loved to see other mothers wearing white and because they gained a lot of respect from the community.

I enjoy my work when someone recovers from an illness. I don't enjoy the overload of patients that we get and when they do not appreciate what the nurses do. They swear at us and always complain about the long queues. I don't want to leave the public sector because I think it is nice to work with your people. I have had offers to work overseas in the United Kingdom in 2003 and then in Australia in 2004, but I refused because I am a patriotic South African and I want to use my talent in my country.

There are many challenges I face at work: government is always changing the medications, the protocols are frustrating, the work load is high and there is a shortage of staff. We are only four nurses at the clinic and we do not have a doctor at the clinic so we have to work as nurses and as doctors. My work is getting harder because there is more demand. According to our statistics at the clinic the number of people infected with HIV is continuously increasing.

The government could improve the situation by hiring more nurses and doctors. Our union is helping us to get free uniforms because at the moment we have to pay for them and that is why we don't wear any."

Molotsi works in Orange Farm.
Report and photo by James Dlamini.

POOR WORKING CONDITIONS

These are the typical problems health workers face:

- **Poor facilities:** Facilities are old and small. They lack equipment and medicines for properly treating patients.
- **No incentive to do well:** There are few opportunities for health workers' professional growth.
- **Not enough on-the-job training:** There is not enough on-the-job training to learn about new developments in medicine.
- **Not enough health care for health workers:** It is actually difficult for many health workers to access health services! If health workers become sick or injure themselves, they are uncertain about getting adequate treatment. This is a particularly big problem with HIV.
- **Money:** Salaries are also a problem. According to *Inside Labour* the real starting salary for a qualified staff nurse after four years of training, has fallen by more than 4.4 per cent over the past four years. This same decline has occurred across all levels. The basic salary of a staff nurse is now R75,412 a year or R6,284 a month. But a staff nurse with ten years' experience may earn R82,482 a year or R6,873 a month, almost the same salary!
- **Frozen posts:** At times over the past decade, important health worker positions have not been filled when they have become vacant. This has made staff shortages worse.
- **Inadequate management:** The shortages of health workers are at all levels, including management. But it is clear that many current people in management in the health service have not been trained to carry out their jobs effectively. For example, TAC with the assistance of the Open Democracy Advice Centre obtained the provincial HIV operational plans. Some of the provincial plans, such as Limpopo Province's, were so poorly drafted that they cannot be considered plans at all.

A TAC poster from 2001, calling for government to spend its money better.

WHAT IS THE NURSING BILL AND WILL IT HELP?

The Nursing Bill is new legislation for nurses meant to replace the current legislation. The South African Nursing Council is responsible for regulating nurses. The Bill aims to transform this body so that it is more accountable.

Although the Bill is a welcome step, it does not achieve this objective in its current form. One problem is that it gives the Minister of Health too much control. She can appoint members to the council, including the chairperson.

The Democratic Nursing Association of South Africa has warned that the Bill "gives all the power to the Minister to determine what should be happening to nurses and midwives."

The Bill also gives the Council lots of powers without any guidance as to how these powers should be used. Also, the Bill does not explain how the Council will be financed. At the moment all of the funds come from license fees of nurses and midwives and other levies on nursing activities.

The Bill also states that a nurse who has been out of the country for three years or more may be removed from the national register (i.e. he or she cannot practice as a nurse anymore). This is strange given the need to attract nurses back to the country.

Parliament had not yet passed the Nursing Bill at the time of going to print.

ARE WE SPENDING ENOUGH MONEY ON HEALTH WORKERS?

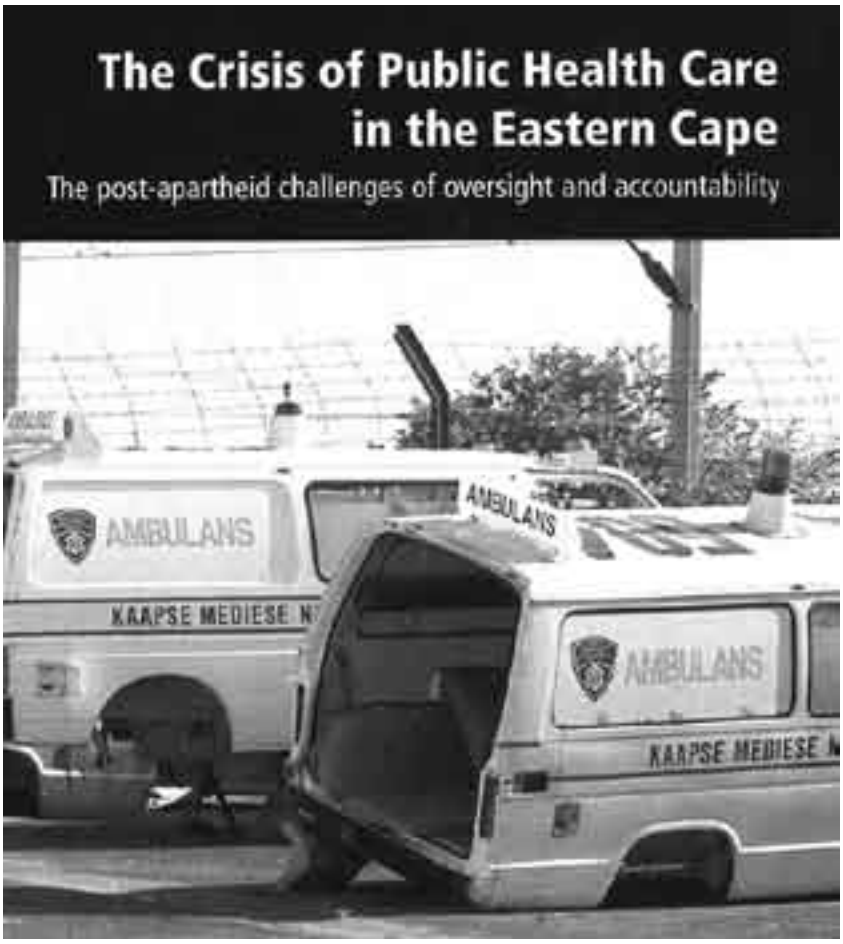
Does South Africa spend enough on our public health workers? Is it due to lack of money that there are staff shortages? These questions are difficult to answer.

The money government allocates to health care has grown over the last few years though between 1998 and 2001 there was a big drop in spending which the public health system possibly has not properly recovered from.

> Small expenditure increases on health workers will be insufficient to meet the demands of the HIV epidemic.

Human resource budgets have however grown since 2002 and provinces are spending most of these budgets. So what's the problem? Why are we not making progress getting enough doctors, nurses, porters, cleaners, pharmacists, counsellors, nutritionists and administrators into our clinics and hospitals?

There is evidence that provinces often fail to spend their money appropriately (see photo, right). But part of the problem is also the HIV epidemic. More people are getting sicker and using hospitals and clinics more often. Small increases in expenditure on health workers each year will be insufficient to meet the unique demands and pressures of the epidemic. Health care expenditure has to increase dramatically. As you can see in the table on the right, the increases in expenditure on health workers have been modest over the last few years.



The front cover of a 2004 report by Public Service Accountability Monitor. The report exposed the wasted spending and poor planning by the Eastern Cape Department of Health.

GROWTH IN HEALTH PERSONNEL EXPENDITURE

PROVINCE	REAL ANNUAL AVERAGE GROWTH 2002/2003 - 2005/2006 %
Eastern Cape	4.2
Free State	4.4
Gauteng	1.6
Kwazulu-Natal	3.5
Limpopo	3.9
Mpumalanga	2.2
North West	3.7
Northen Cape	4.7
Western Cape	-0.3
Total Average	2.9

Source: IDASA Provincial Budget Statements 2003

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IMPACT OF HIV ON HEALTH WORKERS

The HIV epidemic has four important effects on health workers:

- The number of patients has increased because of the disease, thereby increasing the workload of health workers.
- It has also increased the stress of health workers because they are seeing more of their patients dying or getting sicker, and they feel helpless to do anything about it.
- Seeing more patients who are HIV-positive has increased the risk of health workers contracting HIV, for example through needlestick injuries. Some studies have found that health workers consider the risk of getting infected with HIV one of the main reasons why they would prefer to pursue a different career or seek jobs abroad. One study found 16.2% of nurses would consider alternative employment because of this fear.
- The number of health workers with HIV is high, possibly as high as the general population. This means that many health workers have become, or will become, too sick to work or have died. This further increases staff shortages.

Ruth Maoela, who leads the activities of the Bethesda Aids Action Team, attends to a patient, Mkuze/Jozini area, Northern KwaZulu-Natal. © Eric Miller/iAfrika Photos.

WHAT NEEDS TO BE IN A HUMAN RESOURCES PLAN?

Recently government released the *Strategic Framework for Human Resources for Health Plan (Strategic Framework)*. This document needs to be improved. TAC and the AIDS Law Project made a submission to the Department of Health in which we stated our ideas of what needs to be done to solve the human resources crisis. These ideas need to be incorporated into a human resources plan.

How can we make their work easier? Photo by Nokhwezi Hoboyi.

Improving infrastructure, buying new material and more medications and increasing salaries will improve conditions for health workers. The problem however is that the government to date has not developed a comprehensive plan that explains how it will finance these improvements.

Government's draft Strategic Framework does not address the reasons why many health workers are leaving the public sector. It should provide for the following:

- **Career pathing**: This means providing training and incentives for health workers to be promoted and develop their careers.
- **Re-evaluation of the rural and scarce-skills allowances.** This allowance was meant to attract more health workers to rural areas, but it does not appear to be achieving its objectives.
- **Improved access to health care** for health workers themselves.
- **Improvement of public health facilities**, including better equipment, access to more medicines, security, space and housing for health workers.
- **New nursing colleges** need to be started and the current ones need to be given the capacity to train more nurses.
- **Targets and health worker to patient ratios** must be included in the plan.

The human resources plan must also consider the threat of the HIV epidemic to the public health system, especially the increase in demand for health services as a result of HIV and that many health workers live with the disease. Besides treatment for themselves, health workers need access to grief counselling, as well as HIV counselling.

> We need a unified health system. This means rich and poor people would all use the same health facilities.

There also has to be better cooperation between different departments within government as well as with civil society and the private sector. For example, the Department of Health and the Department of Education need to work with each other to train and recruit health workers. Government should also look at ways of using the private sector to reduce the burden on the public health system. This might mean entering deals with private hospitals to treat public sector patients at government expense.

Ultimately though, government will need to introduce a unified health system. This would mean everybody has access to the same health system.

Fixing the human resources crisis will not be easy. It will cost money. Government needs to increase spending on human resources, including offering competitive salaries to attract better managers so that the national and provincial human resources plans can be improved.

The challenge is immense. But if there was political will from the Minister of Health and other key leaders in government it could be achieved.

HOW GETTING TESTED SAVED PINKY'S LIFE

by James Dlamini

Pinky Nocwezo is 29 years old and HIV-positive. She is also the mother of a baby girl, Lesego, who is HIV-negative.

Pinky was born in Whittlesea, Eastern Cape. She now lives in Soweto, South Africa's largest township.

In June 2001, while Pinky was pregnant, she was tested for HIV and discovered her status. She enrolled in the mother-to-child transmission prevention programme and as a result her daughter was not infected.

Pinky enrolled in the mother-to-child transmission prevention programme and as a result her daughter was not infected.

Pinky Nocwezo is open about her HIV status. Photo by James Dlamini.

In 2003 Pinky joined TAC to get more information on HIV/AIDS and now she is a treatment literacy trainer. Pinky disclosed her status for the first time in September 2001. It was at a party and she called her boyfriend outside and told him she was HIV-positive. He got angry with her, but only for two hours. She then found the courage to tell her family.

"I am presently taking AZT, lamivudine and efavirenz. I was taking stavudine (d4T) instead of AZT but I developed peripheral neuropathy (swelling of the feet), so I changed to AZT," explains Pinky.

When Pinky started taking treatment ten months ago her CD4 count was 144 and now it has improved to 229. "Because of the knowledge that I have from TAC, I am now able to access my treatment at Helen Joseph Hospital (in Johannesburg)," she says.

Pinky is healthy today because she got tested and found out her status. She encourages everyone, especially young people, to get tested and find out their status before it is too late.

NTOKOTO WA VUTSHUNGURI BYA HIV/AIDS

hi Joel Ntimbani

Hi ti 03 ku fikela 07 Nhangulo 2005. A xi fhudzheni xa Limpopo a kuri na vumpfhumba bya ku dyondzisiwa hi xitsongwatsongwani xa HIV/AIDS na vutshunguri bya xona. A byi khomeriwile edorobeni mkulu ra xifhundza xa Limpopo, ku nga Polokwane, ePalms Inn.

Laha aku hlanganile swifundzha tsongo swa nthlanu, Mopani, Vhembe, Bohlabela, Capricon na Wateberg. Ntlawa lowu a wu nghenelerile a wu ringana makume-nharhu. Eka makume-nharhu a ku laveka khume-mune wa vanhu lava a va ta yisa ntirho lowu emahlweni. Leswi swi tise nthlo-nthlo eka ntlawa lowu a wu nghenelerile. A va kombisa vutshila lebyi va nga na byona.

Leswi va swi endliwa hi leswi aku ri ro sungula ku va na pfhumba ra muxaka lowu, byi tlela byi landerisiwa kuri byi tirha. Tani hi leswi swifundza leswinwana a swi ri karhi swi tirha.

A kuri khale swi languteriwile ku ri vupfumba byi va kona laha exifundzeni xa Limpopo.

Xikongomelo nkulu a kuri ku kuma ntlawa wa vanhu lowu wu nga ta famba wu nyika switsunduxi, ku dyondzisa vanhu eswikolweni, titliniki, va aka tiko na le swibedlele. Tidyondzo i ta mavabyi hiku angarhela, kambe va kongomisile ngopfu-ngopfu eka HIV/AIDS na vutshunguri. Hikuva nhlayo ya vanhu lava tluleriwaka hi xitsongwatsongwani xa HIV/AIDS yi yaka hohla ma siku hi nkwawo. Leyi i yi nwana ya ti dlela ta ku lemukisa va aka tiko.

A hi tiveni leswaku, xitsongwatsongwani a xi tshunguriwi xo lawuriwa emirhini wa munhu. Vutshunguri hi vula mirhi leyi yi pfundzaka masocha ya mirhi ku lwa na xitsongatsongwana xa HIV/AIDS.

BUILD WOMEN AND PEOPLE WITH HIV/AIDS LEADERSHIP FOR A PEOPLE'S HEALTH SERVICE

On 23 to 25 September 2005 in Cape Town, TAC held its third National Congress. This event takes place every two years. It is the organisation's highest decision making body. It is where the National Executive Committee is elected and resolutions are made for the next two years. Here is a picture essay of the congress describing some of the key resolutions. The full resolutions can be obtained from the TAC website, www.tac.org.za.

Resolution:
Treat 200,000 by 2006

The Congress calls for government to treat at least 200,000 people by March 2006. At least 10% must be children. But many more than this must be treated by the next Congress. Treatment must increasingly be made available at the clinic level, as well as at district, regional and academic hospitals.

Congress photos by Saul Konviser and Devon Manz.

Resolution:
Build women and people with HIV leadership.

TAC must do more to create leadership positions for women and people living with HIV/AIDS. We must set clear targets for participation of women and people with HIV/AIDS in all levels of our organisation.

Cheryl Carolus, veteran ANC activist.

Reverend Molefe Tsele, General Secretary of the South African Council of Churches.

Zwelinzima Vavi, General Secretary of COSATU.

Resolution:
End denial!

TAC and its allies will pressure President Mbeki to distance himself from AIDS denialism and to provide leadership, discipline and inspiration in the fight against HIV.

At the Congress, ANC veteran Cheryl Carolus, head of the South African Council of Churches Reverend Molefe Tsele and COSATU General Secretary Zwelinzima Vavi all explained the terrible effects of denialism. Confused messages from our political leaders result in avoidable deaths.

Over half-a-million people need treatment now. Meeting this challenge requires political leadership.

We need President Mbeki and Minister Tshabalala-Msimang to publicly call for people to get tested and, if necessary, treated.

"This lack of government leadership on HIV is a betrayal of our people and our struggle. We are sitting by while the biggest threat to our nation since Apartheid is ruining our families and our communities."

Zwelinzima Vavi

Resolution:
Build a people's health service

TAC must work with health care unions to campaign for a better health system. TAC and community members must participate in hospital boards and district health committees. The upcoming local government elections must be used to put public pressure on our elected officials to improve local health services. TAC members must be trained on the National Health Act.

Resolution:
Improve HIV prevention

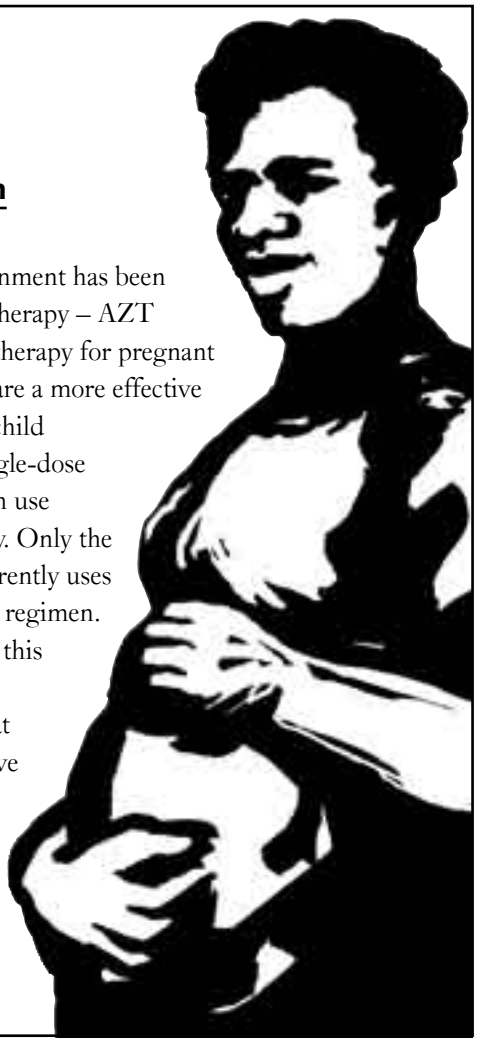
There are over 400,000 new HIV infections a year in South Africa. Getting prevention to succeed is more complicated than the current Abstain Be faithful Condomise (ABC) strategy. TAC needs to work with government and civil society to devise better strategies to overcome the failure of current prevention efforts.

Congress heard evidence on the vulnerability of girls and young women to HIV. This is an area that needs urgent action.

We must address the underlying causes of HIV transmission. Poverty, unemployment and poor housing cause the breakdown of social structures, loss of dignity, higher-risk sexual behaviour and consequently more HIV infections.

Condoms must be made available in all schools. Counselling in clinics must be standardised and include safer sex education.

Resolution:
Use better medicines for mother-to-child transmission prevention



For nearly two years, government has been given evidence that dual therapy – AZT and nevirapine, or triple drug therapy for pregnant women who need treatment – are a more effective means of reducing mother-to-child HIV transmission than the single-dose nevirapine regimen currently in use throughout most of the country. Only the Western Cape government currently uses the better AZT and nevirapine regimen.

Government must introduce this better regimen in all provinces, especially at health facilities that are already offering highly active antiretroviral treatment for people with HIV.

"Many people who were at the last National Congress are not [alive] today. This is not a fashionable struggle but one which is costing lives."

Reverend Molefe Tsele

The TAC KZN choir prepares to sing at the National Congress. Photo by Saul Konviser.

Resolution:
Build and strengthen TAC

Congress resolved to:

- Strengthen TAC's role in building a stronger civil society.
- Give TAC's branches and members the skills to assist local, district and provincial government structures to improve health care delivery.
- Improve gender education in TAC's branches.
- Strengthen TAC's efforts to address the health and social problems of rural areas.

Resolution:
More HIV-positive children must get access to treatment

Children respond well to treatment. However, many adults neglect to get their children tested and many clinics do not provide testing and treatment for children. TAC will campaign for

- health workers at treatment sites to receive training on treating children;
- treatment of children, as well as adults, at all clinics; and
- speedy implementation of **PCR testing** for children under 18 months and the integration of mother-to-child transmission prevention with antiretroviral treatment programmes.

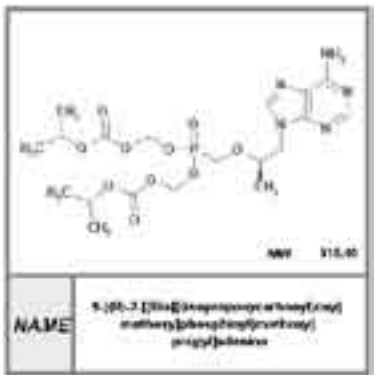
PCR Test: A test that detects HIV directly. The standard HIV antibody test is not accurate in children under 18 months born to HIV-positive mothers. Therefore they should be tested with the PCR test. *PCR stands for Polymerase Chain Reaction.*

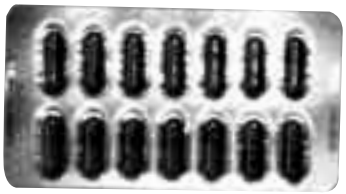
Lusikisiki community members celebrate over 1,100 people on treatment by wearing "Viral Load Undetectable" t-shirts.

Resolution:
Government must improve the antiretroviral treatment guidelines

The treatment guidelines used by national government are based on an international consensus, but we have not kept up with new changes.

For example, stavudine (d4T) continues to be used as part of the first antiretroviral regimen people receive. The vast majority of people who use stavudine are doing well on it. But some people suffer serious side-effects such as peripheral neuropathy, fat redistribution or a life-threatening condition called lactic acidosis. A new drug, tenofovir, is a better antiretroviral than d4T because it has fewer serious side-effects and it has advantages for resistance too. But tenofovir is not yet registered. It must be registered quickly and replace stavudine in the first-line regimen. Also, its price must come down and a sustainable supply is needed.





Above right: formula for tenofovir. Right: stavudine (d4T).

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GEORGE BUSH'S AIDS FUND: A FORCE FOR GOOD OR BAD?

By Jeff Hoover

In January 2003, US President George Bush announced his intention to greatly increase the amount of aid money his government provides to fight HIV/AIDS around the world. Three years after this announcement, the US government response has indeed become larger and more influential. The new response is also controversial, however. The number of critics continues to grow both in the US and abroad, including in the countries where the aid is going.

An escort agency sign in Cape Town. Photo by Nathan Geffen.

The Bush Administration has a policy of not giving money to organisations that work with sex workers. But sex worker education is critical to HIV prevention. Organisations that offer abortion services are also not funded. US money helps make treatment available in poor countries, but it will be more effective if these ideological policies are removed. [Editor]

The controversy centers on the new program created by the president, called the President's Emergency Plan for AIDS Relief (PEPFAR). A total of 15 countries were selected to be PEPFAR target nations: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia. These countries were chosen for different reasons. Many, such as South Africa, already had a severe HIV/AIDS epidemic. Others, like Vietnam, have lower HIV rates in comparison, but are considered to be in danger of experiencing a rapidly growing epidemic if strong measures are not taken soon.

For each of these 15 countries, all US government spending on HIV/AIDS was combined into PEPFAR. In February 2004, the US Congress approved a total of $15 billion in funding for the entire program, to be spread over five years. The amount allocated to each country varies depending on overall population, size of the epidemic, political leadership, and ability to absorb and spend the money effectively. National governments usually do not receive PEPFAR funds directly. Instead, the money is given to "implementing partners" which are often non-profit institutions based in the US. The partners then sign agreements with local organizations that provide prevention, treatment and care services to people living with HIV/AIDS or at high risk of contracting the virus.

PEPFAR's goals include support for antiretroviral treatment for two million people; the prevention of some seven million new infections; and care for ten million affected by HIV/AIDS, such as orphans. The U.S. has received widespread praise for identifying such important goals and for setting aside billions of dollars in an effort to achieve them. Many crucial HIV rogrammes around the world now benefit from PEPFAR money.

Some of PEPFAR's policies and procedures are problematic. US policies on global HIV/AIDS issues are not based on an attempt to truly understand the nature of local and national epidemics. Instead, they are influenced by US political considerations and the need to appeal to socially conservative groups.

For one thing, PEPFAR is required by law to reserve one-third of its HIV prevention funding for activities designed to encourage abstinence and being faithful. These may be worthy objectives, but many people believe that such a policy fails to adequately recognise and respond to the realities of sex and relationships. The most important

Activist pressure has resulted in important concessions from the US government. But there is a long way to go.

prevention objective should be to discuss sex openly, and to encourage and enable the use of condoms among all sexually active individuals.

Equally worrisome is that several of PEPFAR's implementing partners are firmly opposed to sex outside of marriage and the use of condoms or contraceptive devices for any reason. Many are faith-based organizations, for example, and believe that such activities are always immoral. Based on this philosophy, they claim that widespread acceptance of condoms as an HIV prevention method will only encourage people to have sexual relationships that they condemn.

Another controversial issue with PEPFAR is related to treatment. The program guidelines say that the only antiretrovirals that can be purchased with PEPFAR funds are those that have been approved by a U.S. government agency, the Food and Drug Administration (FDA). However, some of the lowest-cost antiretrovirals available in PEPFAR countries have not been approved by this agency. This restriction can raise the cost of antiretrovirals among PEPFAR grantees and therefore limit the number of patients they can provide with treatment.

PEPFAR officials defend this policy, arguing that they are only seeking to ensure the safety and quality of all antiretrovirals. But this ignores that many of the lowest-cost antiretrovirals excluded by PEPFAR have been approved by the World Health Organization (WHO) and regulatory bodies, such as South Africa's Medicines Control Council. The U.S. policy is primarily based on a desire to provide a market for higher-priced antiretrovirals made by U.S. pharmaceutical companies. It should be noted that following pressure from activists, the FDA has approved many low-cost antiretrovirals since the beginning of 2005. This development has quieted the controversy to some extent, even though the policy itself has not been changed.

One final criticism that has been levelled at PEPFAR is that it has undermined the Global Fund to Fight AIDS, TB and Malaria (Global Fund). This is an independent organisation set up specifically to fight those three diseases. Yet it remains seriously underfunded. By putting most of its HIV funds into PEPFAR instead of the Global Fund, the US leaves itself open to accusations of trying to use HIV money for its own political purposes. It also sets a precedent for other wealthy countries to run their own funds rather than donate to the Global Fund.

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DIARRHOEA AND DEATH IN DELMAS

Children play on a municipal rubbish dump next to their shacks in Delmas. Photo by Sydney Masinga.

Delmas is a town of about 50,000 people, 100km from Johannesburg. On 14 September, TAC trainee journalist Sydney Masinga, Mpumalanga provincial co-ordinator Msanyana Skhosana and TAC volunteer Augustus Dludlu visited this small Mpumalanga Province town.

Their purpose was to collect human interest stories about a diarrhoea and typhoid outbreak in the town for *Equal Treatment*. They were interested in finding out how people with HIV were coping with the outbreak.

But instead they uncovered a scandal. They found that the number of deaths due to the outbreak of diarrhoea and typhoid was severely underestimated. TAC then reported this and the story received wide media coverage.

The Mpumalanga Health Department reacted furiously. They said that we could not be sure the additional deaths were due to typhoid. But this missed the point. We were not talking just about typhoid deaths; there was a diarrhoea outbreak in Delmas and more people than usual were dying as a result. It is possible that diseases other than typhoid were causing deaths, but the Mpumalanga Government just ignored these. Whether they did this on purpose or because they did not have the capacity to properly investigate what was going on, we cannot be sure.

The Mpumalanga Government had reported thousands of cases of diarrhoea, hundreds of cases of typhoid, but only three deaths. The three TAC members did what the Mpumalanga Health Department failed to do: they spoke to community members to find out what was really going on.

Below is an edited and updated version of Sydney Masinga's story which received wide media coverage when it was released on 18 September 2005.

Our Delmas Investigation

By Sydney Masinga

The Mpumalanga Health Department claimed on 12 September that there had been three typhoid deaths in Delmas and 483 cases of typhoid. The number of deaths caused by the outbreak of typhoid and diarrhoea were contradicted by reports I received from staff members at Delmas Hospital, claims by the Delmas community and my own investigations.

Two staff members at Delmas Hospital reported to me that the diarrhoea outbreak started in June and that the number of deaths had been greater than reported. Apparently the official figures did not include deaths at Delmas Hospital or people who died at home. A staff member involved in processing deaths at the hospital explained that more than 20 people had died at Delmas Hospital alone, as a consequence of the outbreak.

I spent the afternoon of 12 September locating families of people who contracted diarrhoea and died. I located six in just a short space of time. I personally saw three death certificates stating typhoid as the cause of death and this was still when the official death toll was two. The other three families presented plausible accounts that their lost ones had died as a consequence of the current diarrhoea outbreak.

I also spoke to community members who said that Delmas usually has about ten funerals a week, but the Saturday before there were 21. I spoke to a local clergyman, Pastor Budha, who as part of his job presides over funerals. He had witnessed an increasing number of funerals and complained to the local newspaper that government was underestimating the number of deaths.

Two staff members at Delmas Hospital reported that the number of deaths had been greater than reported.

We also interviewed counsellors and nurses at Delmas Hospital about HIV and the typhoid and diarrhoea outbreak. They did not have knowledge of specific cases of HIV coupled with the outbreak but were concerned that it would hit people with HIV harder because of their compromised immune systems. The counsellors said they test about 30 people per week for HIV and about 20 test positive. (Antiretroviral treatment is not yet available in Delmas. The hospital is being considered for accreditation and one doctor estimated that implementation would begin in January or February 2006.)

We spoke to a woman from the local home-based care forum. She said that since the beginning of the outbreak in June, many more of their HIV-positive patients had died than usual.

A community meeting on 17 September estimated that the number of deaths due to the typhoid and diarrhoea outbreak was 49.

The CEO of Delmas Hospital denied the allegation of unreported deaths. He would not confirm any deaths at Delmas Hospital. He also claimed that the outbreak was under control and getting better. He claimed there were no new cases coming in. All of this was contradicted by another staff member who claimed the outbreak was getting worse and more cases were being admitted all the time. I located the family of a 33-year old woman who died on 15 September at Delmas Hospital. Her death certificate states typhoid as the cause. The CEO denied knowledge of this death.

GOVERNMENT RESPONSE

We asked the Mpumalanga Provincial Health

The Delmas Community Forum, together with TAC, organised an interfaith service after the outbreak. The woman in the photo is a typhoid survivor. Photo Sydney Masinga.

Department for comment and tried unsuccessfully to get comment from the National Department of Health.

The Mpumalanga Health Department spokesperson, Mpho Gabashane, denied that they were underestimating the number of deaths. He also denied knowledge of deaths at Delmas Hospital. He claimed only two people had died, both at Witbank Hospital (this was shortly before the department confirmed the third official typhoid death). Gabashane said that he did not understand why we were making this a serious issue because the department was looking at it.

Children sit next to litter on the banks of a stream in Delmas. Photo by Sydney Masinga.

COMMUNITY DISSATISFACTION

Community members were not only dissatisfied that government was underestimating deaths. They were also dissatisfied with the response to the outbreak. A number of protests have taken place in Delmas and at least one turned violent resulting in a woman being injured when she was shot in the shoulder by police with a rubber bullet.

A staff member at the hospital claimed that patients were not being given sufficient medication. He claimed they are put on drips, recover and are then sent home, often returning again in worse condition.

Tents were established next to Delmas Hospital to handle the overflow during the outbreak. We interviewed a number of patients in the tents who complained they were too cold and that they were often ignored.

We also interviewed seven school children who were being treated in the tents. They attend Sizuzile Primary School and complained about the inadequate water supply being received at the school. We went to the school and confirmed that Rand Water supplied it with 640 litres per day. Either the supply was irregular, poorly timed or inadequate, because when we visited the school, there was no water and the children had no choice but to drink tap water, which was possibly a source of contamination.

It was also brought to our attention that residents of Delmas town were supplied with bottled water, but residents in the township were supplied with tanks of water.

GOOD WORK

Despite the misery of the typhoid and diarrhoea outbreak, there was much good work being done in Delmas to contain it. Government sent more personnel to the area to deal with the outbreak. There was also a sense of urgency among health workers who were clearly trying their best under difficult circumstances.

We met Sister Lillian Cingo, the manager of the Phelophepha train, which is a mobile clinic. They arrived in Delmas during the outbreak and gave much needed assistance.

The South African Red Cross also donated bottled water and personnel to Delmas Hospital.

We went back to Delmas a few weeks later. TAC helped organise a community meeting with the Delmas Community Forum. There was still much unhappiness with the muncipality and the quality of services being provided. The outbreak appeared to be over. But we spoke to more people who told us about the increase in deaths during the outbreak. We confirmed further deaths whose only likely explanation seems to have been the diarrhoea outbreak including a 23-year old woman and a 14-year old girl. A doctor in Delmas has reported that his patients with HIV were much more likely to die during the outbreak.

The last outbreak of typhoid in Delmas occurred only twelve years ago, in 1993. The question now is: what is the Mpumalanga Health Department doing to ensure that the water supply is clean and that there are no more diarrhoea and typhoid epidemics again in Delmas?

The Delmas story highlights the poor quality of local services in many parts of the country.

OUR RIGHTS IN OUR COURTS

TAC takes Minister of Health to Court

TAC has taken legal action against the Minister of Health.

The Minister has failed to stop the illegal activities of Matthias Rath. In our court papers we have argued that it appears that the Minister of Health is supporting Rath and in doing so has allowed him to carry on with his illegal and dangerous activities. Rath has been conducting illegal experiments on people in Khayelitsha and elsewhere. At least five people are known to have already died on his experiment (and possibly many more). TAC complained to the Medicines Control Council and the Department of Health about Rath's activities in March 2005. Others, including MSF and about 200 Western Cape doctors have also complained but so far they have done nothing to stop him. For TAC, this is an important case because it shows the Minister's support of unsubstantiated HIV denialist theories. We want to put an end to such denialism. TAC is also suing Rath and people working with him.

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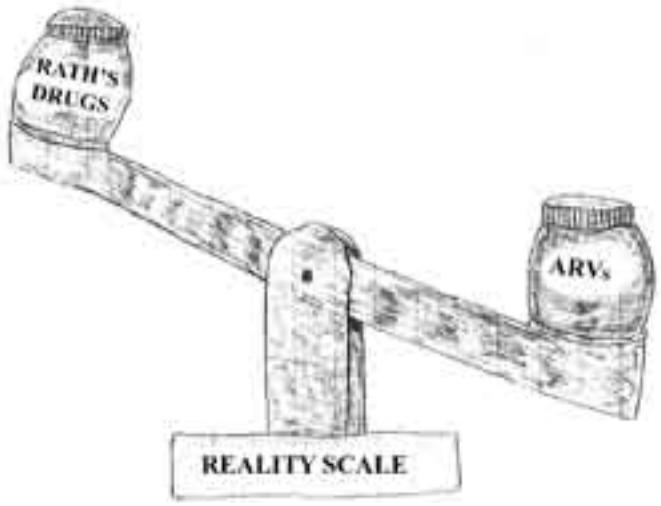


Minister of Health versus pharmacists

On 30 September, the Constitutional Court ruled on a complex court case between the Department of Health and pharmacy owners. TAC participated in the case as a friend of the court. A detailed explanation of the case is on the TAC website (www.tac.org.za). We give a very simplified explanation of it here.

The court decision affects us in the following way: Previously if you bought a medicine at a chemist the price would be determined by the pharmacy. Now the price is set by law. Pharmacists have to charge the price they paid to purchase the medicine plus a dispensing fee. In a nutshell, the main decision of the court concerned the dispensing fee. Government and the pharmacies disagreed mainly over the amount of the dispensing fee and the manner in which it was set.

The pharmacies argued that the dispensing fee was too low and they would go out of business as a result. The Court found that the dispensing fee amount was inappropriate (as required by the legislation). However, the court did not find any problem with the principle of the new legislation of setting a dispensing fee instead of allowing pharmacies to charge what they like. It therefore ordered the Department of Health and the pricing committee (that had set the dispensing fee) to reconsider the fee. The Court required the pricing committee to consider all representations made to it and any new information available, particularly the impact on rural pharmacies.

TAC welcomed the court's decision. It is a fair compromise between the need for pharmacies to stay in business and government's desire to make pharmacies more accessible to poorer people.

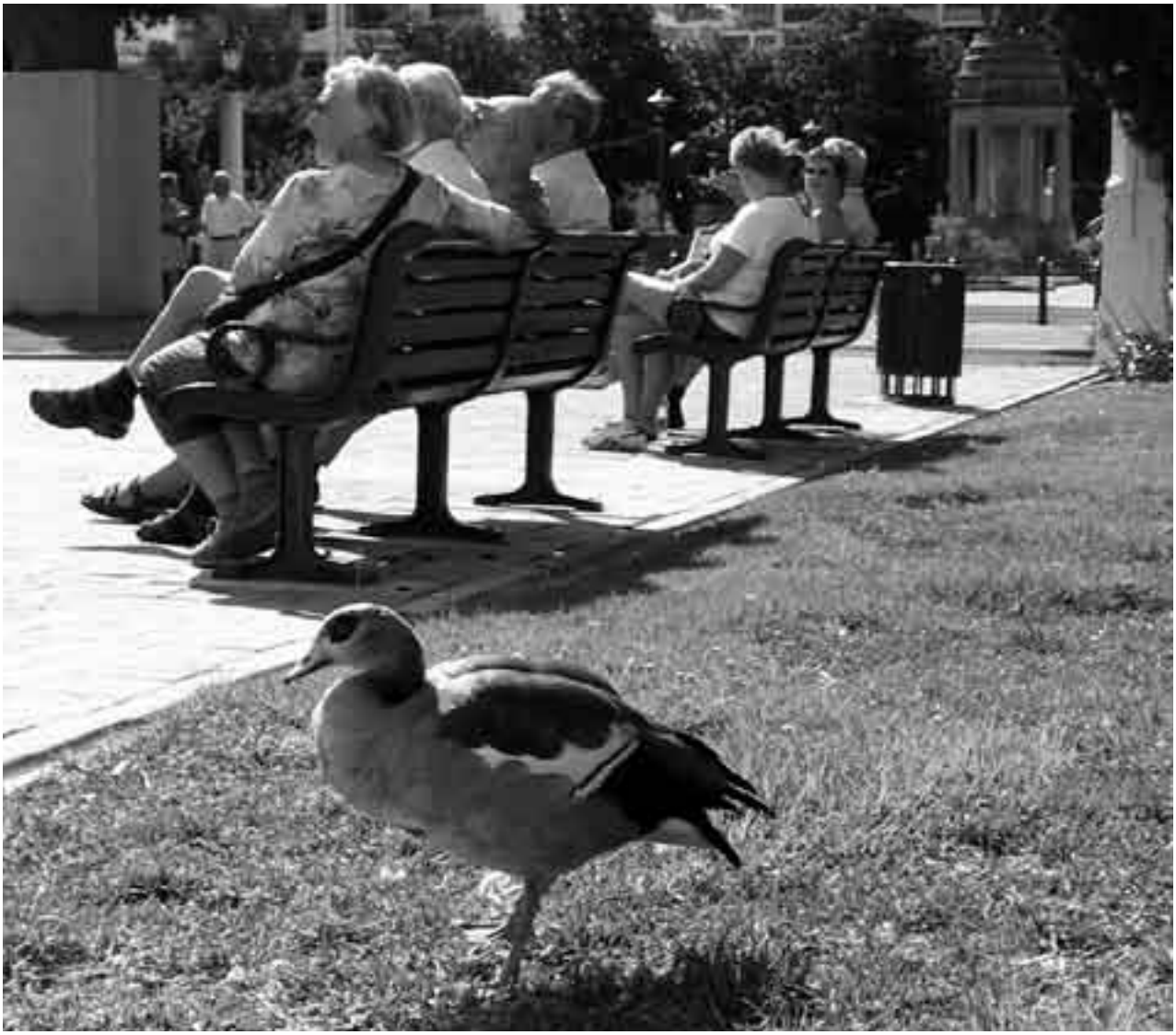
The court, however, was very displeased with the Minister of Health, because she displayed a lack of respect for the Supreme Court of Appeal when the case was heard there (before going to the Constitutional Court). Former Chief Justice Chaskalson said the Minister showed a "lack of respect for [the Supreme Court of Appeal]."

The court demonstrated its disapproval with the Minister of Health by making her pay the full legal costs of the pharmacies in the Supreme Court of Appeal. The Minister also has to pay half the legal costs of the pharmacies in the Cape High Court and the Constitutional Court.

BIRD FLU: ARE WE GETTING OUR DUCKS IN A ROW?

Sources: World Health Organisation, US Centre for Disease Control, New York Times*, as well as much speculation by* Equal Treatment *staff.*

In 1918, the Spanish flu epidemic killed tens of millions of people worldwide in just a few months. It killed more people than have died so far of AIDS in more than twenty years. In recent months, there has been an increase in the number of cases of humans contracting a deadly flu infection from birds. The World Health Organisation (WHO) has warned that this bird flu (also known as avian influenza) could cause a massive worldwide deadly flu epidemic if it begins to spread between humans.



A goose waddles among tourists in Cape Town's Company Gardens. Bird flu is carried by wild water fowl including ducks and geese. Poultry contract bird flu by coming into contact with infected water fowl and their droppings. Bird flu will only become a serious pandemic if it mutates so that it can be spread easily from human to human. The WHO says this is likely to happen.
Photo by Nathan Geffen.

There is a lot we still do not understand about bird flu. But what we do know suggests that all countries, including South Africa, should prepare for an outbreak. We cannot be sure there will be an outbreak. But if one does occur, the consequences will be devastating. If we are prepared, many lives could be saved.

What is Bird Flu?

Bird Flu is disease caused by a virus that usually affects only birds. Bird flu is carried by water fowl, such as wild ducks and geese. But they are quite resistant to its effects. However, a strain of bird flu (known as H5N1) has spread to domestic poultry and they have no resistance to it. Therefore millions of chickens have died of bird flu or been killed in an effort to control the virus.

Has bird flu infected humans?

Yes. There are different bird flu strains that have infected humans working with poultry. A strain known as H5N1 strain is of particular concern because it has developed into the most deadly strain of bird flu ever recorded. Death occurs sometimes only 48 hours after infection. The first cases of human infections of the H5N1 virus were in Hong Kong in 1997. Eighteen people were infected and six died. The government took quick action by destroying the island's entire poultry population.

A poultry outbreak of the H5N1 virus was recorded in 2003 in South Korea and it has since spread through Asia. It has now reached Romania and Turkey. Human infections of the disease have been confirmed in five countries: Vietnam, Thailand, Cambodia, Indonesia and China. As of 23 November 2005 there had been 68 human deaths and 130 infections, Vietnam being the worst affected with 41 deaths. There have been no poultry or human infections of the H5N1 virus in South Africa to date.

How dangerous is bird flu to someone who contracts it?

About half the people who have contracted bird flu so far have died from it. In South Africa, some people with AIDS do die from ordinary flu because their immune systems have been destroyed by HIV and they cannot fight the flu. But bird flu is much worse. Unlike ordinary flu, those infected are at very high risk of dying. This is because our immune systems do not know how to fight bird flu.

How do humans contract bird flu?

Up till now, most infections have occurred because of direct contact with infected poultry, or surfaces and objects contaminated by their droppings.

Can you get bird flu by eating poultry?

Eating poultry is safe although you should not eat raw eggs and you must properly cook poultry. Most humans who have contracted the disease worked with poultry, e.g. in slaughterhouses, or kept them at home.

Should we be concerned about bird flu?

At the moment, contracting bird flu is very difficult since the main way of transmission is from close contact with birds. However, bird flu researchers think it is likely that the bird flu virus will mutate (i.e. its genetic code will change with time) so that it can be passed easily from human to human, e.g. through the air by coughing and sneezing, as well as touching. If this happens, it would be difficult to stop a massive worldwide deadly flu outbreak. Some scientists believe that such a pandemic is inevitable. Even if they are wrong, the world must prepare itself. The risk of not doing so is much too high.

What's changed in the world that has put it at risk of this outbreak?

There have been three serious flu pandemics in the past century: the Spanish influenza of 1918 and those in 1957 and 1969. Increased travel and globalization mean that any new epidemic spread through the air would, within months, affect the whole world and possibly kill millions of people.

Also, the number of chickens and ducks farmed or kept domestically in Asia has grown massively over the last decade. This has increased the number of human-bird contacts as well as the potential for new flu strains to develop.

What about HIV and bird flu?

It is not known what effect bird flu infection would have on people with HIV. It is likely to be worse for people with HIV because of their already compromised immune systems. But there is also speculation that people with advanced HIV disease *might* be less likely to die from bird flu. This is because the disease causes an

excessive immune response that itself might be responsible for the high death rate. People with very weak immune systems from HIV cannot have strong immune responses. But this is speculation. The truth is we do not know at this time how the disease will affect those living with HIV/AIDS.

Can H5N1 bird flu break out in Africa?

Yes. Wild ducks and other birds carry bird flu. Many of these birds migrate from the winter in the northern hemisphere to summer in the southern hemisphere. It is possible that they will spread the H5N1 bird flu to some domestic poultry stocks in Africa, resulting in a bird flu outbreak among poultry on this continent. With the weak health and epidemic control systems on much of the continent, this will increase the risk of bird to human infections and ultimately human to human infections.

Is there a vaccine for the bird flu?

Research is being done to find a vaccine. The problem is that flu viruses change characteristics very quickly making it very difficult to develop a vaccine. A vaccine that works this season for flu may not work next season. If a pandemic were to occur it would be necessary to know the genetic makeup of the pandemic virus before an effective vaccine could be developed. Flu vaccines usually take between four and eight months to be developed. Currently some countries are making efforts to vaccinate poultry, but whether this is feasible on a large scale, or will even help stop the H5N1 bird flu, we do not know.

Are there medicines for treating bird flu?

The antiviral drug, oseltamivir, better known by its brand name Tamiflu, is possibly the best medication available to treat the virus. There is evidence that it reduces symptoms of the disease decreases fatality rates and prevents infection. It is only effective however if administered soon after a person shows symptoms.

However, there are questions concerning the safety of oseltamivir following the deaths of children in Japan. So far, the US Food and Drug Administration has indicated that there is no evidence that these deaths were due to oseltamivir.

At the moment oseltamivir is not registered in South Africa but its approval is being fast-tracked by the Medicines Control Council. The patent-holder of the medicine is the drug company Roche Pharmaceuticals. At the moment the company does not have the capacity to produce enough of this medicine for the whole world in the event of an outbreak. It is developing countries who are most likely to be short of medicines if an outbreak occurs.

What should the South African government do?

The government already has measures in place to protect domestic poultry from getting infected by new bird flu strains such as H5N1. These measures have

been strengthened due to a recent bird flu outbreak that occurred on an ostrich farm in the Eastern Cape in 2003. (NB: this was not the H5N1 virus).

Even though there are concerns about oseltamivir's safety and effectiveness, it is important for South Africa to build up stocks of this medicine. To do this will require giving licenses, possibly against Roche's wishes, to generic pharmaceutical manufacturers. It might also involve building an alliance with other developing countries including Brazil, India, China, Taiwan, Indonesia and Vietnam to (1) share manufacturing capacity and (2) to put pressure on Roche and the US government if they attempt to block generic production efforts.

Taiwan has already announced it will produce generic versions of oseltamivir and it also claims that it can produce the drug four times quicker then Roche and at a fifth of the price.

The Department of Health should issue clear guidelines on how to deal with possible cases of patients infected with the H5N1 virus. This would involve educating health workers on how to treat infected patients. Infected patients must be quarantined until they are no longer infectious and staff must observe protective precautions when dealing with them.

If bird flu does become easily transmitted between humans, government would have to monitor the health of people entering South Africa through international harbours and airports so that people infected with bird flu can be identified and quarantined until they are no longer contagious.

Government should act now. Better to moan about wasted money than deaths that should have been avoided.

HOW BIRD FLU IS SPREAD

1. ORIGIN

Some birds are infected with bird flu. Some species, such as water fowl, are more resistant to infection than others. Infection causes a wide range of symptoms in birds, ranging from mild illness to a highly contagious and fatal disease that causes severe epidemics.

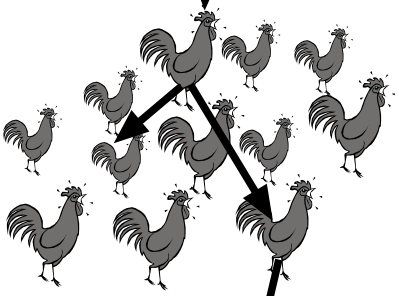
waterfowl

2. MIGRATION

Wild migratory birds carry the virus. Chickens and other poultry become infected through contact with dead birds, droppings and contaminated water.

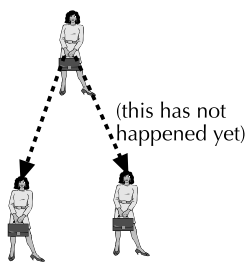
3. CHICKEN EPIDEMICS

The virus can spread between chickens through the air. An uninfected chick becomes infected by inhaling the virus or touching the feathers of an infected chicken. They can also become infected by standing on soil containing the virus.



4. HUMAN INFECTION

Humans can get infected either by being in direct contact with infected birds or with equipment infected by soil with the virus in it. At this point the virus would have to mutate in order to become a pandemic. The WHO warns that this could happen.



Modified from a diagram in the New York Times.

On 29 October, Medecins Sans Frontieres (MSF) and TAC hosted the ZipZap Circus School in Khayelitsha. The audience, mostly youth, was treated to amazing acts of human strength and dexterity, as well as a play about accepting people with HIV. In between the acts, there were talks on destigmatising, preventing and treating HIV. We present here a selection of beautiful photographs taken by Eric Miller (photos are printed courtesy of MSF).

WINNING LETTER

Dealing with rape and HIV

I'm an 18 year old girl doing grade 11. I stay with my father and brothers. My mother is in hospital at the moment. Both of my parents are unemployed. And they are responsible for maintaining us but cannot fulfill all our needs even though our schooling is paid for by our mother's pension money.

This year in July, two men raped me and I reported it and they were arrested. I was taken for tests and my results came back positive for HIV but negative for pregnancy. I don't have other sexually transmitted infections (STI).

Now I'm living a positive life and I have accepted that I am HIV-positive but I don't know how to tell my dad because when I told him that I was raped he got sick. And how am I going to tell my mom when she comes back from the hospital?

Can you please advise me on that? As I am HIV-positive, I know that I need to eat healthy food so that I can improve my health but my family is not working. We eat anything that my father is able to bring home. Where can I go to in order to get food?

I would also like to be a member of TAC.

Regards
Khayakazi (name changed)

TAC Responds:

You are welcome to join TAC. Please feel that you always have a place of help and support with us.

Rape is a trauma that no one should have to experience, and especially not alone; the fact that you are now living with HIV makes coping with your situation difficult. There are services available where you can get counselling on your status and discuss how to talk to your family.

We have sent a letter to you that explains how to access these services in your area, as well as social grants so that you can afford to eat.

It is good that you have accepted your status and are living a positive, healthy life. Hearing about people who have chosen to live positively is inspiring for others, as many people struggle to live with HIV.

You have won this month's prize for the best letter, a R200 Exclusive Books gift voucher.

Write a letter

The writer of the best published letter will receive a R200 Exclusive Books gift voucher.

Keep your letters short and to the point. Indicate if you wish to have your name changed. Remember to include your contact details.

Write, fax or email to:
Equal Treatment
34 Main Road
Muizenberg, 7945
South Africa
Fax: 021 788 3726
Email: et@tac.org.za

EQUAL TREATMENT QUIZ

The first entry drawn from a box that answers 12 or more of the 15 questions below correctly will win a R200 Exclusive Books gift voucher. The winner of last issue's prize is *Xoliswa Melude* of Phillipi.

All the answers are in this month's *Equal Treatment*

1. The age to which the average South African in 2005 can expect to live is below ___ ?
2. Name the country whose health system has the most South African nurses working overseas.
3. What council does the new Nursing Bill aim to transform?
4. What is government's current draft human resources plan for the health system called?
5. List three things that TAC says need to go into a human resources plan for the health system.
6. List three resolutions taken at the TAC National Congress.
7. True or false: The PCR test can detect HIV accurately in children less than one year old.
8. True or false: The standard HIV antibody test can detect HIV accurately in children less than one year old.
9. What is the full name for the PCR test?
10. List three countries that receive PEPFAR funds.
11. What does PEPFAR stand for?
12. True or false: The new Medicines Act pricing regulations allow pharmacists to determine the price of medicines.
13. What is the name of the medicine that scientists think might help against bird flu?
14. Which country as of November 2005 had the most people who have died of bird flu?
15. What is the name of the strain of bird flu that is currently causing so much concern?

How to enter

Send your answers, numbered 1 to 15, by post, email or fax. You must include your correct name and postal address. This competition is not open to TAC employees or recipients of treatment literacy bursaries. Closing date for sending entries is 20 January 2006.

Post: Equal Treatment, 34 Main Road Muizenberg, 7945
Email: et@tac.org.za
Fax: 021 788 3726 - please phone 021 788 3507 to confirm receipt.

Rukia Cornelius (TAC National Manager), Sipho Mthathi and Molly Slingsby (Conference Organiser) show how tired they are towards the end of TAC's third National Congress. Mthathi was elected General Secretary of TAC at the Congress. Photo Saul Konviser.

VOICES BEHIND

by Mthuthuzeli Isaac Skosana

Voices Behind sing, praise and testify
Voices of heroes and heroines
Voices from the south, east, north and west
Voices from townships, rural areas and suburbs
Voices from poor and destitute
Voices from behind

Voices testifying to the nation
Voices unnoticed and unrecognized
Sharing their bravery and vision to heal
Testifying to uplift the spirit from hopelessness
These are the voices I hear

Voices praising each day
For they live to share with others
For they live to heal the pain
The voices we ignore each day

Those we criticize and curse
The voices we ignore

Everywhere they speak
In churches you hear them testify
To friends and family members they speak
In corridors we hear them daily
We travel and hear them in taxis, buses and trains
We read what they say in newspapers
Our radio stations have them too

Voices we can't live without
Voices we need to listen to
Voices whose experiences we need to share
Voices I hear each day
These are the Voices Behind

Dedicated to all people living openly with HIV, as well as those teaching and guiding their communities.

Lusikisiki celebrated over 1,100 people on treatment on 28 October. The joint efforts of health workers, Medecins Sans Frontieres and TAC's Lusikisiki members have helped make this possible.

TAC appeal for funding

In South Africa we have over 5 million people living with HIV.
500,000 people will die if they don't get antiretroviral treatment soon.
TAC campaigns for access to treatment, a people's health service and community driven prevention strategies.

SUPPORT US TO SAVE LIVES

Donate at your nearest bank OR www.tac.org.za/donatenow

DONATE NOW

TAC
TREATMENT ACTION CAMPAIGN

treat 200 000 by 2006

TREATMENT ACTION CAMPAIGN
NEDBANK, BRAAMFONTEIN BRANCH
ACCOUNT NO: 128 405 1870
BRANCH CODE: 195 005

Visit www.tac.org.za for more information on how you can help or volunteer at TAC.

LEON VAN DEN HEEVER CAPE TOWN

I have been on antiretrovirals for five years. I am alive because of them.

MEDECINS SANS FRONTIERES

t r e a t
200 000
by 2006

TAC
TREATMENT ACTION CAMPAIGN