

# **INAUGURAL LAUNCH OF THE JOINT CIVIL SOCIETY MONITORING AND EVALUATION FORUM OF THE OPERATIONAL PLAN FOR COMPREHENSIVE HIV AND AIDS CARE, MANAGEMENT AND TREATMENT FOR SOUTH AFRICA (THE FORUM)**

## **SUMMARY OF DISCUSSION AND RESOLUTIONS TAKEN ON 7 SEPTEMBER 2004 IN POLOKWANE, LIMPOPO**

Released by AIDS Law Project (ALP), Centre for Health Policy (CHP), Médecins Sans Frontières (MSF), Public Service Accountability Monitor (PSAM), Institute for Democracy in South Africa (IDASA), Open Democracy Advice Centre (ODAC), Anglo American, Southern African HIV Clinicians Society (SAHCS), UCT School of Public Health and Family Medicine and Treatment Action Campaign (TAC)

13 September 2004

### **Introduction:**

On 7 September 2004, a number of civil society organisations launched a joint civil society monitoring forum (the forum) in Polokwane, Limpopo. The forum aims to assist with the monitoring and assessment of the implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (the Operational Plan) from a public health and human rights perspective. Its objective is to provide government and the public generally with an ongoing and accurate assessment of the programme's implementation, to act as an early warning system for problems, and to help communicate successes. It would like to build a constructive relationship with national and provincial health departments, and in particular the programme's recently appointed manager, Dr David Kalumba.

It is currently composed of the following civil society organisations:

- AIDS Law Project (ALP),
- Centre for Health Policy (CHP),
- Médecins Sans Frontières (MSF),
- Public Service Accountability Monitor (PSAM),
- Institute for Democracy in South Africa (IDASA),
- Open Democracy Advice Centre (ODAC),
- Anglo American,

- Southern African HIV Clinicians Society (SAHCS),
- UCT School of Public Health and Family Medicine and
- Treatment Action Campaign (TAC).

These organisations do not represent a closed list of members. The forum is open to any organisation that is committed to the implementation of the Operational Plan. The forum therefore invites and encourages civil society organisations to join and/or participate in its work.

### **Preamble:**

The goal of the forum and its common objectives are

- to monitor and assist with the effective and efficient implementation of the Operational Plan from a public health and human rights perspective;
- to attempt to redress the inequities in access between the private and public health sectors; and
- to address issues affecting access to ARV treatment in both the public and private sector across the country.

The forum commits to ensure that people's human rights are respected, protected, promoted and fulfilled. It aims to assist government with the acceleration of the implementation of the Operational Plan by providing vital information on treatment uptake and problems experienced so that optimal patient targets can be reached within reasonable time-periods. The forum hopes that through the provision of accurate and timely information it will assist government with reaching its objective.

The initial focus of the forum on patient targets is particularly important after the Minister of Health's recent announcement that the patient targets for 2005 (the previous 2004 targets) are unlikely to be reached. The forum reaffirmed the importance of meeting patient targets that were set by Cabinet in November 2003 when it adopted the Operational Plan.

The forum is not however just focused on patient numbers. We are concerned that the introduction of ARVs must be done in a manner that strengthens health services and transforms our national response to the HIV epidemic into a much more effective response.

The forum noted that the recently released strategic priorities of the Department of Health for 2004-2009, identifies the 'acceleration' of the Operational Plan as a key activity under its priority to improve the management of communicable and non-communicable diseases. The forum hopes that through the provision of accurate and timely information

it will assist government with reaching its objective.

At its first meeting, the forum considered reports about aspects of the implementation of the Operational Plan at both a national and provincial level. In addition, detailed reports on the Eastern Cape and Limpopo were presented and discussed.

### **Findings:**

Close to 8 000 people are now on ARV treatment at public facilities nationally (this figure is about 2 000 more than when the TAC and the ALP issued their joint report in July 2004) and concurs with the figure announced by the Minister of Health. The forum welcomes the progress made in scaling up treatment in some provinces and is encouraged by the efforts and determination of health care workers (HCWs) and some provincial governments in accelerating the implementation of the Operational Plan.

However, the forum recognised that in several provinces, not enough is being done to ensure access to ARV treatment for people who need treatment.

### **Current patient numbers**

The following figures are best estimates of the numbers of patients receiving ARV treatment in public health facilities nationally– they do not include gender, age or adult-child breakdowns. However, it should be noted that the majority of patients are adults.

13 September 2004

Province	Operational Plan March 2004 target (Revised for 2005)	Numbers on treatment (Adults and children)
Gauteng 11 SITES	10 000	+/-2800
North West 3 SITES	1 808	+/-130 Not more than 200
Northern Cape 4 SITES	790	+/- 150

Eastern Cape 8 or 9 SITES PLUS MSF	2750	+/-124 plus MSF 380 = 504
Western Cape 24 SITES	2728	+/-3834
KZN 9 SITES	24 902	+/-535
Limpopo 1 SITE 7 ACCREDITED	6965	+/-20
Mpumalanga 5 or 6 SITES	1934	+/-130
Free State 3 SITES	2127	+/-240 [*SACBC 100 patients at 3 sites per y pending]
TOTAL	54 004 (53 000)	CLOSE TO 8000

The forum also noted that in provinces where monitoring of ARV treatment has commenced, such as in Khayelitsha in the Western Cape, measured outcomes after 30 months indicate that health outcomes are very good.

There is a significant demand for ARV treatment in all provinces. However, in some provinces the ability to access ARV treatment is being frustrated by long waiting lists for

enrollment into care as well as to access ARVs. For example, it was reported that at one treatment site in KwaZulu-Natal, waiting lists are running into August 2005, that is, about a year from now. Reports such as these confirm that the demand for ARV treatment outweighs current capacity despite statements to the contrary by the Minister of Health in parliament.

The forum unambiguously agreed that the demand for treatment is evident in all provinces, but that in many provinces the numbers of patients on ARV treatment are minimal because the service is not yet being offered. The low patient numbers are explained by the late commencement of ARV programmes in some parts of the country, rather than lack of demand. For example, in Limpopo only one health facility is prescribing ARVs at present. In addition, in rural provinces in particular, many patients have trouble in accessing ARV treatment sites because of transport difficulties.

The forum noted that political and managerial oversight as well as overall commitment to the Operational Plan varies from province to province. It was also reported that there is a need for systematic national management and oversight, especially in respect of poorer and weaker provinces.

The most serious problems identified are listed below:

- Participants reported that there are severe human resources (HR) shortages in clinics and hospitals across the country. Inadequate working conditions and the prevalence of HIV amongst HCWs are fuelling HR shortages. The absence of sufficient mechanisms to provide on-going care and treatment for HCWs affects the ability of HCWs to seek proper medical attention and to care for patients living with HIV/AIDS.
- Despite a Constitutional duty of national and provincial government to act in an open and transparent manner, the national Department of Health and some provincial health departments have not publicly released and/or shared information about the extent of implementation of the Operational Plan. Site details, commencement dates, patient numbers and adult-children-gender breakdowns are not publicly available. The forum applauded the efforts of the Free State province in making information about the implementation of the Operational Plan available on its website. In addition, provinces such as Gauteng, Northern Cape and the Western Cape should be congratulated for their willingness to publicly share vital information about implementation in their provinces.
- In respect of budgetary allocations and funding, it is unclear to what extent provinces are using conditional grants allocated by the National Treasury and/or funds from their own budgets to implement the Operational Plan in their province. There is a concern that the spending rate on HIV/AIDS conditional grants for the first quarter of 2004/5 (which is not limited to ARV treatment) was slightly lower than the spending rate in the first quarter of 2003/4. The reasons why provinces spent on average about 15% of the year's total health HIV/AIDS conditional grant

allocation in the first quarter of 2003/4 but only spent 6.5% of the year's total allocation in the first quarter of 2004/5 are unclear. Provinces should account for this. Caution should be taken in this regard since slow spending affects the overall provision of comprehensive HIV/AIDS prevention, care and treatment services. However, in light of the adoption of the Operational Plan in November 2003, one would have expected the provinces to spend much more in the first quarter of 2004/5.

Reports also indicate that there is a severe lack of HR capacity in all provinces. For example, in provinces such as Limpopo and Mpumalanga posts that have been advertised for doctors, nurses and pharmacists are not being filled. There is also a reported over-reliance on doctors and an inappropriate use of existing human resources, such as lay counsellors and nurses.

In addition, there appears to be under-utilisation of existing capacity to implement the ARV treatment plan. This has resulted in non-accreditation of sites that are actually ready to provide ARV treatment such as the Tintswalo hospital in Limpopo. The refusal to make greater use of public private partnerships in some instances undermines site capacity.

One of the criticisms leveled at the current approach to implementing the Operational Plan is the adoption of a mechanical approach to management that undermines creative and flexible approaches to finding solutions to both infra structural and HR problems. For example:

- With a few exceptions, the possibility of public-private partnerships is not being fully explored. The opportunity to take advantage of private sector medical professionals that have been trained in the management of HIV/AIDS, is not being utilized;
- Some public sector sites that have the requisite capacity and the commitment to provide ARV treatment are not yet accredited (sites in Limpopo and the Eastern Cape). Some sites that have been accredited are still not offering treatment (sites in KZN and Limpopo);
- A rigid accreditation approach and the reluctance to provide reasons for refusing accreditation coupled with the failure to assist facilities with infrastructure strengthening is undermining the development and expansion of site capacity;
- The lack of approval of decentralised approaches to providing greater access to ARV treatment by using nurses and clinics in areas that are distant from tertiary hospitals will hinder acceleration of implementation. The forum agreed that there is a need to decentralise HIV/AIDS prevention and treatment services, and instead, adopt a more flexible treatment paradigm.

- Although the forum welcomed the commitment to ARV roll-out shown in the Western Cape and Gauteng, these provinces nevertheless demonstrate that detailed attention must be given to the development of sites at primary care level. This will make treatment more accessible, improve patient adherence and monitoring and reduce out of pocket costs for poor people.

## **Concerns:**

The delays in most provinces in systematically expanding access to ARVs have caused several public health problems. First, patients are commencing treatment very late. Second, in the Eastern Cape and elsewhere, patients are dying while waiting for an opportunity to be clinically assessed (waiting lists). This is true everywhere.

The spending rate of HIV/AIDS conditional grants by provinces has been lower in the first quarter of 2004/5 when compared to the same period in 2003/4. The forum will seek an explanation from relevant provincial departments, the National Department and the National Treasury. However, the forum observed that effective monitoring of provincial spending and implementation of HIV/AIDS programmes is difficult because in some provinces provincial treatment and business plans are not publicly available and accessible.

The formal drug procurement and tender process has not been concluded yet. Although 10 companies have been short-listed, tender contracts have not been awarded. The unnecessarily slow procurement process is frustrating the efforts of some provinces to scale up speedily. It also affects provincial budgetary planning and the continued utilisation of available resources.

Important drug combinations have been omitted from the national tender. There is no transparency as to the progress being made on the fast-track registration of generic medicines, in particular, fixed-dose combinations (FDCs). The slow pace of the registration of key ARV medicines is hampering access. The forum recognised that there is a need to ensure that registration is fast-tracked. The registration of tenofovir and fixed-dose combination ARVs such as Triomune, which are crucial in improving patient adherence and resulting in better treatment outcomes must be fast-tracked. Triomune is also crucial because it contains three ARVs that form one of the two standard first-line regimens as contained in the Operational Plan. Tenofovir is not yet being used in the public sector, but in all likelihood will become required at a later point.

The National Health Laboratory Service (NHLS) appears to lack capacity at some of its laboratories that are performing CD4 and viral load tests. At these laboratories, issues of quality assurance, quality control, and information managements systems require greater attention and review. Site inspection visits may be necessary. In addition, the forum recommends that the NHLS contract out services to the private sector in areas and

provinces where it lacks adequate capacity.

There is no national HR Plan that addresses HCW training, attraction, retention and attrition. The development of such a plan is urgently required within the context of the implementation of the ARV treatment plan. The 'scarce skills and rural allowance strategy' also needs to be fully communicated to civil society and government officials for better comprehension of its application.

### **Recommendations:**

- Wealthier provinces such as Gauteng and Western Cape are scaling up much more speedily than poorer provinces such as the Eastern Cape and Limpopo. However, while a few thousand people are benefiting from accessing ARV treatment, there is still considerable room for improvement. Crucially, effective site management is lacking at many sites, which can be adequately remedied through appointments of managers and administrators.
- Provincial spending of first quarter HIV/AIDS conditional grant transfers should have been sped up with urgency, and without compromising efficiency. Available resources should have been utilized on, inter alia, health facility and system upgrades, education (training) and communication, continued prevention and care campaigns, ARV drug procurement and staffing. Provinces must account for their slowness in this regard.
- Accreditation must be viewed as a process and not a single event. Apart from ensuring compliance with a set of minimum standards, accreditation should be used as a mechanism for continuous quality improvement over time. At the outset, partial compliance to a level, which satisfies minimum criteria for the safe delivery of ARV's, should be all that is required to commence treatment programmes.
- Government needs to develop flexible and creative models for effectively encouraging private sector partnerships to assist with expanding public sector capacity. The Southern African HIV Clinicians Society (SAHCS) has about 4000 members that have already undergone HIV/AIDS clinical management training.
- The sheer number of patients that they have to manage is over burdening many doctors and nurses. Therefore, a plan to employ (as opposed to working on a stipend basis) as well as deploy and accredit VCT counselors to assist doctors and nurses with the day-to-day management of patients is necessary to relieve their burden. In addition, a career path for counsellors to become adherence counsellors in ARV programmes is necessary.
- Special programmes are necessary to promote and offer comprehensive treatment to HCWs who are living with HIV/AIDS.

- We look forward to seeing some of the outcomes of the programme reported as a measure of quality of care and programme success. In addition, reporting on CD4 counts of patients enrolling for treatment would be a useful barometer of patient access to the ARV programme.
- The Southern African HIV Clinicians Society (SAHCS) should develop a system for monitoring patient numbers and health outcomes of patients (mostly workers) being treated through private sector funding (medical schemes, donor funded programmes, PPPs and workplace treatment programmes).
- The national and provincial government must make national, provincial and district business plans publicly available. Failing this, forum members (ODAC, IDASA and PSAM) will attempt to obtain these documents on behalf of the forum.
- The national government must make Annexure A (and any revised version) to the Operational Plan available. Annexure A (and revisions) contains patient targets and timelines for implementation of the Operational Plan. It has not been publicly released since November 2003 when the Operational Plan was adopted.
- The forum will request the Eastern Cape Health department and the MEC for Health in the Eastern Cape to explain a claim made by the head of the provincial HIV/AIDS Directorate (and Director of the Eastern Cape AIDS Council), Mrs Nomalanga Makwedini, that 17000 patients in the Eastern Cape have been screened and diagnosed within a 3 month period as part of the EC provincial treatment plan. This reportedly amounts to more than 14 times the target number of 400 persons per month. At some sites in the EC the reported capacity to screen is between 60-100 per week. The total figure of 17 000 therefore seems unlikely.
- Government and civil society must develop a plan to support poorer provinces. National government should assist poorer provinces by providing them with comprehensive support and assist with the speedier transference of HIV/AIDS conditional grants. In this regard, we welcome the appointment of Dr Kalumbo and look forward to effective functioning of a fully capacitated national implementation unit.

The minutes of the meeting will be publicly available by 13 September 2004. It was agreed that the next forum meeting would take place at the end of November 2004.

### **Summary of resolutions and discussion compiled by:**

- AIDS Law Project (ALP)
- Centre for Health Policy (CHP)
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