

# HATIP

HIV & AIDS Treatment in Practice

Issue 23 | 06 February 2004



## In this issue:

### South Africa's national treatment programme; *page 2*

- Is slow progress a sign of lack of commitment?
- Key points
- South Africa seems to change direction on ART
- Initial reactions
- Key points of the operational plan
- Not even out of the starting gate
- Storm-SA Brewing

# South Africa's national treatment programme

## Is slow progress a sign of lack of commitment?

This article was written by Theo Smart (Cape Town) with contributions from South African members of HATIP's advisory panel.

### Key points

- Initial optimism over the South African government's national treatment plan has been tempered by a slow start.
- Amongst the obstacles to fast progress, a lack of communication and onerous requirements for accreditation of facilities that will deliver ARVs stand out as key obstacles.
- A major investment in training will be necessary in order to expand the number of treatment centres. There is still a lack of clarity as to who is directing training.
- Government needs to communicate better with key partners, including doctors and community activists, on whom the success of the strategy will depend.
- The programme appears to be behind schedule, but the implementation schedule originally agreed still remains secret. Openness on the implementation schedule is a key means of building trust and mobilising resources outside government in order to reach the programmes goals.

## South Africa seems to change direction on ART

People were guardedly optimistic last August when the South African Cabinet issued instructions to its Department of Health to develop an operational plan to provide ART in the public sector. Many were surprised. For years, the current administration had delayed taking any clear-cut positive actions and often seemed hostile to the idea.

Activists initially may have questioned the composition of the team appointed to develop it but when the very aggressive operational plan for comprehensive HIV and AIDS care, management and treatment including the roll-out of antiretroviral therapy (ART) was presented and then approved by the Cabinet, people were literally dancing in the streets.

The plan promised to distribute free ART within a year to at least 50,000 people in the nation's 77 health districts and to reach every South African in need of treatment within five years. It also committed government to investing substantial finances into upgrading the national healthcare system via "recruitment of thousands of professionals and a very large training programme to ensure nurses, doctors, laboratory technicians, counsellors and other health workers have the knowledge and the skills to ensure safe, ethical and effective use of medicines."

The plan was praised around the globe. Some wrote that South Africa could become a model for AIDS treatment in Africa. According to press releases and statements from Treatment Action Campaign (TAC), the plans approval also seemed to herald a new era in the relations between the South African Government and Treatment Action Campaign (TAC), whose spokesman Nathan Geffen said his organization can finally move forward and begin working with the government to make this plan a reality.

## Initial reactions

After the plans approval, HATIP queried South African members of its Advisory Panel on what they thought of the new treatment programme. Responses ranged. A self-proclaimed optimist, Dr Francesca Conradie works with the HIV clinic at Helen Joseph Hospital, a site already designated as a service point. To a small extent, [we] were involved in the task team discussions. The plan is very ambitious. I agree with most of the choices.

We are ready to roll out therapy tomorrow if need be. Half of our patients need therapy as a matter of urgency. We have been training registrars and other medical officers in the rollout plan.

Dr. Douglas Wilson, of Greys Hospital (a government facility in Pietermaritzburg) thought it best to temper initial expectations, but then his enthusiasm for the new challenges ahead began to show. It's a major milestone in the history of the HIV epidemic in South Africa, but initially will not have much impact on a human tragedy of staggering proportions. Human resources and infrastructure are in short supply, and what there is will be increasingly divided between providing acute care to HIV infected patients with opportunistic infections and long-term care for those embarking on ART.

Initially the challenge will be to set up small, successful local treatment programmes. Treating patients with antiretrovirals is one of the most rewarding areas of medical practice, and, hopefully, junior nurses and doctors will want to join the winning teams.

Dr. Catherine Orrell of Somerset Hospital, a public hospital in Cape Town had doubts. "While I'm quite happy that the plan has finally been approved my excitement is tempered because it is going to be very difficult to implement and is going to take years to get treatment out to everyone who needs it, particularly in areas that are already under-resourced.

It's been over a year, and we haven't yet succeeded in ramping up the PMTCT program and that only takes the administration of one dose of drug. How are we going to quickly and successfully implement anything more complex?

Everyone talks about all this money that is available but I haven't seen any of it. They say that they are going to train and hire more personnel. This is crucial staffing the new program will be a huge challenge. With staff shortages jeopardising other programs already how are we going to establish and staff a [site] in each health district within one year?

To offer HIV care, the OP requires facilities to meet stringent accreditation criteria. It's a big list and quite a tall order. It might be possible to achieve in some districts in Gauteng or the Western Cape but what of the Northern Cape or Limpopo or Mpumalanga? The program is going to have to be driven at the national level.

Dr. Norman Nyazema who works at least half the year in Limpopo Province said bluntly. People are playing games. It's not going to happen."

Most of the operational plan can be downloaded from: <http://www.gov.za/issues/hiv/careplan19nov03.htm>.

## Key points of the operational plan

- The goal is to provide high quality comprehensive care and treatment for all people living with HIV and AIDS in South Africa within the next five years.

Anyone testing positive should be provided with a continuum of care and support services that respond to their changing needs over the course of their infection. This includes immunizations,

prophylaxis and treatment for opportunistic infections and ART in adults with CD4 cells below 200 or WHO stage IV disease. Substantial funding has been also allotted for the nutritional/food support of people with AIDS. Traditional and complementary medicines will be made available as an alternative treatment option for patients.

- The HIV treatment programme will be integrated into and reinforce the existing healthcare infrastructure.

The plan recommends that care be delivered in an integrated fashion within the framework of the existing public health care system in order to avoid the creation of parallel competing health systems. Over half of the total budget to be spent on implementing the plan will actually go to upgrading South Africa's overall health infrastructure, including HIV prevention programmes.

- In the public sector, only accredited facilities or service points will be allowed to dispense ART.

A service point could be a group or network of linked health facilities operating through a hospital or clinic in a defined area. The plan identifies 77 sites, at least one in each health district, which it says should be capable of delivering ART to patients within 12 months. However, considerable technical assistance will be necessary in many of these sites to help them prepare for accreditation. A service point must meet an extensive list of criteria for accreditation. This will prove more difficult in resource-poor settings, and poses considerable problems for ensuring equity of access to treatment.

Within the next five years, the plan calls for the establishment of at least one service point in every municipality in the country an even more arduous challenge.

- The rollout will occur gradually.

Treatment should be rolled out at service points once they are accredited. Within the first year, the goal is to provide ART to at least 50,000 patients, and within five years, ART will be provided to any patient that needs it (estimated to be around one million people).

- Very large numbers of healthcare workers need to be recruited or trained to run the treatment programme.

The plan calls for the recruitment of thousands of health professionals in a country already suffering from a severe shortage of medical personnel. Very few healthcare workers in South Africa have been adequately trained to provide treatment to people with HIV. Training programmes must be designed and implemented with the capacity to supply enough nurses, doctors, laboratory technicians, counsellors and other health workers to staff the service points and related facilities. The Service points can't be accredited without adequate staff.

- Antiretrovirals must be purchased at the lowest price and distribution systems must be upgraded to maintain steady supply of medication.

To find the best priced quality drug, the government is opening a bidding process to potential vendors. Maintaining a consistent drug supply is a particularly serious problem. Last year, supplies of co-trimoxazole and nevirapine solution used for infants in PMTCT programs ran out in some areas. Delays in purchasing or reordering could jeopardize the success of the entire program and the health of the patients. At the same time, the drug procurement process should encourage the development of local pharmaceutical capacity in South Africa to produce essential medicines, including antiretroviral drugs locally at a low cost.

- The capacity of the National Health Laboratory Service must be expanded to match the greater demand in services.

Every service point needs reliable access to laboratory services and in particular, CD4 and viral load testing must become more widely available.

- Patient information systems should be standardised.

An effective and efficient system for data collection, collation, monitoring, and feedback must be established nationwide. Current systems in use by the different provinces may be similar but are not compatible.

- The programme needs to have ongoing robust monitoring and evaluation systems to assess the success of its activities.

The plan calls for monitoring and evaluation of virtually every aspect of the treatment programs implementation and performance. Drug safety and efficacy must also be closely monitored

- Success depends on good communication with the public and within government.

The plan recommends a proactive communications strategy to ensure that all relevant government programmes, health care providers, PLWHA, their families, care-givers and stakeholders are fully knowledgeable about all of the key provisions and requirements of the plan, as well as their respective roles and responsibilities.

- Partnering necessary for uptake of the programme.

Government needs to involve individuals infected and affected by HIV and AIDS to be involved in the design and implementation of communication campaigns. In particular, if government and community based organisations cannot work together and develop campaigns promoting voluntary counselling and testing services, people may not utilise the program and it could cause under or late enrolment just as in the program in Botswana.

- The South African government shall allocate and distribute adequate funds to pay for the program.

The budget starts at 296 million rand for the rest of this fiscal year and rises to approximately 4.5 billion rand per year by fiscal year 2007-08. The South African government claims that it is doing this on its own rather than looking for international aid or public-private partnerships in order to guarantee the sustainability of the program.

- Although the plan is national, much of the implementation depends on the provinces.

Some tasks such as oversight of care, human resource development and training, and the mobilisation of community support groups will be coordinated at the provincial level. Provinces such as the Western Cape, Gauteng and KwaZulu Natal, which each have large urban centres, are better equipped and may be more aggressive in implementing the plan. Less developed provinces may need extra help to manage these tasks as well as to recruit and prepare their service points.

The South African Constitution and government require that implementation of any important programme must be carried out in a universal and equitable manner. The operational plan takes into account of the needs of the historically disadvantaged populations and underserved health districts. Additionally, the operational plan makes it the responsibility of the Department of Health to provide further help in these areas when needed.

- The Strategic Management Team (SMT) has been put in charge of the programmes coordination and implementation.

The SMT consists of all the managers in the Department of Health, and is chaired by the Director-General. This differs markedly from the approach in Botswana where a dedicated implementation team and an operations manager were recruited to spearhead implementation of the MASA project. For the members of the SMT, the shared management of the HIV Treatment and Care Programme is just one of their many responsibilities.

- The plan includes a detailed implementation schedule (known as Annex A) that has not been released to the public.

This annex lists the sequence of tasks that need to be performed to implement this programme successfully. It also proposes a week-by-week initial schedule for the performance of those tasks in order to help ensure that the various actions necessary for successful implementation occur in tandem.

- Successful implementation of the program depends on careful coordination of tasks.

Management failure to execute one part of the plan could jeopardise the whole plan. For example, service points cannot be accredited and thus cannot provide treatment if they cannot hire trained staff. If training programmes with the capacity to train local health care workers are not developed, the programme wont even get started.

Indeed, it seems like there are quite a few variables that can go wrong. The plan admits: A large number of people must complete tasks and their work must be integrated together in a timely fashion for the programme to succeed. The entire programme can be delayed if any of the multiple essential elements of the plan are not executed efficiently.

### Not even out of the starting gate

So far, a little more than two months after its approval, there is little evidence that tasks are being implemented in a timely fashion. No one has received treatment except in the Western Cape, which has little to do with the operational plan because the province had already allocated funds to provide ART on its own. In fact, the drug procurement process has only just begun. This week the government began tendering requests for proposals to drug suppliers to shop around for the best price. Treatment probably wont become available until April.

But aside from the drug supply, Dr. Conradie doesnt think the situation is so bleak. We have been gearing up our system for the roll-outs interacting with people in the national government who are quite actively working on the implementation of the plan.

It should be noted that Dr. Conradie works at what could be considered a flagship site. Still other South African clinicians contacted concur that they are working closely with the Department of Health on improving infrastructure for the rollout. However, one of these, a HATIP panel member who wishes to remain anonymous, said that parts of the Department of Health seem to be in complete disarray and the right hand often doesnt know what the left is doing.

Given the grand scale of the treatment programme and the effort needed to coordinate its implementation, a slow start is perhaps to be expected. But is this merely a slow start, or the first of many such delays? It is very difficult to say, because of one central problem: a lack of communication between the government and the HIV community.

### Storm-SA Brewing

Frustration is building amongst those who actively want to work with government to secure the implementation of the plan.

- Communication Breakdown.

TAC complains that the operational plan commits to communication of its details, but this hasnt happened. Perhaps the government felt that posting most of the operational plan and other materials online on November 19 fulfilled that commitment. However, there has been no further communication about the operational plan since that day. It is somewhat telling that the downloadable copy of the plan posted on the government website is still marked DRAFT Confidential.

- The community has already become disillusioned.

Virtually the day after the operational plans approval, TAC had mobilised to do its part. They began marshalling community -based organisations and other non-governmental organisations to fight stigma, encourage voluntary testing, scale up treatment education, home-based care and other related activities. They believed that the government was acting in good faith and that there would be a new era of cooperation between TAC and the national government. TAC offered an olive branch but has been rebuffed. Now the organisation demands to know what is going on.

- Funds have not been allocated.

According to a recent TAC National Executive Committee report, only R90 million of the R296 million requested by the operational plan for the fiscal year ending March 2004 has been allocated. None of that appears to have been disbursed to the provinces. TAC wants funds disbursed so that the provincial governments can buy ART on their own. They have also asked where is the funding for the provincial responsibilities mandated by the operational plan? These include identifying and preparing service points for accreditation and, perhaps, though it isnt clear, training healthcare staff. Unless the provinces secure funding elsewhere, they can do little to fulfil the tasks laid out by the operational plan, and their capacity to treat people with HIV will remain limited.

- Some provinces still have no local implementation plans.

The Task Force expected some regions to be behind the others. What has the national government done to drive the process?

- Site accreditation problems.

TAC also feels that the accreditation process for service points in the operational plan is unduly onerous and the NEC was reliably informed that sites that were accredited by the operational plan task team are being re-evaluated for accreditation. Is the goal to accredit or discredit sites? What is the national government doing to help these sites become accredited?

Dr. Douglas Wilson agrees that some of the accreditation requirements dont seem to be especially pertinent to South African clinics, particularly the laboratory tests necessary, and seem to be lifted from American sources or worse, antiquated recommendations. CMV serology? Whats the use of that? he asks. Most Africans have been exposed to cytomegalovirus. Similarly Western Blot. The test is no longer used in South Africa.

- Who is training the healthcare workers?

Around the country various groups have Or are developing training programmes locally. In the strategic management chapter of the plan, the responsibility for training seems to be delegated to the provinces. But there have been no appropriated funds disbursed for this purpose, which is crucial if the treatment programme is ever going to provide care to people with HIV outside of a few flagship sites in the nation.

But here as well, there could be a communication breakdown the training section of the plan clearly states that training materials are be designed by the national government which will then launch a massive training programme to be implemented on a national level. If this is what the government is doing or intends to do, it is a little late in the game. Regardless, this should be discussed openly as soon as possible before resources are wasted.

An incident last year is worth mentioning. Various groups in different parts of the country were independently drafting competing South African National HIV treatment guidelines. After months of work, the national government told these groups to stop what they were doing. The guidelines are to be issued instead by the national government.

- Accountability

All too often secrecy is simply a fear of public accountability. Conspicuously, a crucial piece of the operational plan has still not been released to the public: Annex A. This document details the implementation schedule and week-to-week tasks required to implement the treatment program. TAC is calling on the government to make Annex A public.

If the government fails to do this, or does not communicate on its various OP implementation activities, it could look as though little or nothing is being done. Shrouding the implementation schedule in secrecy will not improve the programmes chance of success and could contribute to its failure by allowing mismanagement to continue out of public eyesight.

- Who is driving the process? Where is the leadership?

The operational plan is well designed and doubtless there are many in government working hard to make it happen. But as the task force acknowledged, its implementation can be delayed or undermined if even one strategic manager does not do his or her essential task in a timely manner. Openness or strict oversight by a strong manager or leader who is committed to the programme could prevent such delays and help drive the process. But who is leading the charge for the South African treatment rollout? Who in the government is committed put and keep the plan in motion?

There has hardly been a peep out of the government concerning the plan since it was approved. In his State of the Union address on February 6, 2004, HIV/AIDS was listed by President Mbeki as one of the major challenges facing the nation, but little else was said. It is also worrisome that the policy group South African National AIDS

Council (SANAC), whose membership consists mostly of government officials, and is chaired by the embattled deputy president Jacob Zuma always an advocate for people with AIDS in the government, still hasn't even met to discuss the plan since before it was approved.

As long as the SA National AIDS Council is dysfunctional forget it! Dr. Nyazema says. And as long as there is going to be the urban and rural dichotomy in terms of HIV/AIDS activism forget it!

But he also feels that: People must stop looking at HIV/AIDS through ART. They will miss the bigger picture. If people involved are to see things through the same eyes, any plan has to have a clearly stated objective. I am afraid in this case the opposite is true. On one side people who see the provision of ART as a CIVIL RIGHTS ISSUE and on the other those who see it as A PUBLIC HEALTH CRISIS. Each group is reactionary depending on which side of the fence you belong. HIV/AIDS in South Africa has been politicised ad nauseum.

For those readers outside of South Africa and who may not know, this is an election year in South Africa. When the plan was first announced and approved, leading opposition claimed was a brazen attempt to win votes, or at least defuse/confuse the issue, without any real intention to implement it. And if there is no drive to implement this plan before the election, what can we expect from this administration if it is re-elected?"

As Dr. Ernest Darkoh, operations manager of MASA in Botswana noted during the close of his speech at NHASORC in Gabarone, last December: Finally, management, political will, courage, information, and accountability are more critical than money in the broader scheme."

And ultimately, no matter how well the operational plan was thought out or put together, its chances of success are limited unless someone high up in government gets behind it. If HIV treatment does eventually rollout in the public sector in South Africa, the program is unlikely to be a model for the rest of Africa at least not as long as there its implementation remains cloaked in secrecy.

## about HATIP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

For further information please visit the HATIP section of [aidsmap.com](http://aidsmap.com)